C AND O EMPLOYEES' HOSPITAL ASSOCIATION

RULES AND REGULATIONS
MASTER PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR COMPONENT PLAN SEVEN AND PLAN TEN
("MEDICARE SUPPLEMENTAL HANDBOOK")

October 2020

The Board of Directors of COEHA reserves the right to amend, modify or terminate COEHA and any Plan at any time and from time to time. Receipt of this Medicare Supplemental Handbook does not confer or guarantee eligibility for benefits.

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MEMBER'S RESPONSIBILITIES

- Be considerate and respectful to all COEHA staff and participating providers
- Read all COEHA document materials and ask questions if you do not understand
- Know your benefits
- Provide complete health status information as needed to receive appropriate care
- Respond to letters from COEHA promptly
- Always utilize your membership identification card when seeking healthcare services
- Forward to COEHA any bills you receive more than once for the same services
- Maintain your health and participate in decisions concerning your treatment

IF YOU HAVE ANY QUESTIONS REGARDING BENEFITS, CLAIMS OR ELIGIBILITY UNDER COEHA, CONTACT THE C AND O EMPLOYEES' HOSPITAL ASSOCIATION AT:

C and O Employees' Hospital Association
511 Main Street, 2nd Floor
Clifton Forge, Virginia 24422-1166

Telephone Numbers:
(800) 679-9135 (toll free)
(540) 862-5728 (bell)
(8) 443-1463 (RR)

Fax Numbers:
(540) 862-3552 (claims)
(540) 862-4958 (membership eligibility)

Web site: www.coeha.com

Facebook page: facebook.com/candoemployeeshospitalassociation

Hours of Operation:
Monday through Thursday, 8:30am to 5:00 pm
Friday, 8:30am to 4:00 pm
Lunch daily, 12:00pm to 1:00 pm

INTRODUCTION

The Board of Directors of the C and O Employees' Hospital Association (COEHA) is pleased to provide you with this Medicare Supplemental Handbook, which also serves as the Summary Plan Description and Plan Document. This Medicare Supplemental Handbook describes the supplemental benefits to Medicare provided to eligible former employees by COEHA through Plan Seven and Plan Ten (collectively, "Medicare Supplemental Plans"). The benefits described herein, unless otherwise noted, are provided directly by COEHA. COEHA is a voluntary employees' beneficiary association that provides several different plans of benefits.

Important Plan Information

Name and Address of the Plan
C and O Employees' Hospital Association (COEHA)
511 Main Street, 2nd Floor
Clifton Forge, Virginia 24422-1166

Plan Identification Numbers
Employer Identification Number (EIN): 23-7082348
Plan Number: 501

Administration of Plan
The Plan is self-funded and administered by the Board of Directors of the C and O Employees' Hospital Association (COEHA), which is a voluntary employees' benefit association. COEHA is located at 511 Main Street, 2nd Floor, Clifton Forge, Virginia 24422-1166 (the "COEHA Office"). COEHA is governed by a Board of Directors, and the Board of Directors of COEHA may delegate responsibility for the day-to-day administration to an individual or committee. The Board of Directors has delegated the day-to-day operations of COEHA to the Administrator of COEHA.

Type of Plan
COEHA provides welfare benefits through component plans of benefit. Plan 7 and Plan 10 sponsored by COEHA are Medicare supplemental plans and are welfare benefit plans.

Plan Year
January 1 through December 31

Contributions and Funding
The benefits described in this booklet are provided through contributions through a monthly dues assessment from Members. All assets are held in trust by the Board of Directors for the purpose of providing benefits to eligible Employees and their dependents and for defraying reasonable administrative expenses.

Agent for Service of Legal Process
Michelle Hoke
C and O Employees' Hospital Association
511 Main Street, 2nd Floor
Clifton Forge, Virginia 24422-1166

Plan Eligibility
The types of benefits provided and the Plan's eligibility requirements are fully described in this booklet. There are some circumstances that may result in denial or loss of any benefits that would otherwise be payable, and these are also described in this Medicare Supplemental Handbook. For example, when the Plan's Coordination of Benefits or Subrogation rules apply, benefits may be reduced or eliminated. Also, when you erroneously receive benefits that are not properly payable under the Plan, the Plan may reduce future benefits, to which you would otherwise be entitled, in order to recover a prior overpayment.

Plan Purpose
The C and O Employees' Hospital Association was established in 1897 as a joint effort between the Chesapeake and Ohio Railway Company and its employees to provide certain healthcare benefits for the employees and retirees of the Chesapeake and Ohio Railway Company.

Healthcare benefits will be furnished in accordance with such rules and regulations as may from time to time be approved by the Board of Directors of the C and O Employees' Hospital Association, provided, that at all times the C and O Employees' Hospital Association shall conduct itself strictly as a non-profit organization pursuant to Section 501(c)(9) of the Internal Revenue Code of 1986, as amended.

All benefits are subject to the limitations and exclusions in this Medicare Supplemental Handbook and are payable when determined by the Plan to be medically necessary. **No oral statement of any person shall modify or otherwise affect the benefits, limitations, and exclusions of this Medicare Supplemental Handbook, convey or void any coverage, increase or reduce any benefits under this Plan, or be used in the prosecution or defense of a claim under this Plan.**

COEHA is governed by a Board of Directors, and the current members are:

Director	**Union Affiliation**
Kenneth Farley **President, COEHA** 271 Township Road 1167 Proctorville, Ohio 45669 (304) 638-2343	Local Chairman SMART Transportation Union AT LARGE
Tim Braden **Vice-President, COEHA** 6014 Dee Court Ashland, KY 41102 (606) 923-7407	Local Chairman Brotherhood of Locomotive Engineers AT LARGE
Jonathan Barron **Secretary-Treasurer, COEHA** 17295 Shiloh Church Road Montpelier, VA 23192 (804) 317-4109	Local Chairman SMART Transportation Union ACTIVE

Director	**Union Affiliation**
Glenn Hazelwood **Director, COEHA** 2423 Old Geneva Road Henderson, KY 42420 (270) 454-1616	Yardmaster SMART Transportation Union
Keith Kerley **Director, COEHA** P. O. Box 49 Etowah, TN 37331 (423) 368-1862	General Chairman Brotherhood of Locomotive Engineers
Travis Raynes **Director, COEHA** 3731 Cross Creek Buffalo, WV 25033 (304) 767-8321	General Chairman SMART Transportation Union
Gregory S. Warlitner **Director, COEHA** 1411 Concord St. Selma, VA 24474 (540) 968-1437	Local Chairman Brotherhood of Locomotive Engineers ACTIVE

The **COEHA Administrator:**

Michelle Hoke
michellehoke@coeha.com
C and O Employees' Hospital Association
511 Main Street, 2nd Floor
Clifton Forge, Virginia 24422-1166
(800) 679-9135 (toll free)
www.coeha.com

COEHA MEDICARE MEMBERS – ELIGIBILITY

Individuals eligible to participate in the Plan are: (1) participants in a plan of benefit under COEHA who become eligible for Medicare by virtue of attaining age (65), or by meeting the disability requirements established by the Railroad Retirement Board/Social Security Administration, and (2) other individuals, which the Board of Directors may from time to time identify in writing in its sole discretion, including the individuals listed below, subject to applicable law. When a participant in a plan of benefit under COEHA becomes eligible for one of the COEHA Medicare Supplemental Plans (Plan Seven or Plan Ten), such individual may convert his participation under COEHA to one of the COEHA Medicare Supplemental Plans, at which time he or she will pay the appropriate premium for the Plan. Medicare, provided by the federal government, consists of Part A, which pays for hospital services, and Part B, which pays for physician and other medical services. As a participant in a COEHA Medicare Supplemental Plan, you are required to enroll in Medicare Parts A & B. If you are enrolled in a Medicare Advantage Plan, you **cannot** enroll in Medicare Parts A & B.

The Board of Directors of COEHA has designated the following individuals as eligible to participate in the COEHA Medicare Supplemental Plans:

- **Medicare retiree from any CSX/C&O railroad (all crafts)**
- **Medicare spouse or widow(er) of current or former COEHA member or of any CSX/C&O Railroad**
- **Medicare dependent child of current or former COEHA member or of any CSX/C&O Railroad member on disability**
- **Medicare divorcee of COEHA member or of any CSX/C&O railroad (as long as he or she has not remarried to a Non-COEHA member or CSX/C&O railroader)**
- **Former employee of The Chesapeake and Ohio Hospital in Clifton Forge, Virginia who as of 1976 was participating in a plan of benefit under COEHA, with Medicare coverage**
- **Former employee of The Chesapeake and Ohio Hospital of Huntington, West Virginia who as of 1976 was participating in a plan of benefit under COEHA, with Medicare coverage**

COEHA does not exclude or limit membership based on your health condition.
COEHA is not an attained age or community rated insurer.

Anyone who wishes to participate in one of the Medicare Supplemental Plans must submit an application on COEHA's Medicare Supplemental Enrollment Form. By signing the Medicare Supplemental Enrollment Form, all applicants authorize the Centers for Medicare and Medicaid Services ("CMS") to provide COEHA with information concerning their entitlement to Medicare and their Part B claims history. For a copy of the enrollment form, please contact the COEHA office.

Any member of the C and O Employees' Hospital Association who fails to submit current premiums shall be notified of the delinquency and given ninety (90) days to bring membership status up to date. Failure to comply with this notice will result in termination of coverage under COEHA, retroactive to the date the premium was due.

As a cost containment measure, COEHA has instituted an automatic dues deduction program for monthly membership premiums from your checking account. You may participate in the automatic dues deduction program or you may remit your dues directly to COEHA either monthly, quarterly, semi-annually, or annually. Your check should be made payable to the C and O Employees' Hospital Association and must be received by the 5th of each month. If you choose to participate in the automatic dues deduction program, your premiums will be deducted on the fifth (5th) day of each month unless the 5th of the month is on a weekend or holiday, in which case your premiums will be deducted on the next following business day.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits where other duplicative coverage exists. It applies when the *covered member* is also covered by other insurance or another plan. In no circumstance will COEHA provide duplication of benefits.

The Coordination of Benefits provision applies whether or not a claim is filed under the other insurance or plan. If needed, authorization must be given COEHA to obtain information as to benefits or services available from the other plan or plans, or to recover overpayment.

Definitions

The term "plan" as used herein will mean any plan providing benefits or services for or by reason of medical, vision, or dental treatment, and such benefits or services are provided by:

1. Group insurance or any other coverage arrangement for covered members in a group whether on an insured or uninsured basis, including but not limited to:
    a. Hospital indemnity benefits.
    b. Hospital reimbursement-type plans which permit the covered member to elect indemnity at the time of the claims
2. Hospital or medical service organizations on a group basis, group practice, and other group pre-payment plans.
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision.
4. A licensed Health Maintenance Organization (H.M.O.).
5. A Medicare supplemental plan.
6. Any coverage for students which is sponsored by or provided through a school or other educational institution.
7. Any coverage under a governmental program, and any coverage required or provided by any statute.
8. Group automobile insurance.
9. Individual automobile insurance coverage based upon personal injury protection or medical payments coverage.
10. Individual automobile insurance coverage based upon the principles of "No-Fault" coverage.

The term "plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Order Of Benefit Determination

If a *covered member* is covered under one or more Medicare supplemental plans or policies, whether through a spouse or otherwise, the COEHA Plan will always be secondary to that other policy or plan. Under no circumstances will the COEHA Plan pay duplicate benefits.

If a *covered member* is covered under one or more other plans including, but not limited to, automobile or health insurance, the benefits under this *Plan* incurred in a calendar year will be reduced by the amount of any benefits payable by such other plan so that the total benefits paid will

not exceed 100% of the expenses incurred. COEHA will determine which plan is the primary plan that will pay its benefits first according to the following rules: (1) When only one of the plans has a coordination of benefits provision, then the plan without such a provision will be the primary plan. (2) If both plans have such a provision, the plan under which the *covered member* is covered as an active employee will be the primary plan. (3) If both of the foregoing rules do not establish which plan is the primary plan, then the plan that has covered the person for the longer period of time will be the primary plan.

Example
You are a Medicare member under Plan Seven of COEHA, and you are also a covered beneficiary under your spouse's Medicare supplemental insurance plan. Your spouse's Medicare supplemental insurance plan has covered you and your spouse for three (3) years longer than Plan Seven. As a result, Plan Seven is tertiary coverage to your spouse's coverage and Medicare Parts A and B coverage. Your spouse's insurance or health plan is primary to coverage under Plan Seven.

COEHA MEDICARE PLANS

Plan benefits are highlighted below. For specific benefits, please refer to the section on "Benefits" below.

Plan Seven

Hospital, Medical and Prescription Drug Coverage

- Supplements your Medicare coverage and covers most services paid by Medicare
- Full payment of the Medicare deductibles and/or coinsurance amounts for covered services rendered by providers participating with Medicare
- Effective January 1, 2018, we have contracted with Navitus MedicareRx to administer your Medicare Part D Prescription Drug Plan.

Plan Ten

Hospital and Medical Coverage Only

- Supplements your Medicare coverage and covers most services paid by Medicare
- Full payment of the Medicare deductibles and/or coinsurance amounts for covered services rendered by providers participating with Medicare

COEHA Health Care Prepayment Plan (part of Plan Seven and Plan Ten)

COEHA is contracted as a Health Care Prepayment Plan ("HCPP") with the Center for Medicare and Medicaid Services ("CMS"), the Federal Agency that administers Medicare. This contract authorizes COEHA to pay your Medicare Part B claims to participating providers for office visits and related office services, consultations, hospital visits, x-rays and surgical procedures. When COEHA HCPP receives a participating provider's claim for services, payments for Medicare Part B benefits and your COEHA Medicare Supplemental Plan benefits are made in one check directly to the provider, which eliminates billing Medicare and you. If you are a member of a COEHA Medicare Supplemental Plan, you are automatically enrolled in the COEHA Medicare Health Care Prepayment Plan.

The COEHA HCPP contract with CMS renews annually on January 1st. Either CMS or COEHA may terminate the contract by providing advance notice to each other and to participants in the Medicare Supplemental Plans. If the contract ends, your COEHA Medicare Supplemental Plan benefits will continue to be in force. As a result of any such contract termination, there is no change or temporary loss of access to Medicare Parts A and B. COEHA HCPP members continue to access Medicare Parts A and B whether or not the provider is participating with COEHA. The Board of Directors of COEHA determines only the premium amounts and the benefits that are paid as a supplement to your Medicare coverage under the COEHA Medicare Supplemental Plan.

You may choose to go out-of-network anywhere and at any time using your Medicare benefits. Note, however, that COEHA, as a HCPP, cannot pay the Medicare Part B payments for these non-participating providers. Medicare processes these out-of-network claims directly (not through COEHA). However, your COEHA Medicare Supplemental Plans will pay the deductible and/or coinsurance for these providers in accordance with the level of coverage outlined in this Medicare Supplemental Handbook.

ENROLLMENT PERIOD

The COEHA Medicare Supplemental Plans do not have an open enrollment period. You may enroll in Plan Seven or Plan Ten at any time. For more questions about enrollment, please contact the COEHA office.

DISENROLLMENT

Disenrollment from the COEHA Medicare Supplemental and Medicare HCPP Plans means ending your participation in the Medicare Supplemental Plans.

Voluntary Disenrollment: You may choose to end your membership in the COEHA Medicare Supplemental and HCPP Plans at any time and for any reason by completing "C and O Employee's Hospital Association Disenrollment Form" provided in the attached Appendix A.

Involuntary Disenrollment: Disenrollment from the COEHA Medicare Supplemental and HCPP Plans does not affect your enrollment in original Medicare Part A and B. The following are the only reasons that members may be involuntarily disenrolled by COEHA:

- Failure to abide by the regulations of the COEHA Medicare Supplemental and HCPP Plans, including the provisions outlined in this Medicare Supplemental Handbook.
- Failure to make the required COEHA premium payments. After making a reasonable effort to collect your COEHA dues, COEHA will notify you of the effective date of disenrollment.
- Entitlement and enrollment in Medicare Part A and/or Medicare Part B ends.
- Provision of fraudulent information or misrepresentation on the membership application form that materially affects your eligibility to enroll in the COEHA. CMS considers this to be abuse and COEHA is required to refer the information to the Inspector General, which may result in criminal prosecution.
- Disruptive, unruly, abusive or uncooperative behavior to the extent that COEHA's ability to administer the Plan is impaired.
- Knowingly permitting abuse or misuse of your Medicare Card and/or your COEHA Health Insurance Card. CMS considers this to be abusive and COEHA is required to refer the information to the Inspector General, which may result in criminal prosecution.

Disenrollment from the COEHA Medicare Supplemental and HCPP plans will be effective on the first day of the month following the month COEHA receives the disenrollment form (unless a later date of disenrollment is requested and approved by COEHA).

COEHA NETWORK

To give you the highest quality medical care available, COEHA has an extensive network of healthcare providers. COEHA has an open network, which means you can use the services of providers who belong to our network without first getting a referral from another physician. COEHA accepts any provider who participates and accepts an assignment with Medicare, which means the provider has agreed to accept Medicare's approved charge and they cannot bill the patient for the amount not approved by Medicare.

The existence of an open network does not mean that every service and specialty will automatically be covered. The section on "Benefits" below provides coverage information regarding specific healthcare services.

OUT-OF-NETWORK

You may also seek treatment out-of-network with a provider of your choice, and COEHA will be responsible for the deductible and/or coinsurance not covered by Medicare. **If the provider does not accept an assignment with Medicare, COEHA will be responsible for only the deductible and/or coinsurance, and not the amount which Medicare does not approve. Payment will be directly made to the member instead of the provider.** In most instances, the non-participating provider is allowed to bill the patient for 15% over Medicare's approved charge—this is called the "limiting charge." **As a cost-saving measure, always ask your provider whether they accept assignment with Medicare before receiving services.**

BENEFITS

This section shall apply to all benefits provided under any section of the C and O Employees' Hospital Association Medicare Supplemental Plans (Plan Seven or Plan Ten).

Identification Cards (COEHA & Medicare)

Your COEHA identification card identifies you as a member of COEHA. It contains a unique member identification number which helps COEHA protect you against possible identity theft. You must present this card when you receive medical services. You should make sure the provider copies the front and back of the card. Please have this number available when you call COEHA. Also, please list this number on any correspondence or premium payments sent to COEHA.

Your COEHA membership card does not guarantee coverage of all services or current eligibility. You or your provider can verify your eligibility by contacting COEHA. Should your membership card become lost, stolen or damaged, you can call COEHA with a replacement request at 1-800-679-9135 or locally 1-540-862-5728.

You should also present your red, white and blue Medicare Card when you receive medical services.

Time Limits for Filing Claims for Coverage

All claims for services provided our members must be received within one year from the date the services were rendered to be eligible for payment by COEHA. Also, all corrected rebills should be received within one year from the original denial date to be eligible for payment by COEHA.

How to File Medicare Supplemental Claims

COEHA can process Medicare Parts A and B from the remittance notices received during the crossover from GHI (Medicare COB contractor), and paper claims are no longer required.

If a paper claim is filed, it should be on a UB-04 or CMS-1500 Form, with the appropriate Medicare Remittance Notice and/or other insurance payment record attached, to the following address:

C and O Employees' Hospital Association
511 Main Street, 2nd Floor
Clifton Forge, VA 24422

How to File COEHA HCPP Claims

Providers may file claims on a CMS-1500 Form by mail to the following address:

C and O Employees' Hospital Association
511 Main Street, 2nd Floor
Clifton Forge, VA 24422

Claims may also be filed electronically. COEHA is contracted with Change Healthcare to accept medical claims through Change Healthcare as a Blanket No-Card Payer.

The Payer ID for COEHA is 23708. If you have any questions regarding this process, please call Change Healthcare Customer Solutions at 1-866-371-9066.

Your COEHA benefits supplement your **basic** Medicare benefits. COEHA covers full payment of the Medicare deductible and/or coinsurance amounts for covered services. **Services denied by Medicare are not covered by COEHA.**

Ambulance Services
COEHA will provide medically necessary ambulance service to the nearest treatment facility under **emergency** circumstances when other transportation would endanger your health. In the event necessary specialty service is not available at this facility, COEHA will provide medically necessary ambulance service to the nearest facility where specialty service is available.

Chemo/Radiation Therapy
Covered services.

Chiropractic Services
The Plans cover the deductible and/or coinsurance after Medicare for covered chiropractic services. Medicare Part B covers limited chiropractic services to help correct a subluxation using manipulation of the spine.

Medicare does not cover any other services or tests ordered by a chiropractor (including x-rays or massage therapy).

Durable Medical Equipment
This is equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. COEHA covers certain durable equipment items such as CPAP/BiPAP devices, oxygen, oxygen equipment, wheelchairs, and hospital beds. **It will be at the plan's discretion if the maintenance, repair, or replacement of such items will be covered. Typically, only one of each article is covered.**

Not all durable medical equipment is covered. To qualify for coverage, you must provide certification of medical necessity and related documentation, and preauthorization by COEHA is required. Please contact the COEHA office for specific information on coverage for durable medical equipment.

Effective July 2013, Medicare implemented a National Mail-Order Program for diabetic testing supplies. If you get your diabetic testing supplies by mail, you will need to use a National Mail-Order Program Medicare contract supplier for Medicare and COEHA to pay. Visit **Medicare.gov/supplierdirectory** to find a list of suppliers for your area.

Gastric Bypass/Stomach Stapling/Lap Belt
There is a one-time limit of $25,000 per lifetime. COEHA will cover the deductible and/or coinsurance after Medicare for this procedure. Surgery must be due to a medical necessity and preauthorization by COEHA is required.

Hospitalization
A benefit period begins on the first day you go into the hospital and ends when you have not received any hospital care for 60 consecutive days. If you go to the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

For periods of hospitalization up to 60 days, COEHA will cover the deductible. For the 61st through the 90th day, COEHA will cover the coinsurance not covered by Medicare. For the 91st through the 150th day, (which are your 60 lifetime reserve days), COEHA will pay the balance of covered charges which Medicare does not cover. Services in excess of 150 days (your lifetime reserve days) are not covered by Medicare or COEHA.

Private rooms are covered when it has been determined by the attending physician that it is medically necessary.

COEHA will cover the cost of the first three pints of blood, if used and not replaced, which is your blood deductible.

Private duty nursing is not covered.

Kidney Dialysis
Covered services.

Mental Health
COEHA will cover the deductible and/or coinsurance for services associated with the treatment of mental health **only to the limit of Medicare coverage, subject to Medicare guidelines.**

For mental healthcare (outpatient), Medicare covers mental healthcare services to help with conditions such as depression or anxiety. Coverage includes services generally provided in an outpatient setting, including visits with a psychiatrist or other doctor, clinical psychologist, nurse practitioner, physician's assistant, clinical nurse specialist, or clinical social worker, certain treatment for substance abuse, and lab tests. Certain limits and conditions apply.

For mental healthcare (inpatient), Medicare covers semi-private rooms, meals, general nursing, and drugs as part of your inpatient treatment, and other hospital services and supplies. This includes mental healthcare.

Ophthalmology
Routine eye examinations and refractions for the **purpose** of prescribing glasses or other visual aids which may be required are not covered by COEHA.

Coverage for other services is provided. **Refractions are not covered under any circumstances, since Medicare does not participate in the cost of this expense.**

Organ Transplants
Coverage is provided for human kidney, cornea, bone marrow, liver or heart transplants. **Transplant services must be preauthorized by COEHA**. COEHA does not cover transplant cases which are considered experimental.

Immunosuppressive drugs (anti-rejection drugs) are covered. However, they are not available through your prescription drug program because Medicare will pay for these drugs. They should be purchased through a provider who will file the expense with Medicare and file the deductible and/or coinsurance with COEHA.

Orthotic Devices
These are items serving to protect, restore or improve function. COEHA covers certain orthotic devices such as braces and supports. **Repair, replacement or maintenance of such items is up to the plan's discretion. Typically, only one of each article is covered.**

Not all orthotic devices are covered. To qualify for coverage, you must provide certification of medical necessity and related documentation, and preauthorization by COEHA is required. Please contact the COEHA office for specific information on coverage for orthotic devices.

Outpatient Office Visits, Consultations &Diagnostic Testing
Covered services.

Physical, Occupational & Speech Therapy
Covered services.

Podiatry
COEHA will cover services by a Podiatrist. Arch supports and foot orthotics, such as inserts, are not covered.

Prescription Drugs
Effective January 1, 2018, we have contracted with Navitus MedicareRx to administer your Medicare Part D Prescription Drug Plan.

Prosthetic Devices
This includes artificial substitutes that replace missing body parts. COEHA covers certain prosthetic devices such as artificial limbs, eyes, etc. **Maintenance, repair, or replacement of such items is up to the plan's discretion. Typically, only one of each article is covered, except for breast prosthetics.**

Prosthetic devices also include items used to replace an internal body part or function such as ostomy supplies and parenteral/enteral nutrition therapy. COEHA does cover the balance after Medicare on ostomy supplies; however, parenteral/enteral nutrition therapy is not covered.

Not all prosthetic devices are covered. To qualify for coverage, you must provide certification of medical necessity and related documentation, and preauthorization by COEHA is required. Please contact the COEHA office for specific information on coverage for prosthetic devices.

(See Section on "Reconstructive Surgery Following Mastectomy" for coverage on breast prosthetics.)

Reconstructive Surgery Following Mastectomy
In accordance with the Women's Health and Cancer Rights Act of 1998 (WHCRA), COEHA provides coverage, in the case of a member who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, (i) all stages of reconstruction of the breast on which the mastectomy has been performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prostheses and physical complications of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient. Such coverage is subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the Plan. Plan limits, deductibles, copayments, and

coinsurance apply to these benefits. For more information on WHCRA benefits, contact the COEHA Office.

Removal of Excess Skin After Gastric Bypass or Extreme Weight Loss/Tummy Tuck
There is a one-time limit of $7,500 per lifetime. COEHA will cover the deductible and/or coinsurance after Medicare for this procedure. Surgery must be due to a medical necessity, and preauthorization by COEHA is required.

Skilled Nursing Facility Care
Medicare defines "Skilled Nursing Facility (SNF) Care" as skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Medicare covers semi-private rooms, meals, skilled nursing and rehabilitative services, and other services and supplies that are medically necessary after a **three-day minimum medically necessary inpatient hospital stay** for a related illness or injury. An inpatient hospital stay begins the day you are formally admitted with a doctor's order and does not include the day you are discharged. To qualify for care in a skilled nursing facility, your doctor must certify that you need daily skilled care like intravenous injections or physical therapy. Medicare does not cover long-term care or custodial care.

COEHA will cover the balance after Medicare for SNF. COEHA will not cover skilled care if you do not meet Medicare's requirements. COEHA will not cover skilled care once your Medicare coverage is exhausted.

COEHA does not cover custodial care. Custodial care is care that helps you with usual daily activities like walking, eating, or bathing.

COEHA does not cover long-term care facility charges. Long-term care is a variety of services that help people with health or personal needs and activities of daily living over a period of time. Most long-term care is custodial care.

Effective January 1, 2008, COEHA will cover the deductible and/or coinsurance after Medicare for certain medical services provided a member while a resident in a long-term nursing home facility, such as physician visits and physical therapy.

Transgender Services
Effective January 1, 2017, coverage is provided for transgender services.

Exceptional Cases
Cases may arise involving medical care that is not specified in this Medicare Supplemental Handbook. In these cases, contact the COEHA Office for specific coverage information.

ADVANCE DIRECTIVE

You can decide in advance what medical treatment you want to receive if you become physically or mentally unable to communicate your wishes. You can do this by preparing an Advance Directive.

An Advance Directive is a written document which states your choice about medical treatment. It can also designate someone else to make medical decisions for you, if you are unable to make these choices yourself. This document is called an Advance Directive because it is signed in advance to let your doctor know your wishes concerning medical treatment. You do not have to have an Advance Directive if you do not want one.

The laws for Advance Directives differ from state to state. There are different types of advance directives and different names for them depending on your state or local area. For example, documents called "living will" and "power of attorney for healthcare" are examples of advance directives. If you are interested in obtaining Advance Directive information for the state in which you reside, please contact us, and the COEHA office will send you the appropriate information.

It is your choice whether you want to fill out an advance directive. The law forbids any discrimination against you in your medical care based on whether you have an advance directive or not.

EXCLUSIONS

The following services are not covered by C and O Employees' Hospital Association—this does not mean that Medicare does not cover all of these services.

- Acupuncture
- Appliances used in birth control
- Arch supports and foot orthotics
- Blood pressure monitor
- Charge for completion of insurance papers, reports, etc.
- Cochlear implants
- Compression stockings
- Cosmetic/Reconstructive surgery, except for repair or alleviation of damage to the member caused solely by bodily injury while the member is covered and except for breast reconstruction following a mastectomy covered by the Plan.
- Custodial or long-term care (except as defined in the Skilled Nursing Facility Section of this Handbook)
- Dental services
- Dependent child's pregnancy or the resulting childbirth, abortion or miscarriage
- Evaluation and studies performed in connection with litigation
- Experimental procedures
- Eye refractions
- Family counseling
- Fertility drugs
- Fertility procedures and tests
- Glasses or other visual aids, including glasses after cataract surgery
- Half-way house
- Hearing aids and exams for fitting them /batteries for such
- Home Health nursing visits
- Instructional booklets or videos
- In vitro fertilization, embryo transfer procedures, artificial insemination, immunotherapy for treatment of infertility
- Marriage counseling
- Medical services or testing provided a member incident to treatment of a spouse and/or dependent
- Membership to YMCA or other fitness organizations
- On-duty injuries that occur while working and receiving compensation from a person, firm, company, or organization other than the CSXT and/or subsidiaries and affiliated companies
- Outpatient self-administered drugs
- Personal convenience items (television, radios, telephone calls, guest trays, private room differential, etc.)
- Pharmacy Consultations
- Physician certification and re-certification for home health and hospice services
- Physician supervision of home health and hospice services
- Prescribed drugs and/or items which can be purchased over-the-counter (with the exception of Nexium OTC, Zyrtec OTC, Claritin OTC and some Low-to Moderate-Dose Statins)

- Radial Keratotomy/Lasik Surgery

- Retin-A
- Reversal of sterilization
- Sales tax; shipping and handling for medical supplies
- Services that are not reasonable and customary under the Original Medicare program standards
- Special lift chairs, or separate chair lift for patient owned furniture, geriatric chairs
- Special shoes (including diabetic shoes), unless they are attached to braces; shoe lifts
- Supplemental feeding (parenteral/enteral nutrition therapy) and feeding supply kit
- Transfer bench/shower chair
- Treatment outside of the United States (unless your circumstances fall under the Medicare exceptions category for travel)
- Treatment rendered by a family member (spouse, mother, father, children, sister, brother, in-laws, grandparents, grandchildren, etc.)
- Vaccines (except for tetanus when medically necessary—some vaccines may be covered under the Navitus MedicareRx Prescription Drug Plan)
- Water beds
- Work hardening through physical therapy

SUBROGATION AND REIMBURSEMENT

Benefits Subject to this Provision
This provision shall apply to all benefits provided under any section of the C and O Employees' Hospital Association Plan.

Statement of Purpose
Subrogation and *reimbursement* represent significant C and O Employees' Hospital Association Plan assets and are vital to the financial stability of the Plan. *Subrogation* and *reimbursement* recoveries are used to pay future claims for other C and O Employees' Hospital Association members. Anyone in possession of these assets holds them as a fiduciary and constructive trustee for the benefit of C and O Employees' Hospital Association**.** The Plan Administrator has a fiduciary obligation under ERISA to pursue and recover these Plan assets to the fullest extent possible.

Definitions
"Another Party"
"A*nother party*" shall mean any individual or entity, other than C and O Employees' Hospital Association, who is liable or legally responsible to pay expenses, compensation or damages in connection with a *covered member's* injuries or illness.

"*Another party*" shall include the party or parties who caused the injuries or illness; the liability insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a *covered member's* own insurance coverage, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other insurer; a workers' compensation insurer; governmental entity or any other individual, corporation, association or entity that is liable or legally responsible for payment in connection with the injuries or illness.

"Covered Member"
A "*Covered Member*" shall mean any person, dependents or representatives, other than C and O Employees' Hospital Association**,** who is bound by the terms of the Subrogation and Reimbursement Provision herein.

A "*Covered Member*" shall include but is not limited to any beneficiary, dependent, spouse or person who has or will receive benefits under a plan of the C and O Employees' Hospital Association, and any legal or personal representatives of that person, including parents, guardians, attorneys, trustees, administrators or executors of an estate of a covered member, and heirs of the estate.

"Recovery"
"*Recovery*" shall mean any and all monies identified or paid to the *covered member* through or from *another party* by way of judgment, award, settlement, covenant, release or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the *injuries* or *illness*. A *recovery* exists as soon as any fund is identified as compensation for a *covered member* from *another party*. Any *recovery* shall be deemed to apply, first, for *reimbursement* of C and O Employees' Hospital Association's lien.

"Subrogation"
"*Subrogation*" shall mean C and O Employees' Hospital Association's right to pursue the *covered member's* claims for medical or other charges paid by the Plan against *another party*.

"Reimbursement"
"*Reimbursement*" shall mean repayment to C and O Employees' Hospital Association of recovered medical or other benefits that it has paid toward care and treatment of the injury or illness for which there has been a *recovery*.

Plan Administrator Discretion
The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

When this Provision Applies
A *covered member* may incur medical or other charges related to injuries or illness caused in part or in whole by the act or omission of the *covered member* of another person; or *another party* may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness. If so, the *covered member* may have a claim against that other person or *another party* for payment of the medical or other charges. In that event, the C and O Employees' Hospital Association Plan will be secondary, not primary. The *covered member* agrees, if charges are paid by C and O Employees' Hospital Association, to transfer all rights to recover damages in full to C and O Employees' Hospital Association.

Duties of the Covered Member
When a right of recovery exists, and as a condition to any payment by C and O Employees' Hospital Association (including payment of future benefits for other illnesses or injuries), the *covered member* will execute and deliver all required instruments and papers, including a subrogation and reimbursement agreement provided by C and O Employees' Hospital Association as well as doing and providing whatever else is needed, to secure C and O Employees' Hospital Association's rights of *subrogation* and *reimbursement*, before any medical or other benefits will be paid by C and O Employees' Hospital Association for the injuries or illness. The Plan Administrator may determine, in its sole discretion, that it is in C and O Employees' Hospital Association's best interests to pay medical or other benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, C and O Employees' Hospital Association still will be entitled to *subrogation* and *reimbursement*. In addition, the *covered member* will do nothing to prejudice C and O Employees' Hospital Association's right to *subrogation* and *reimbursement* and acknowledges that the Plan precludes operation of the make-whole and common fund doctrines. A *covered member* who receives any *recovery* (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the portion of the *recovery* subject to the Plan's lien to C and O Employees' Hospital Association under the terms of this provision. A *covered member* who receives any such *recovery* and does not immediately tender the *recovery* to C and O Employees' Hospital Association will be deemed to hold the *recovery* in constructive trust for C and O Employees' Hospital Association, because the *covered member* is not the rightful owner of the *recovery* and should not be in possession of the *recovery* until C and O Employees' Hospital Association has been fully reimbursed.

The *covered member* must:

- Execute and deliver a subrogation and reimbursement agreement, if requested by the Plan Administrator;

- Authorize C and O Employees' Hospital Association to sue, compromise and settle in the *covered member's* name to the extent of the amount of medical or other benefits paid for the injuries or illness under the C and O Employees' Hospital Association Plan and the

expenses incurred by C and O Employees' Hospital Association in collecting this amount, and assign to C and O Employees' Hospital Association the *covered member's* rights to *recovery* when this provision applies;

- Include the benefits paid by C and O Employees' Hospital Association as a part of the damages sought against another party. Immediately reimburse C and O Employees' Hospital Association, out of any *recovery* made from *another party*, the amount of medical or other benefits paid for the injuries or illness by C and O Employees' Hospital Association up to the amount of the *recovery* and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;

- Notify C and O Employees' Hospital Association in writing of any proposed settlement and obtain C and O Employees' Hospital Association's written consent before signing any release or agreeing to any settlement; and

- Cooperate fully with C and O Employees' Hospital Association in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by C and O Employees' Hospital Association.

First Priority Right of Subrogation and/or Reimbursement

Any amounts recovered will be subject to *subrogation* or *reimbursement*. In no case will the amount subject to *subrogation* or *reimbursement* exceed the amount of medical or other benefits paid for the injuries or illness under the Plan and the expenses incurred by C and O Employees' Hospital Association in collecting this amount. The Plan will be *subrogated* to all rights the *covered member* may have against that other person or *another party* and will be entitled to first priority *reimbursement* out of any *recovery* to the extent of the Plan's payments. In addition, C and O Employees' Hospital Association shall have the first priority lien against any *recovery* to the extent of benefits paid and to be payable in the future. C and O Employees' Hospital Association's first priority lien supersedes any right that the *covered member* may have to be "made whole." In other words, C and O Employees' Hospital Association is entitled to the right of first *reimbursement* out of any *recovery* the *covered member* procures or may be entitled to procure regardless of whether the *covered member* has received full compensation for any of his or her damages or expenses, including attorneys' fees or costs; and regardless of whether or not the recovery is designated as payment for medical expenses or otherwise. Additionally**,** C and O Employees' Hospital Association's right of first *reimbursement* will not be reduced for any reason, including attorneys' fees, costs, comparative or contributory negligence, limits of collectability or responsibility, characterization of recovery as pain and suffering or otherwise. As a condition to receiving benefits under the Plan, the *covered member* agrees that acceptance of benefits is constructive notice of this provision.

When a Covered Member Retains an Attorney

The *covered member's* attorney should recognize that this section precludes the operation of the "make-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine against C and O Employees' Hospital Association in his pursuit of *recovery*. The Plan will not pay the *covered member's* attorneys' fees and costs associated with the recovery of funds, nor will it reduce its reimbursement pro rata for the payment of the *covered member's* attorneys' fees and costs.

An attorney who receives any *recovery* (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the *recovery* to C and O Employees' Hospital Association under the terms of this provision. As a possessor of a portion of the

recovery, the *covered member's* attorney holds the *recovery* as a constructive trustee and fiduciary and is obligated to tender the *recovery* immediately over to the Plan. A *covered member's* attorney who receives any such *recovery* and does not immediately tender the *recovery* to C and O Employees' Hospital Association will be deemed to hold the *recovery* in constructive trust for C and O Employees' Hospital Association, because neither the *covered member* nor his attorney is the rightful owner of the portion of the *recovery* subject to C and O Employees' Hospital Association's lien.

When the Covered Member is a Minor or is Deceased or Incapacitated

The provisions of this subrogation and reimbursement provision apply with equal force to the parents, trustees, guardians, administrators, or other representatives of a minor *covered member* and to the heirs or personal and legal representatives of the estate of a deceased or incapacitated *covered member*, regardless of applicable law and whether or not the representatives have access or control of the *recovery*. No representative of a *covered member* listed here may allow proceeds from a *recovery* to be allocated in a way that reduces or minimizes the C and O Employees' Hospital Association's claim by arranging for others to receive proceeds of any judgment, award, settlement, covenant, release or other payment; or releasing any claim in whole or in part without full compensation therefore.

When a Covered Member Does Not Comply

When a *covered member* does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the *covered member* and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the C and O Employees' Hospital Association Plan by the amount due as a dollar for dollar satisfaction for the *reimbursement* to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by C and O Employees' Hospital Association, subject to applicable law**.** The reductions will equal the amount of the required *reimbursement*. If C and O Employees' Hospital Association must bring an action against a *covered member* to enforce the provisions of this section, then that *covered member* agrees to pay C and O Employees' Hospital Association's attorneys' fees and costs, regardless of the action's outcome.

Recovery of Future Benefits

In certain circumstances, a *covered member* may receive a *recovery* that exceeds the amount of C and O Employees' Hospital Association's payments for past and/or present expenses for treatment of the illness or injury that is the subject of the *recovery.* In other situations, a *covered member* may have received a prior recovery that was intended, in part or in whole, to be compensation for future expenses for treatment of the illness or injury that is the subject of a current claim for benefits under the Plan. In these situations, the Plan will not cover any present or future expenses related to the illness or injury for which compensation was provided through a current or previous *recovery*. The *covered member* is required to submit full and complete documentation of any such *recovery* in order for C and O Employees' Hospital Association to consider eligible expenses that exceed the *recovery.* To the extent a *covered member's recovery* exceeds the amount of the C and O Employees' Hospital Association's lien, the Plan is entitled to a credit or cushion in that amount against any claims for future benefits relating to the illness or injury. In those situations following any *recovery* that exceeds the amount of C and O Employees' Hospital Association's lien, the *covered member* will be solely responsible for payment of medical bills related to the illness or injury out of the remaining *recovery*. The Plan also precludes operation of the make-whole and common fund doctrines in applying this provision.

The Plan Administrator has sole discretion to determine whether expenses are related to the *illness* or injury to the extent this provision applies. Acceptance of benefits under the C and O Employees' Hospital Association Plan for an illness or injury which the *covered member* has already received a *recovery* may be considered fraud, and the *covered member* will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate, including denial of present or future benefits under the Plan.

ADMINISTRATION OF THE PLAN

Discretionary Rights and Duties

The Plan Administrator is the named fiduciary of the Plan for all purposes except claim appeals, as specified in the Claims and Appeals Procedure. As fiduciary, the Plan Administrator maintains discretionary authority with respect to those responsibilities for which it has been designated a named fiduciary, including, but not limited to, interpretation of the terms of the Plan, and determining eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan; any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Authority of the Board of Directors of COEHA

The Board of Directors of COEHA has sole authority to make final determinations regarding any application for benefits. The Board of Directors also has sole authority over the interpretation of the Medicare Supplemental Handbook and any other regulations, procedures or administrative rules adopted by the Board of Directors. Benefits under COEHA will be paid only if the Board of Directors or persons delegated by them decide, in their discretion, that the member or beneficiary is entitled to benefits under the terms of the Plan. The Board of Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from COEHA. If a decision of the Board of Directors is challenged in court, it is the intention of the parties to the Trust that the Board of Directors' decision is to be upheld unless it is determined to be arbitrary or capricious.

Benefit Rights Not Vested

No one has a vested (that is, non-forfeitable) right to future coverage under COEHA or to the continuation of any given benefit under COEHA. The Board of Directors has the right to modify or discontinue any benefit or any component of any Plan, at any time and from time to time. The Board of Directors also has the right to terminate COEHA.

AMENDMENT

The Board of Directors of the C and O Employees' Hospital Association has the sole right to amend the benefits and plans provided by COEHA. Any such amendments shall be in writing, setting forth the modified provisions of the Plan**,** the effective date of the modifications, and shall be approved by a majority of the Board of Directors and signed by the President of the Board of Directors.

Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with the C and O Employees' Hospital Association, or a written copy thereof shall be deposited with such master copy of the Plan. Appropriate filing and reporting of any such modification or amendment with governmental authorities and to covered members shall be timely made by the C and O Employees' Hospital Association.

To the extent permitted by law, any such amendment or termination may take effect retroactively or otherwise. In the event of a termination or reduction of benefits, COEHA shall be liable only for benefit payments due and owing as of the effective date of such termination or reduction and no payments scheduled to be made on or after such effective date shall result in any liability to COEHA or the Board of Directors.

INTERNAL GRIEVANCE PROCESS

Grievances

COEHA maintains an internal grievance process through which members may seek resolution of grievances other than claims denials or adverse organization determinations. Grievances involving other than claims denials or adverse organization determinations may be resolved only through COEHA's internal grievance process. Examples of such grievances include:

- complaints about waiting times, physician demeanor and behavior, or adequacy of healthcare facilities
- quality of care issues
- change in premiums
- getting through to us on the telephone
- rudeness
- involuntary disenrollment issues
- materials that you get from our plan
- respecting your privacy (HIPAA)
- if you requested an expedited or "fast" response for a coverage decision or a reconsideration of a coverage decision and the COEHA Office has said it will not grant the expedited response

If you have a complaint, please contact the Customer Service Department at 1-800-679-9135. The professional staff of COEHA will try to resolve any complaint that you might have over the phone. If COEHA cannot resolve your complaint over the phone, please follow the formal procedure described below.

Procedures

Filing of Grievances

If you have a complaint involving other than a claims denial or an adverse organization determination, you may file a written grievance with the COEHA Office within 60 days of the event underlying the complaint. The written grievance must include your name, address and a full explanation of your complaint, including specific dates, persons, places and events relevant to your complaint. Please include supporting documentation, if any, when filing your written grievance.

Internal Committee Review

After your written grievance is received, the Administrator will review your grievance for completeness. If the Administrator does not think the grievance is complete, they can request additional information from you. Once the Administrator deems your grievance complete, they will refer your grievance to an Internal Committee of the Administrator and other COEHA administrative staff members appointed by the Administrator as appropriate and as needed. The

Internal Committee may include among its members COEHA administrative staff member(s) from the department relevant to your complaint. For example, if your grievance involves an involuntary disenrollment issue, at least one of the Internal Committee members shall be from COEHA's Retired Dues Department. If your grievance involves a complaint about physician demeanor or behavior, at least one of the Internal Committee members shall be from COEHA's Credentialing Department.

The Internal Committee will review your complaint and make a decision within 30 days of the Administrators' receipt of the grievance, unless special circumstances (such as the need for additional information and the delay is in your best interest) require an extension. If such an extension is necessary, COEHA can take up to 14 more days (44 calendar days total) to answer your complaint and COEHA will notify you in writing of the delay. Once a decision has been made, COEHA will notify you in writing of the Internal Committee's findings and resolution of the complaint.

Finance Committee Review
If you do not agree with the Internal Committee's decision, you may request that it be reviewed by the Finance Committee of the Board of Directors. To do so, you must submit a written request for Finance Committee review to the Administrator within 10 days of receiving the Internal Committee's decision. The Administrator will then forward your grievance file to the Finance Committee for review. The Finance Committee will review the grievance file and make a decision within 30 days of receiving the grievance file, unless special circumstances (such as the need for additional information and the delay is in your best interest) require an extension. If such an extension is necessary, COEHA can take up to 14 more days (44 calendar days total) to answer your complaint and COEHA will notify you in writing of the delay. Once a decision has been made, COEHA will notify you in writing whether the Finance Committee approves or disapproves (in whole or in part) the Internal Committee's decision, and, if appropriate, will set forth the Finance Committee's findings and resolution of the complaint.

Expedited Grievance/Fast Complaint
If you are making a complaint because COEHA denied your request for a "fast response" to a coverage decision or appeal, COEHA will automatically give you a "fast" complaint (expedited grievance). If you have a "fast" complaint, it means COEHA will give you an answer within 24 hours.

Decisions of the Finance Committee are final.

Whether you call or write, you should contact the COEHA Customer Service Department right away. The complaint must be made within 60 calendar days after you had the problem you want to complain about.

COMPLAINTS TO A QUALITY IMPROVEMENT ORGANIZATION

You can also file a complaint about quality of care to a Quality Improvement Care Organization ("QIO"). A complaint to the QIO is separate and distinct from the internal grievance described above.

The QIO is a group of practicing doctors and other healthcare experts paid by the Federal government to check and improve the care given to Medicare patients.

When your complaint is about quality of care, if you prefer, you can make your complaint directly to this organization (without making the complaint to us).

To find the name, address and phone number of the QIO in your state, visit www.medicare.gov/contacts to get your QIO's phone number. You can also call 1-800-MEDICARE (1-800-633-4227). COEHA will cooperate with QIO in resolving the complaint.

APPEAL PROCEDURES: TWO TYPES

This provision shall apply to all benefits provided under any section of the C and O Employees' Hospital Association Medicare Supplemental Plan or Health Care Prepayment Plan.

There are two types of appeal procedures for our Medicare members. The first appeal procedure listed under the heading, "Appeal Rights and Procedures for COEHA Medicare HCPP Enrollees," deals with your appeal procedure for the amount Medicare denied when services were rendered by COEHA network physicians and when COEHA processed this Medicare Part B claim. In this instance, you would utilize the first appeal procedure. A copy of this appeal procedure will be attached to your written notice of denial.

The second appeal procedure listed under the heading, "Claims and Appeals Procedure for Supplemental Medicare Coverage," deals with your appeal procedure for the coinsurance and/or deductible amounts or for non-covered services. For example, Medicare covers physician services provided in a nursing home; however, COEHA does not unless you are receiving skilled nursing facility care as defined in this Handbook. If you wish to appeal COEHA's denial of the coinsurance, deductible amounts and/or non-covered services, you would utilize the second appeal procedure. A copy of this appeal procedure will be attached to your written notice of denial.

Outline of Appeal Procedures for COEHA Medicare HCPP Enrollees

For your convenience, listed below are step by step directions on how to file a reconsideration request for service or payment of the Medicare Part B portion of your claim for HCPP members. There are six possible steps for requesting care or payment for care you can take to request the care or payment you want from COEHA. At each step, your request is considered and a decision is made. If you are unhappy with the decision, there may be another step you can take if you want to continue requesting the care or payment. These six steps are summarized below. **These same six steps are covered in more detail under Appeal Rights and Procedures for COEHA Medicare HCPP Enrollees.**

In Steps 1 and 2, you make your request directly to COEHA. The COEHA Office reviews it and gives you our decision.

In Steps 3 through 6, people in organizations that are not connected to COEHA make the decisions about your request. To keep the review independent and impartial, those who conduct the review and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

The six possible steps are summarized below:

Step 1: The initial decision by COEHA

The starting point is when COEHA makes an "initial decision" (also called an "organizational decision") about your medical care or about paying for care you have already received. When COEHA makes an "initial decision," COEHA is giving its interpretation of how the benefits and services that are covered for members of COEHA apply to your specific situation.

Step 2: Appealing the initial decision by COEHA
If you disagree with the decision made in Step 1, you may ask for reconsideration of the decision. This is called an **"appeal"** or a "request for reconsideration." After reviewing your appeal, COEHA will decide whether to stay with our original decision or change this decision and give you some or all of the care or payment you want.

Step 3: Review of your request by an Independent Review Organization
If your request in Step 2 is denied, COEHA is **required** to send your request to an independent review organization that has a contract with the federal government and is not part of COEHA. This organization will review your request and make a decision about whether COEHA must give you the care or payment you want.

Step 4: Review by an Administrative Law Judge
If you are unhappy with the decision made by the organization that reviews your case in Step 3, you may ask for an **Administrative Law Judge** to consider your case and make a decision. The Administrative Law Judge works for the federal government. The dollar value of your medical care must be at least a certain amount to be considered in Step 4. The amount in controversy for the 2021 calendar year is $180.

Step 5: Review by the Medicare Appeals Council ("MAC")
If you or COEHA are unhappy with the decision made in Step 4, you or COEHA may ask for the **Medicare Appeals Council** to review your case. This Board is part of the federal department that runs Medicare.

Step 6: Judicial Review
If you or COEHA are unhappy with the decision made by the Medicare Appeals Council in Step 5, either you or COEHA may be able to file a civil action in a district court of the United States. The dollar value of your medical care must be at least a certain amount to go to a district court. For 2021, the amount in controversy is $1,760.

Appeal Rights and Procedures for COEHA Medicare HCPP Enrollees
COEHA HCPP is responsible for your appeal if COEHA HCPP paid your original Medicare Part B claim for benefits. COEHA HCPP appeals involve your Medicare Part B claims for services that you have already received and you are disputing the payment amount or denial of payment. Remember, COEHA only pays Medicare Part B claims for COEHA participating physician office visits and office services, consultations, hospital visits, x-rays and surgical procedures if the claim is sent to us.

You, your representative, or a participating physician may appeal the payment amount or denial of payment made by COEHA HCPP within 60 days of the time the original claim was processed. The appeal must be made in writing. COEHA recommends that any additional information that may help your appeal be submitted to us at the time of the written request. COEHA will never perform this type of appeal for Medicare Part A services, or nonparticipating provider (out-of-network) services because COEHA HCPP would not have processed the original Medicare claim.

You have a right to appeal
You can appeal if you do not agree with COEHA HCPP decisions about payment of your Medicare Part B claims that were originally paid by us. You have a right to appeal if you think that COEHA HCPP has not paid a bill or has not paid a bill in full. Your appeal will apply to payment of claims for services that have already been received by you.

60-day appeal process
If you want to file an appeal request that will be processed within 60 days, do the following:

File your request within 60 days of the date of the notice of our initial decision. Mail or deliver your written appeal request to the following address:

COEHA
511 Main Street, 2nd Floor
Clifton Forge, VA 24422

You may send your written appeal to your local Railroad Retirement Board office or your local Social Security Administration office if you are a Social Security retiree.

Fax your written request to COEHA HCPP at (540) 862-3552 or (540) 862-4958.

For additional information on filing your appeal, read the sections below entitled "Support for Your Appeal" and "Who May File an Appeal."

If You File Your Appeal with the Railroad Retirement Board or Social Security Administration
If you file your appeal request with the Railroad Retirement Board office or Social Security office, they will transfer it to COEHA HCPP. This could cause some delay for you because COEHA is responsible for processing your appeal request within 60 days from the date of receipt.

If COEHA Does Not Rule Fully In Your Favor
If COEHA does not rule fully in your favor, and you could have any financial responsibility on the claim(s) that were appealed, COEHA will forward your appeal to MAXIMUS Federal Services, the independent review organization for the Center for Medicare and Medicaid Services, for a decision.

Review by an Administrative Law Judge
If you are unhappy with the decision made by the organization that reviews your case, you may ask for an Administrative Law Judge to consider your case and make a decision. The Administrative Law Judge works for the federal government. The dollar value of your medical care must be at least a certain amount to be considered. The amount in controversy for the 2021 calendar year is $180.

Review by a Medicare Appeals Council
If you or COEHA is unhappy with the decision made by the Administrative Law Judge, either party may be able to ask the Medicare Appeals Council to review your case.

Judicial Review
If you or COEHA is unhappy with the decision made by the Medicare Appeals Council, either party may be able to file a civil action in a district court of the United States. The dollar value of your contested medical care must be at least a certain amount to go to a district court. For 2021, the amount in controversy is $1760.

Support For Your Appeal
You are not required to submit additional information to support your appeal. However, if you include additional information to clarify or support your position it may help your appeal. You

may want to include supportive information such as medical records or physician opinions. To obtain medical records, send a written request to your physician. If you have seen other specialist physicians, you may need to make a separate written request for your medical records to each of the specialist physicians who provided medical services for you.

Who May File An Appeal
You, the COEHA participating physician who provided your services, a court appointed guardian or an agent under a healthcare proxy (to the extent provided under state law) can file an appeal request.

You may appoint a representative to file the appeal request for you. Please refer to the section entitled "Representative Filing On Behalf Of The Member." **A signed representative form must be included with each appeal.**

COEHA HCPP Standard Pre-Service Organization Determinations
This type of appeal applies only if the service has not yet been provided, and does not apply to services that have already been provided or claims that have been processed. If the services have already been performed, one of the previously described appeals processes applies.

COEHA HCPP pre-service organization determinations only affect approval of original Medicare Part B payment for services COEHA normally processes. If the claim is not sent to the COEHA HCPP for processing after approval is given, the claim could be denied.

COEHA HCPP approval does not guarantee Medicare payment from Railroad Medicare (Palmetto GBA) or Medicare Part A intermediaries, or that the service is a covered benefit under the COEHA Medicare Secondary Plan.

If COEHA or an HCPP COEHA physician denies a service to you and you believe it is a medically necessary covered benefit under original Medicare Part B, COEHA HCPP will make a standard 30-day pre-service organization determination (an appeal). COEHA may extend the time frame up to 14 calendar days if you request the extension or if COEHA needs additional information and the delay is in your best interest. If such an extension is necessary, COEHA will notify you in writing of the delay.

Certain stipulations must be met in order to qualify for a COEHA HCPP standard pre-service 30-day organization determination. The service must be:

- Denied or discontinued by a COEHA participating physician.
- A service that would be processed by COEHA HCPP if COEHA were to receive the Medicare claim (such as participating physician office and hospital visits, and surgical services).
- A service the member believes is medically necessary and a covered benefit under original Medicare Part B.

COEHA does **not** perform pre-service organization determinations for those services that would not be processed by COEHA HCPP.

COEHA HCPP Expedited Pre-Service Organization Determination
Expedited decisions may not be requested for cases in which the only issue involved a claim for payment for services that you have already received.

You or **any** physician may request that COEHA expedites a reconsideration of an organization determination in situations where applying the standard procedure could seriously jeopardize your life, health, or ability to regain maximum function.

If COEHA decides that it is a time-sensitive situation, or if any physician states that it is one, COEHA will make a decision on your request for a service on a fast (expedited) 72-hour basis. Fast decisions only apply to a service that has been denied to you by COEHA, a COEHA HCPP physician or a COEHA HCPP physician who wants to discontinue a service that you are receiving and you believe it is medically necessary and a covered benefit under original Medicare Part B.

COEHA may extend this time frame by up to 14 calendar days if you request the extension or if COEHA needs additional information, and the extension of time benefits you. For example, COEHA may need additional medical records from medical providers that could change a denial decision. COEHA must make a decision as expeditiously as your health requires, but no later than the end of any extension period. If such an extension is necessary, COEHA will notify you in writing of the delay.

If COEHA denies your request for reconsideration of an expedited organization determination, COEHA will automatically transfer the request to the standard time frame and make a determination within 30 calendar days.

You have the right to file an expedited grievance if you disagree with our determination not to expedite the appeal.

Where to submit your pre-service appeal request
To request a COEHA HCPP standard or expedited pre-service appeal, you or your authorized representative may call, write, fax, email, or visit COEHA. **If you want an expedited determination, you must specifically state this at the time of your request.**

Mail or deliver your pre-service appeal to the following address:

COEHA
511 Main Street, 2nd Floor
Clifton Forge, VA 24422

Fax your written pre-service appeal to COEHA at 1-540-862-3552 or 1-540-862-4958.

Telephone your pre-service appeal request to COEHA Customer Service at 1-800-679-9135 or if you are local at 862-5728, Monday through Friday from 8:30 am to 5:00 pm (EST).

Forwarding Your Case to the Independent Review Contractor

If COEHA makes an adverse organization determination, COEHA will forward your case to the Center for Medicare and Medicaid Services independent review contractor, MAXIMUS Federal Services, for a decision. COEHA will notify you that it has forwarded your case to the independent review contractor.

Outline of Appeal Procedures for Supplemental Medicare Coverage

For your convenience, listed below are step by step directions on how to file an appeal for the coinsurance and/or deductible portion of your claim or to file a claim regarding non-covered services. For more detail, please refer to the procedure listed under **Claims and Appeals Procedure for Supplemental Medicare Coverage.**

- Submit a written appeal to the Plan Administrator/Finance Committee of the Board of Directors of COEHA within 180 days from the receipt of a denial.

- The Plan Administrator/Finance Committee will notify the member of the Plan's benefit determination upon review of a denied claim within:

  (i) for an urgent claim, within 72 hours;

  (ii) for pre-service claims, within a reasonable period of time appropriate to the medical circumstances. The notification shall be provided no later than 30 days after the Plan's receipt of the member's request of a review of an adverse benefit determination;

  (iii) for a post-service claim, within a reasonable period of time. If the appeal is received within the 60-day period immediately preceding the regular meeting of the Finance Committee, the appeal will be decided at that meeting unless special circumstances require an extension of time for processing. If there is no regular meeting of the Finance Committee within the 60-day period after receipt of the appeal, the Finance Committee shall convene a special meeting to discuss the appeal, and such meeting shall occur within 60-days of receipt of the appeal, unless special circumstances require an extension of time for processing. Whenever there are "special circumstances" that require additional time, the member shall be advised in writing of why the extension of time was needed and when the appeal will be decided. The Plan will mail the member written notice of the Finance Committee's decision within 5 days after the decision has been made;

  (iv) an adverse benefit determination includes medical judgments or rescissions of coverage.

- You will receive a written decision from the Finance Committee.

- Decisions of the Finance Committee are final.

Claims and Appeals Procedures for Supplemental Medicare Coverage

The claims procedures described below are effective January 1, 2003 and supercede any conflicting language in this Medicare Supplemental Handbook.

If a member's claim under the Plan is wholly or partially denied, he or she will be notified of the decision, after the Plan's receipt of the claim, within:

(i) 72 hours for an urgent care claim,
(ii) 15 days for a pre-service claim,
(iii) 30 days for a post-service claim, or

(iv) 45 days for a disability claim, as applicable.

A determination regarding a request for the Plan to approve an on-going course of treatment will be made in sufficient advance of the proposed reduction or termination of treatment to allow the member to appeal before the benefit is reduced or terminated.

Under special circumstances, the notice period may be extended for an additional:

(1) 48 hours for urgent care claims,
(2) 24 hours for concurrent care decisions,
(3) 15 days for pre-service claims,
(4) 15 days for post-service claims, or
(5) 30 days for disability claims.

If an extension is required, the member will be notified of the special circumstances involved and the date by which the Plan Administrator expects to render a final decision.

If the member's claim is denied, the Plan Administrator will provide the member with a written or electronic notification of an adverse benefit determination. The notice will:

(i) provide the specific reason(s) for the denial,

(ii) refer the member to the pertinent Medicare Supplemental Handbook provisions on which the denial is based,

(iii) describe any additional information necessary for the member to perfect his or her claim and explain why such information is necessary,

(iv) describe the Plan's review procedure and time limits applicable to the member's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review,

(v) (A) in the case of an adverse benefit determination, refer the member to the criteria that was relied upon in making the adverse determination, or a statement that certain criteria was relied upon and that a copy of such rule(s) will be provided to the member free of charge upon request, or (B) if the adverse determination is based on a medical necessity, experimental treatment or similar exclusion or limit, provide either an explanation of the clinical judgment for the determination or a statement that such an explanation will be provided free of charge, upon request,

(vi) in the case of an adverse determination for urgent care, describe the expedited review process applicable to such claims, and

(vii) in the case of an adverse benefit determination, identify the claim involved by providing the date of service, the health care provider, the claim amount (if applicable), and upon request, the diagnosis code (if available)..

In the case of an adverse benefit determination involving a claim for urgent care, the information described above may be provided to the member orally within the permitted time frame provided that written or electronic notification is furnished to the member no later than three days after such oral notification.

Appeal of Denied Claims
If the member's claim is denied, the member will be provided:

(i) a full and fair review with at least 180 days to appeal an adverse benefit determination,

(ii) a review that does not defer to the initial adverse benefit determination, and is conducted by an appropriate named fiduciary who is not involved with the adverse appeal,

(iii) a determination which is based on a medical judgment and for which the named fiduciary has consulted with a healthcare professional with suitable expertise related to the area of medicine required, and

(iv) the identity of the experts whose advice was solicited on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination.

Further, the review must provide that the consulted healthcare provider was not consulted upon for the adverse determination which is subject to the appeal (nor his or her subordinate) and provide, in the case of an urgent care claim, an expedited review process, to which the member's request may be submitted orally or in writing. All necessary information may be transmitted between the Plan and the member by telephone, facsimile, or other available method.

The Plan Administrator will notify the member of the Plan's benefit determination upon review of a denied claim within:

(i) for an urgent care claim, within 72 hours;

(ii) for pre-service claims, within a reasonable period of time appropriate to the medical circumstances. The notification shall be provided no later than 30 days after the Plan's receipt of the member's request of a review of an adverse benefit determination;

(iii) for post-service claims, within a reasonable period of time. If the appeal is received within the 60-day period immediately preceding the regular meeting of the Finance Committee, the appeal will be decided at that meeting unless special circumstances require an extension of time for processing. If there is no regular meeting of the Finance Committee within the 60-day period after receipt of the appeal, the Finance Committee shall convene a special meeting to discuss the appeal, and such meeting shall occur within 60-days of receipt of the appeal, unless special circumstances require an extension of time for processing. Whenever there are "special circumstances" that require additional time, the member shall be advised in writing of why the extension of time was needed and when the appeal will be decided. The Plan will mail the member written notice of the Finance Committee's decision within 5 days after the decision has been made.

The Plan's decision on review may be either a written or electronic notification. The notification will set forth for the member:

(i) the specific reason for the adverse determination;

(ii) reference the specific Plan provisions on which the benefit determination is based;

(iii) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;

(iv) a statement describing any voluntary appeal procedures offered by the Plan and the member's right to obtain the information about such procedures, and a

statement regarding the member's right to bring an action under ERISA Section 502(a);

(v) if an internal rule or protocol was relied upon in making the adverse determination, a copy of such rule or protocol shall be provided free of charge to the member upon request;

(vi) if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Dept. of Labor Office and your State insurance regulatory agency."; and

(vii) in the case of an adverse benefit determination, identify the claim involved by providing the date of service, the health care provider, the claim amount (if applicable), and upon request, the diagnosis code (if available).

EXTERNAL REVIEW PROCESS AND STANDARDS

The Plan is intended to constitute a self-insured group health plan subject to ERISA which shall be administered as a group health plan that follows standards to comply with the Federal External Review regulations and process or private accredited Independent Review Organization (IRO) process as described in regulations and guidance published by the Department of Labor and Internal Revenue Service. The external review process is available at no charge to Plan participants.

An adverse benefit determination includes medical judgments or rescissions of coverage. Medical judgments include medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, experimental or investigational treatments, reasonable alternative standards for a reward under a wellness program, compliance with the nonquantitative treatment limitation provisions of IRC Section 9812 and its regulations thereunder, and eligibility under the Plan.

If the participant's claim is denied on appeal, the participant may file a request for an external review with the Plan Administrator within four (4) months, or the first day of the fifth (5th) month if earlier, after the date of receipt of a notice of final internal adverse benefit determination. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Within five (5) business days following the date of receipt of the external review request, the Plan Administrator must complete a preliminary review of the request to determine whether:

(i) The member is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

(ii) The final internal adverse benefit determination does not relate to the member's failure to meet the requirements for eligibility under the terms of the Plan;

(iii) The participant has exhausted the Plan's internal appeal process; and

(iv) The participant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan Administrator must issue a notification in writing to the participant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and current contact information, including the phone number, for the DOL - Employee Benefits Security Administration. If the request is not complete, such notification must describe the information or materials needed to make the request complete, and the Plan must allow a participant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

The IROs must be accredited by URAC or a similar nationally-recognized accrediting organization. The IROs may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. The IRO may not impose any costs on the participant requesting the review. The Plan must provide or transmit all necessary documents and information considered in making the final internal adverse benefit determination to the assigned IRO electronically, or by telephone, facsimile or any other available expeditious method.

The Plan must include the following standards in the IRO contract between the Plan and the IRO:

(i) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan or coverage;

(ii) The assigned IRO will timely notify a participant in writing whether the request is eligible for external review. This notice will include a statement that the participant may submit in writing to the assigned IRO, within ten (10) business days following the date of receipt of the notice, additional information. This additional information must be considered by the IRO when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days;

(iii) Within five (5) business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the final internal adverse benefit determination. Within one (1) business day after making the decision, the IRO must notify the participant and the Plan;

(iv) Upon receipt of any information submitted by the participant, the assigned IRO must within one (1) business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its final internal adverse benefit determination and provide coverage or payment. Within one (1) business day after making such a decision, the

Plan must provide written notice of its decision to the participant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Plan;

(v) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

A. The participant's medical records;

B. The attending health care professional's recommendation;

C. Reports from appropriate health care professionals and other documents submitted by the Plan, participant, or the participant's treating provider;

D. The terms of the participant's Plan or coverage to ensure that the IRO's decision is not contrary to the terms of the Plan or coverage, unless the terms are inconsistent with applicable law;

E. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

F. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or coverage or with applicable law; and

G. To the extent the final IRO decision maker is different from the IRO's clinical reviewer, the opinion of such clinical reviewer, to the extent the information or documents are available and the clinical reviewer or reviewers consider such information or documents appropriate.

(vi) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of the final external review decision to the participant and the Plan; and

(vii) The assigned IRO's written notice of the final external review decision must contain the following:

A. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the Plan's denial);

B. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

C. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

D. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

E. A statement that the IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to the participant, or to the extent the Plan voluntarily makes payment on the claim or otherwise provides benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits;

F. A statement that judicial review may be available to the participant;

G. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793;

H. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six (6) years. An IRO must make such records available for examination by the participant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws; and

I. Upon receipt of a notice of a final external review decision reversing the final adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing care or immediately paying benefits) for the claim.

The Plan must comply with the following standards with respect to an expedited external review:

(i) The Plan must allow a claimant to make a request for an expedited external review with the Plan at the time the participant receives a final internal adverse benefit determination, if the participant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the participant or would jeopardize the participant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the participant received emergency services, but has not been discharged from the facility; and

(ii) Immediately upon receipt of the request for expedited external review, the Plan must determine whether the request meets the reviewability requirements set forth above and notify the participant of its eligibility determination.

Upon a determination that a request is eligible for expedited external review following the preliminary review, the Plan will assign an IRO. The IRO will be one of three IROs contracted by the Plan which rotate among them. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The Plan's contract with the assigned IRO must require the IRO to provide notice of the final external review decision as expeditiously as the participant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the participant and the Plan.

Representative Filing on behalf of the Member

Individuals who represent members may either be appointed or authorized to act on behalf of the member in filing a grievance, requesting an organization determination or in dealing with any of the levels of the appeals process. A member may appoint any individual (such as a relative, friend, advocate, an attorney, or any physician) to act as his or her representative. Alternatively, a representative may be authorized by the court or act in accordance with State law to act on behalf of a member.

To be appointed by a member, both the member making the appointment and the representative accepting the appointment (including attorneys) must sign, date, and complete a representative form. You can obtain a representative form by calling COEHA Customer Service and requesting a form called *"Appointment of Representative."* This form is also available on Medicare's website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.

The signed representative form for a representative appointed by a member, or other appropriate legal papers supporting an authorized representative's status, must be included with each request for a grievance, an organization determination, or an appeal. When a request for a grievance, organization determination, or appeal is filed by a person claiming to be a representative, but the representative does not provide appropriate documentation, COEHA cannot undertake a review until or unless such documentation is obtained.

Legal Proceedings

You may not bring an action in court to recover benefits from COEHA before you have exhausted all your remedies under the Medicare Supplemental Plan's claim and appeal procedures as outlined in this Medicare Supplemental Handbook. **Any action in court to recover benefits from COEHA must be brought within one (1) year after the final adverse determination of your claim and must be brought in a federal district court in Virginia.** A member may not anticipate, alienate, sell, transfer, pledge, assign, or otherwise encumber any interest in benefits to which he or she is or may become entitled under COEHA. The Board of Directors may, however, honor your assignment of benefits to the provider of covered services.

HIPAA PRIVACY AND SECURITY REQUIREMENTS

Certification and Disclosure to Plan Sponsor

Neither the Plan nor any Business Associate servicing the Plan will disclose Plan Participants' protected health information ("PHI") to the Plan Sponsor or the Board of Directors of the C and O Employees' Hospital Association, unless the Plan Sponsor certifies that the Plan Documents have been amended to incorporate this Article and that the Plan Sponsor has agreed to abide by this Article.

The Plan and any Business Associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing Regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by the Plan Sponsor of Plan Participants' PHI will be subject to and consistent with the provisions of this Article.

Neither the Plan nor any Business Associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to the Plan Participants.

Neither the Plan nor any Business Associate servicing the Plan will disclose Plan participants' PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Uses and Disclosures of Protected Health Information by the Plan Sponsor

The Plan Sponsor will neither use nor further disclose Plan Participants' PHI, except as permitted or required by the Plan Documents, as amended, or as required by law.

The Plan Sponsor will ensure that any agents or subcontractors to whom it provides PHI, received from the Plan, agree to the restrictions and conditions of the Plan Documents, including this Article, with respect to the Plan Participants' PHI.

The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan, as required in the HIPAA Security Standards.

The Plan Sponsor will not use or disclose Plan Participants' PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will promptly report to the Privacy Official any use or disclosure inconsistent with the uses or disclosures permitted under this Article.

The Plan Sponsor will make PHI available for inspection to the Plan Participant who is the subject of the information in accordance with 45 C.F.R. § 164.524.

The Plan Sponsor will make PHI available for amendment and will on notice amend Plan Participants' PHI, in accordance with 45 C.F.R. § 164.526.

The Plan Sponsor will track disclosures it may make of Plan Participants' PHI so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

The Plan Sponsor will make its internal practices and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services to determine compliance with 45 CFR Parts 160-64.

The Plan Sponsor will, if feasible, return or destroy all Plan Participant PHI, in whatever form or medium (including any electronic medium under the Plan Sponsor's custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the PHI, when the Plan Participants' PHI is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Plan Participant PHI, the Plan Sponsor will limit the use or disclosure of any Plan Participant PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Adequate Separation Between the Plan Sponsor and the Plan

The following employees or classes of employees or other workforce members under the control of the Plan Sponsor may be given access to the Plan Participants' PHI received from the Plan or a business associate servicing the Plan:

Board of Trustees
Plan Administrator(s)
Claims Processors
Dues Clerk
Customer Service Representative
Subrogation and Refund Specialist
Mail Entry Clerk

This list includes every employee or class of employees or other workforce members under the control of the Plan Sponsor who may receive Plan Participants' PHI relating to payment under, healthcare operations of, or other matters pertaining to the Plan in the ordinary course of business.

The employees, classes of employees or other workforce members identified above will have access to Plan Participants' PHI only to perform the plan administration functions that the Plan Sponsor provides for the Plan.

The employees, classes of employees or other workforce members identified above will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Plan Participants' PHI in breach or violation of or noncompliance with the provisions of this Article to the Plan Documents. Plan Sponsor will promptly report such breach, violation or noncompliance to the Plan and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.

NOTICE ABOUT NON-DISCRIMINATION

Discrimination is against the law. COEHA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. COEHA does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. COEHA also complies with Sections 504 and 508 of the Rehabilitation Act of 1973, as amended.

COEHA:

- Provides auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Ms. Michelle Hoke, the Civil Rights Coordinator.

If you believe that COEHA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Michelle Hoke
C and O Employees' Hospital Association
511 Main Street, 2nd Floor
Clifton Forge, Virginia 24422-1166
(800) 679-9135 (toll free), TTY/TDD users call 711 for all states
(540) 862-3552 (fax)
michellehoke@coeha.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ms. Michelle Hoke, Civil Rights Coordinator, is available to help you.

You can contact CMS directly if your grievance is not resolved by the Plan or if you believe that your grievance was not resolved correctly. You can file a grievance with CMS by doing one of the following:

1. Calling 1-844-ALT-FORM (1-844-258-3676). TTY users should call 1-844-716-3676;
2. Sending a fax to 1-844-530-3676;
3. Sending an email to AltFormatRequest@cms.hhs.gov ; or
4. Sending a letter to: Centers for Medicare & Medicaid Services Offices of Hearings and Inquiries, 7500 Security Boulevard, Room S1-13-25, Baltimore, MD 21244-1850 Attn: CMS Customer Accessibility Resource Staff.

CMS expects individuals to file the complaint within 180 calendar days of the alleged discrimination.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. The complaints must be filed within 180 days of the date of the alleged discrimination.

Virginia Top 15 Languages:

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-679-9135.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-679-9135 번으로 전화해 주십시오.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-679-9135.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-679-9135.
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-679-9135
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-679-9135.
Persian (Farsi)	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-679-9135 تماس بگیرید.
Amharic	ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-679-9135.
Urdu	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-679-9135
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-679-9135.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-679-9135.
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-679-9135 पर कॉल करें।
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-679-9135.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-1-800-679-9135
Kru (Bassa)	Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá 1-800-679-9135.
Ibo	Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-800-679-9135.
Yoruba	AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-679-9135.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) RIGHTS

As a participant in benefits provided by COEHA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX A: DISENROLLMENT FORM

C AND O EMPLOYEES' HOSPITAL ASSOCIATION DISENROLLMENT FORM

If you wish to discontinue your membership in the C and O Employees' Hospital Association, please **COMPLETE AND RETURN** this form to:

C and O Employees' Hospital Association
511 Main Street, 2nd Floor
Clifton Forge, Virginia 24422
ATTN: MEMBERSHIP DUES DEPT.

I, _____,
(name of member)
wish to discontinue my membership in the C and O Employees' Hospital Association, effective the first day of
_____,
(month)
_____.
(year)

I understand that by discontinuing my membership in the C and O Employees' Hospital Association, I am also disenrolling from your COEHA Health Care Prepayment Plan (HCPP).

_____
(Social Security Number) (HPIN)

_____
(Signature) (Date)

This form is for disenrollment in the C and O Employees' Hospital Association. Your Medicare coverage is intact. If you would like assistance in obtaining other healthcare insurance, you may contact your State Health Insurance Assistance Program, State Insurance Department and State Medical Assistance Office.