PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

CATHOLIC EMPLOYEE BENEFIT GROUP

EFFECTIVE JULY 2015

TABLE OF CONTENTS

INTRODUCTION

This document is a description of Catholic Employee Benefit Group (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

The Plan believes that it is a "grandfathered" health plan under the Patient Protection and Affordable Care Act ("Health Care Reform"). As permitted by Health Care Reform, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of Health Care Reform that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections under Health Care Reform such as the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of continuation of benefits elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation of Benefits Coverage. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

SCHEDULE OF BENEFITS

Verification of Eligibility 800-953-2024

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Note: The following services must be pre-certified or services are not covered by the Plan.

Hospitalizations
Home Health Care
Outpatient Hospice Care
Chemotherapy
Specialty drugs and medicines
Durable Medical Equipment or Prosthetics–purchase over $1,000 or rental exceeding $1000 over the course of treatment
Transplants
Angioplasty (in or outpatient)
Cardiac Catheterization (in or outpatient)
Vascular Surgery
Nasal Surgery
Neuro Stimulator
Outpatient surgical procedures:

(a) carpal tunnel release - surgery to relieve a pinched nerve in the hand;
(b) cochlear implants - insertion of small computer device to transmit to the auditory nerve;
(c) endometrial ablations - complete removal of the lining of the uterus;
(d) hysterectomy - surgical removal of the uterus;
(e) pelvic laparoscopy - examination of the female organs by a scope;
(f) tonsillectomy with/without adenoidectomy - surgical removal of the tonsil and adenoids;
(g) septoplasty - surgical procedure to straighten the nasal septum; and
(h) UPP (uvulopalatopharyngoplasty) or laparoscope aided UPP - removal of a portion of the uvula and soft palate.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Please see the Cost Management section in this booklet for details.

The Plan is a plan which contains a Participating Provider Organization.

PPO name: Aetna Signature Administrators
E-mail: www.aetna.com/asa

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Participating Provider, that Covered Person will receive better benefits from the Plan than when a Non-Participating Provider is used. It is the Covered Person's choice as to which Provider to use.

A directory of network providers is available on-line at www.aetna.com/asa.

Deductibles/Copayments/Coinsurance payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person.There is a specific deductible amount for Participating Providers and a separate deductible amount for Non-Participating Providers, and they do not cross-allocate. Applicable deductible amounts must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required. Deductibles do not accrue toward the 100% maximum out-of-pocket payment.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments do not accrue toward the 100% maximum out-of-pocket payment.

Coinsurance is an amount of money that the Plan Participant is responsible for after the Calendar Year deductible has been satisfied and before the out-of-pocket maximum has been reached.

MEDICAL BENEFITS SCHEDULE

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
MAXIMUM BENEFIT AMOUNT: Aggregate Annual Limit	***UNLIMITED***	
Note: The maximums listed below are the total for Participating and Non-Participating expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Participating and Non-Participating providers.		
DEDUCTIBLE, PER CALENDAR YEAR (The Participating and Non-Participating deductibles are separate and do NOT cross-allocate)		
Per Covered Person	$750	$1,700
Per Family Unit - *aggregate*	$2,000	$5,000
The Emergency room copayment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator, WebTPA, must be notified at 800-697-9757 within 2 business days of the admission, even if the patient is discharged within 2 business days of the admission.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (The Participating and Non-Participating Out-of-pocket amounts are separate and do NOT cross-allocate)		
Per Covered Person	$3,000	$5,100
Per Family Unit - *aggregate*	$5,000	$15,250
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Deductible(s) Cost containment penalties Copayments Amounts over Usual and Reasonable Charges		
COVERED CHARGES		
Hospital Services – Facility Fees		
Room and Board *semiprivate room rate*	80% after deductible	60% after deductible
Intensive Care Unit	80% after deductible	60% after deductible
Inpatient Rehablitation Facility *30 days Calendar Year maximum*	80% after deductible	60% after deductible
Emergency Room Visit - The Emergency room copayment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator, WebTPA, must be notified at 800-697-9757 within 2 business days of the admission, even if the patient is discharged within 2 business days of the admission		
ER Facility Fees	$100 copayment each visit, then 80% after deductible	$100 copayment each visit, then 60% after deductible
Urgent Care	$25 copayment each visit, then 80%, *deductible waived*	60% after deductible
23-hour Observation	80% after deductible	60% after deductible
Skilled Nursing Facility *30 days Calendar Year maximum*	80% after deductible	60% after deductible to a maximum allowable of $200 per day

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Occupational Therapy *30 visit Calendar Year maximum*	$25 copayment, then 80%	60% after deductible
Speech Therapy *30 visit Calendar Year maximum (Includes speech pathology)*	$25 copayment, then 80%	60% after deductible
Physical Therapy *30 visit Calendar Year maximum (Includes aquatic therapy and osteopathic manipulative treatment).*	$25 copayment, then 80%	60% after deductible
Dialysis Treatment - Outpatient	100% of the Usual and Reasonable Charge after all applicable deductibles and coinsurance Please refer to Dialysis Treatment Outpatient Description in the Covered Charges section.	
Cardiac Rehabilitation *30 visit Calendar Year maximum*	$25 copayment, then 80%	60% after deductible
Diagnostic Testing Outpatient (X-ray & Lab)	80% after deductible	60% after deductible
High End Radiology- CT, MRI, MRA, PET	80% after deductible	60% after deductible
Independent Lab	80% after deductible	60% after deductible
Physician Services		
Inpatient/outpatient visits	80% after deductible	60% after deductible
ER Physician fees	80% after deductible	60% after deductible
Office visits *PCP or Specialist*	$25 copayment, then 100% *deductible waived*	60% after deductible
Copay will apply to injections, lab,and x-ray charges even if an office visit is not billed		
OB/GYN office visit	$25 copayment, then 100% *deductible waived*	60% after deductible
Supplies in office	80% after deductible	60% after deductible
Surgery – *office, inpatient or outpatient*	80% after deductible	60% after deductible
Anesthesia – *office, inpatient or outpatient*	80% after deductible	60% after deductible
Allergy testing, serum and injections	80% after deductible *(Office visit copayment will apply only if office visit is billed)*	60% after deductible
Other Covered Charges		
Home Health Care/ Private Duty Nursing *60 visit Calendar Year maximum*	80% after deductible	60% after deductible up to maximum allowable of $55 per visit
Inpatient/outpatient hospice maximum limited to 185 visits per Calendar Year		

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Hospice Care – inpatient	80% after deductible	60% after deductible up to maximum allowable of $55 per day
Hospice Care – outpatient	80% after deductible	60% after deductible up to maximum allowable of $55 per visit
Bereavement Counseling *Maximum bereavement counseling benefit of $250 for all members of the covered person immediate family.*	80% after deductible	60% after deductible up to maximum allowable of $55 per visit
Ambulance Service	80%, *deductible waived*	80%, *deductible waived*
Dental Injury Services *office visit and x-rays*	$25 copayment, then 100% *deductible waived*	$25 copayment, then 100% *deductible waived*
Dental Injury Services *All other Covered Charges*	80% after deductible	80% after deductible
Wig After Chemotherapy	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Prosthetics	80% after deductible	60% after deductible
Orthotics Devices *Custom molded foot orthotics are not covered*	80% after deductible	60% after deductible
Diabetic Education/Training	80% after deductible	60% after deductible
Natural Family Planning *$200 Calendar Year maximum*	$25 copayment, then 100% *deductible waived*	$25 copayment, then 100% *deductible waived*
Spinal Manipulation Chiropractic *30 visit Calendar Year maximum*	$25 copayment, then 80% *deductible waived*	60% after deductible
Preventive Care		
Routine Well Adult Care – *age 18 & over*	$25 copayment, then 100% *deductible waived* *(copay only applies to office visit charge)*	60% after deductible
Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory tests, , immunizations and bone density scans.		
Routine Immunization – *For Covered Persons age 50 and over*	100%, *deductible waived*	60% after deductible
Flu shots	100%, *deductible waived*	100%, *deductible waived*
Routine Mammograms	100%, *deductible waived*	60% after deductible
Frequency limits for mammogram Ages 35 and over . . . . . annually		
Routine Well Child Care *through age 17-*	$25 copayment, then 100% *deductible waived* *(copay only applies to office visit charge)*	60% after deductible
Includes: office visits, routine physical examination, laboratory tests, and x-rays through age 17.		
Routine Immunization- *Covered Persons through age 6*	100%, *deductible waived*	60% after deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Routine Well Newborn Care	100%, *deductible waived*	100%, *deductible waived*
Sick Newborn Care	80% after deductible	60% after deductible
Organ Transplants	80% after deductible	No Coverage
Donor Benefits *$25,000 Lifetime maximum*	100%, *deductible waived*	No Coverage
Travel, Lodging & Meals *$1,000 Lifetime maximum*	100%, *deductible waived*	
Mental & Nervous/Substance Abuse	No Coverage	No Coverage
Pregnancy-*initial office visit*	$25 copayment, then 100% *deductible waived*	60% after deductible
Pregnancy – *global fees*	80% after deductible	60% after deductible
Dependent daughters not covered.		

PRESCRIPTION DRUG BENEFIT SCHEDULE

PRESCRIPTION DRUG BENEFIT – Express Scripts – 800-233-8065 – www.express-scripts.com		
	PARTICIPATING	**NON-PARTICIPATING**
Pharmacy Option (30 Day Supply) – Plan pays 100% after:		**Plan pays 100% after:**
Generic Drugs	$4 copayment	40% coinsurance
Formulary Brand Name Drugs	$34 copayment	40% coinsurance
Diabetic Supplies Formulary Brand	$4 copayment	40% coinsurance
Diabetic Supplies Non-Formulary Brand	$44 copayment	40% coinsurance
Non-Formulary Brand Name Drugs	$64 copayment	40% coinsurance
Mail Order Option (90 Day Supply) - Plan pays 100% after:		**Plan pays:**
Generic Drugs	$8 copayment	No Benefit
Formulary Brand Name Drugs	$68 copayment	No Benefit
Diabetic Supplies Formulary Brand	$8 copayment	No Benefit
Diabetic Supplies Non-Formulary Brand	$88 copayment	No Benefit
Non-Formulary Brand Name Drugs	$128 copayment	No Benefit
Contraceptives are excluded. Compound Drugs have a limit of $500 per prescription. A restricted Generic substitution program applies to covered drugs. **Refer to the Prescription Drug Section for details on the Prescription Drug benefit.**		

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. The following Classes of Employees:

(1) All Eligible active ordained.

(2) All Eligible pre-ordained.

(3) All other eligible religious order.

(4) All eligible lay Employees.

(5) All eligible terminated Employees electing Continuation of Benefits Coverage.

(6) All Eligible retired ordained with Medicare.

(7) All Eligible retired ordained without Medicare.

(8) All eligible spouses of Medicare eligible ordained Employees who terminate coverage.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is in a class eligible for coverage.

(2) completes the employment Waiting Period, if applicable to the Employee's class, of 60 consecutive days as an Active Employee. A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

(3) The Waiting Period is not applicable to Priests and Seminarians (Class A001 and Class A002). These Employees become eligible for coverage under the Plan on the day the Employee begins Active Employment.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives or was married, and shall include common law marriages. The term "Spouse" shall not include partners of the same sex who were legally married under the laws of the State in which they were married. The Plan Administrator may require documentation proving a legal marital relationship.

(2) A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, stepchild living with the Employee, adopted child, or a child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

However, for Plan Years beginning before January 1, 2014, an Employee's Child is not an eligible Child if the Child is eligible to enroll in an employer-sponsored health plan other than the group health plan of a parent of the Child.

(3) A covered Employee's Qualified Dependents.

The term "children" shall include children for whom the Employee is a Legal Guardian who reside in the Employee's household.

To be eligible for Dependent coverage under the Plan, a Qualified Dependent must be under the limiting age of 26 years. When a Qualified Dependent reaches the applicable limiting age, coverage will end on the Qualified Dependent's birthday.

If a covered Employee or Spouse is the Legal Guardian of a child or children under the limiting age of 26, these children may be enrolled in this Plan as Qualified Dependents.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(4) A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap and primarily dependent upon the covered Employee for support and maintenance. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's or Retiree's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee or Retiree; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee or Retiree.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, Qualified Dependent or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. Catholic Employee Benefit Group shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

If an Employee makes a request to begin Dependents coverage within 31 days after an event, coverage will become effective on the first day of the calendar month following the Administrator’s receipt of the enrollment request, or on an earlier date, as agreed to by the Administrator and Us.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. If the covered Employee already has Dependent coverage, a newborn child will be automatically enrolled for 31 days from birth; otherwise, separate enrollment for a newborn child is required.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee who has Dependent coverage is automatically enrolled in this Plan for 31 days. Charges for covered nursery care will be applied toward the Plan of the covered parent. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on July 1st.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Catholic Employee Benefit Group, 1320 Greenway, Suite 170, Irving, Texas, 75038, 972-714-0004.

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period. The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period..

(1) **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(a) The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits. This provision shall no longer apply for Plan Years starting after September 22, 2010.

(b) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals for example: part-time employees).

(c) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(d) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(e) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) **Acquiring a newly eligible Dependent may create a Special Enrollment right.** If:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent may be enrolled under this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Special Enrollment Period for newly eligible Dependents is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(4) **Eligibility changes in Medicaid or State Child Health Insurance Programs may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for Continuation of Benefits Coverage. For a complete explanation of when Continuation of Benefits Coverage is available, what conditions apply and how to select it, see the section entitled Continuation of Benefits Coverage):

(1) The date the Plan is terminated.

(2) The date the covered Employee's Eligible Class is eliminated.

(3) The day the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation of Benefits Coverage.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(5) If an Employee commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

(6) the day before the Employee enters the Armed Forces on active duty (except for temporary active duty of two weeks or less); or

(7) The Employee has not been Actively Employed for a period of 90 consecutive days. This 90-day period will run concurrently with any time period during which the Employee's coverage remains in force in accordance with the Family and Medical Leave provision of this Plan.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.

For leave of absence or layoff only: the date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Continuation of Coverage. If an Employee's termination is due to Illness, sick time and vacation time will be exhausted prior to any FMLA continuation. Once the FMLA continuation has expired, if any, the Employee and any eligible Dependents will be allowed the opportunity to continue coverage if the Employee's eligibility terminates due to termination of employment or disability, provided the Employee was covered under the Plan for a minimum of 6 months while Actively Working. Upon payment of premium, coverage can be continued for up to 18 months. To cover any Dependents under the Plan, the Employee must be covered. If the Employee's coverage ends, any Dependent coverage will also end. Please contact the Plan Administrator regarding procedures for election of premium payments.

NOTE: Sick leave and vacation time run consecutively with FMLA with sick leave and vacation time, then FMLA, in that order.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from Continuation of Benefits Coverage, this Employee does not have to satisfy any employment waiting period.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Active Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's covered Dependents under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Catholic Employee Benefit Group, 1320 Greenway, Suite 170, Irving, Texas, 75038, 972-714-0004. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for Continuation of Benefits Coverage. For a complete explanation of when Continuation of Benefits Coverage is available, what conditions apply and how to select it, see the section entitled Continuation of Benefits Coverage):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation of Benefits Coverage.)

(3) The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation of Benefits Coverage.)

(4) On the first date that a person ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation of Benefits Coverage.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively, the Plan will provide at least 30 days' advance written notice of such action.

Retiree Eligibility

All eligible ordained are eligible for retiree benefits at age 75, or earlier as defined by the Canonical Bishop or the Pope.

If coverage continued under a prior plan maintained by Us on or after retirement, all future rights to retiree coverage under this Plan are waived.

A retiree becomes eligible for coverage under this Plan on the date of retirement.

When Retiree Coverage Begins

An eligible retiree must request coverage by:

1. Properly completing and signing a form acceptable to the Plan Administrator; and
2. submitting the form to Us.

If the Plan Administrator receives a retiree's request for coverage on or before the 31st day following the day the retiree becomes eligible, the retiree will become covered on the first day of the Plan month which coincides with or follows the day the retiree becomes eligible.

If the Plan Administrator receives a retiree's request for coverage after the 31st day following the day the retiree becomes eligible, the retiree will not be covered under the Plan.

When Retiree Coverage Ends

Retiree coverage will end at midnight at the main office of the Plan Administrator on the earlier of:

1. The day the Plan ends;
2. the day any premium contribution for coverage is due and unpaid; or
3. the day of the retiree's death.
4. If a retiree commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the retiree for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively, the Plan will provide at least 30 days' advance written notice of such action.

Coverage under this Plan cannot be reinstated once retiree coverage ends.

OPEN ENROLLMENT

Every May, the annual open enrollment period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Every May, the annual open enrollment period, eligible Employees and their eligible Dependents who are Late Enrollees will be able to enroll in the Plan.

Current enrollment information will be provided on the pre-printed Health Benefit Open Enrollment Form. If there are no changes, the Employee will just sign and return the form to the Diocese HR/Benefits Office.

If there are enrollment changes, the Employee will complete the Health Benefit Enrollment/Change Form, sign it, and return the form to the Diocese HR/Benefits Office.

Benefit choices made during the open enrollment period will become effective July 1st and remain in effect until the next July 1st unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective July 1st.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

This amount will not accrue toward the 100% maximum out-of-pocket payment.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person for Essential Health Benefits during the Plan Year. The Maximum Benefit applies to all plans and benefit options offered under the Catholic Employee Benefit Group, including the ones described in this document.

COVERED CHARGES

Covered Charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

(2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not

prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

There is no coverage of Pregnancy for a Dependent child other than a Covered Spouse.

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility; and

(b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Bereavement counseling services provided by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or other covered Dependents) are covered. Bereavement services must be furnished within six months after the patient's death.

Charges for Bereavement counseling are subject to the limits as described in the Schedule of Benefits.

(8) **Dialysis Treatment - Outpatient**.

This Section describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

A. Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:

(1) the concentration of dialysis providers in the market in which Plan members reside may allow such providers to exercise control over prices for dialysis-related products and services,

(2) the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members,

(3) evidence of (i) significant inflation of the prices charged to Plan members by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan members to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers, and

(4) the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Plan members' interests, such as subsidies for other plans and discriminatory profit-taking.

B. Dialysis Program Components. The components of the Dialysis Program are as follows:

(1) Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").

(2) Claims Affected. The Dialysis Program shall apply to all dialysis-related claims

received by the Plan on or after July 1, 2015, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.

(3) Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator shall consider factors including:

i. Market concentration: The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

ii. Discrimination in charges: The Plan Administrator shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

(4) In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Plan member, to the following payment limitations, under the following conditions:

i. Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the Plan member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

ii. Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's members, upon the Plan Administrator's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.

iii. Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

iv. Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors

concerning the nature and severity of the condition being treated.

v. Additional Information related to Value of Dialysis-Related Services and Supplies. The Plan member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

vi. All charges must be billed by a provider in accordance with generally accepted industry standards.

5. Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

6. Discretion. The Plan Administrator shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law.

(9) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) **Ambulance** services for:

(1) Professional ambulance service when:
a. transportation is Medically Necessary; and
b. transportation is to the nearest Hospital equipped to furnish the services; and

(2) transportation within the United States by a professional ambulance or on a regularly scheduled flight on a commercial airline when;
a. such transportation is Medically Necessary; or
b. special and unique Hospital services are required which are not provided by a local Hospital.

(b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(c) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(d) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(e) Initial **contact lenses** or glasses required following cataract surgery.

(f) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

(g) **Natural Family Planning Services.** Benefits will be payable for office visits, consultations and educational classes provided by a covered Physician in a Physician's office or in a Hospital outpatient department.

Benefits will not be payable for:

(a) Your Dependent children;
(b) services provided by a provider not covered under the Plan;
(c) services performed during a Hospital confinement;
(d) tests or procedures performed during the office visit, consultation or educational classes;
(e) educational materials (such as, but not limited to, brochures, flyers, etc.);
(f) nutritional supplements, non-prescription items or prescription drugs not otherwise covered under the Plan or Prescription Drug Plan
(g) services provided to individuals not covered under the Plan; and
(h) services in excess of the Maximum Natural Family Planning Benefit.

(h) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

(i) Injury to or care of **mouth, teeth and gums**. Dental services by a Physician or Dentist for the treatment of a Dental Injury to Sound Natural teeth (including the replacement of the injured teeth and any necessary dental x-rays), provided the treatment plan begins within 90 days of the Injury and is completed within one year after the injury.

The Plan will pay benefits for Covered Charges incurred for dental procedures, including, but not limited to crowns, bridges, orthodontia, due to a Dental Injury as indicated in the Schedule of Benefits.

(j) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(k) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue. Covered Charges also include the use of temporary mechanical equipment, pending the acquisition of "matched" organ(s)/tissue.

Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

evaluating the organ or tissue;

removing the organ or tissue from the donor; and

transportation of the living donor, organ or tissue from within the United States and Canada to the place where the transplant is to take place.

Benefit payments for Covered Charges are subject to the Maximum Benefit limit as shown in the Schedule of Benefits.

Institute of Excellence (IOE)
This is a facility that is contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

Transplant Expenses

Once it has been determined that you or one of your dependents may require an organ transplant, you, or your Physician should call the WebTPA's precertification department to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements. Organ means solid organ; stem cell; bone marrow; and tissue.

Benefits vary if an Institute of Excellence™(IOE) facility or non-IOE is used. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered as preferred care only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to transplants that is provided by a facility that is not specified as an IOE network facility, even if the facility is considered as a preferred facility for other types of services, will NOT be covered. Please read each section carefully.

Covered Transplant Expenses

Covered transplant expenses include the following:

- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your: biological parent, sibling or child.
- Inpatient and outpatient expenses directly related to a transplant.
- Charges made by a Physician or transplant team.
- Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one Transplant Occurrence.

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date you are discharged from the Hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one Transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant Evaluation/Screening: Includes all transplant-related professional and

technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.

2. Pre-transplant/Candidacy Screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.

3. Transplant Event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement.

4. Follow-up Care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For the purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart
- Lung
- Heart/ Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell transplant
- Multiple organs replaced during one transplant surgery
- Tandem transplants (Stem Cell)
- Sequential transplants
- Re-transplant of same organ type within 180 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the Plan

The following will be considered to be more than one Transplant Occurrence:

- Autologous Blood/Bone Marrow transplant followed by Allogenic Blood/Bone Marrow transplant (when not part of a tandem transplant)
- Allogenic Blood/Bone Marrow transplant followed by an Autologous Blood/Bone Marrow transplant (when not part of a tandem transplant)
- Re-transplant after 180 days of the first transplant
- Pancreas transplant following a kidney transplant
- A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant (e.g., a liver transplant with subsequent heart transplant).

Limitations

The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence.
- Services and supplies furnished to a donor when recipient is not a covered person.
- Home infusion therapy after the Transplant Occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness.

•Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.
• Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by WebTPA.

Travel & Lodging Expenses

Distance Requirement

The IOE facility must be more than 100 miles from the patient's residence.

Travel Allowances

Travel is reimbursed between the patient's home and the facility for round trip (air, train or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll cost are reimbursed. Mileage Reimbursement is $0.555/mile.

Lodging Allowances

Reimbursement of expenses incurred by patient and companion for hotel lodging away from home is reimbursed at a rate of $50 per night per person (or $100 per night total).

Overall Maximum

Travel & Lodging reimbursement is limited to $1,000 for any one transplant or procedure type, including tandem transplants. This is a combined maximum for the member, companion and donor.

Companions

Adult – 1 companion is permitted.
Child – 1 parent or guardian is permitted.

(l) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Custom Molded foot orthotics are not covered.

(m) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

(n) **Prescription** Drugs (as defined).

(o) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

(p) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(q) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

Specialized post-mastectomy or breast cancer surgery bras will be covered, not to exceed four (4) in any Calendar Year.

(r) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder. This benefit is payable even when due to developmental delay.

(s) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.

(t) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(u) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent.

(v) Charges associated with the initial purchase of a **wig after chemotherapy**.

Charges for wig after chemotherapy are subject to the limits as described in the Schedule of Benefits.

(w) Diagnostic **x-rays**.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The services will be for the Employee Assistance Program which will provide participants 6 face to face counseling sessions with a licensed clinician. Participants can speak to a therapist in regards to any issue(s) that may be affecting them. A participant can definitely speak to a counselor in regards to weight issues if this is something that is affecting them.

As an additional resource, there is an online website that will be available to all participants where health and wellness resources may be accessed. The service provides resources such as personal health profiles, weight management, welltips, health tutorials for healthier living which include: CookWell, WellFit, and WellBeing, as well as wellness modules and gym discounts to local gyms.

COST MANAGEMENT SERVICES

The provider, patient or family member must initiate precertification for all inpatient admissions, certain outpatient surgical procedures, Home Health Care, Hospice Care, Skilled Nursing Facility, Prosthetics and Durable Medical Equipment for purchases of $1,000 or more or rentals exceeding $1000 over the course of treatment, and Chemotherapy/Specialty Drugs. For emergency admissions, contact the Plan within 2 days of treatment. For Pre-Certification, the Provider must call WebTPA Pre-Certification at 1-800-697-9757.

NOTE: IF PRE-CERTIFICATION IS NOT OBTAINED, SERVICES ARE NOT COVERED..

Any costs incurred because of reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Hospitalizations
Home Health Care
Outpatient Hospice Care
Chemotherapy
Specialty drugs and medicines
Durable Medical Equipment or Prosthetics– purchase over $1,000 or rental exceeding $1000 over the course of treatment
Transplants
Angioplasty (in or outpatient)
Cardiac Catheterization (in or outpatient)
Vascular Surgery
Nasal Surgery
Neuro Stimulator
Outpatient surgical procedures:

(a) carpal tunnel release - surgery to relieve a pinched nerve in the hand;
(b) cochlear implants - insertion of small computer device to transmit to the auditory nerve;
(c) endometrial ablations - complete removal of the lining of the uterus;
(d) hysterectomy - surgical removal of the uterus;
(e) pelvic laparoscopy - examination of the female organs by a scope;
(f) tonsillectomy with/without adenoidectomy - surgical removal of the tonsil and adenoids;
(g) septoplasty - surgical procedure to straighten the nasal septum; and
(h) UPP (uvulopalatopharyngoplasty) or laparoscope aided UPP - removal of a portion of the uvula and soft palate.

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency inpatient basis or receives other the other medical services listed above, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator WebTPA at 800-697-9757 **at least 7 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact WebTPA **within 2 business days** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by 100%.

Exceptions:

1. Pre-certification is **not** required when the Covered Person has Medicare coverage which;
   (a) has primary responsibility for the Covered Person's claim, and;
   (b) must pay its full benefits before Plan benefits are paid in accordance with the Medicare Coordination of benefits provision of the Plan.

2. Pre-certification is **not** required for services or supplies performed or provided, outside of the Administrator States, Mexico and Canada or any state, district, province, territory or possession thereof.

Request for an Appeal of Utilization Review Decision

The Covered Person, family member or provider of health care have the right to request an appeal regarding Utilization Review decisions. The request should be submitted in writing and should include any additional information that may have been omitted from review or that should be considered. Requests should be sent to:

WebTPA
Medical Management
Appeals and Grievance
P.O. Box 1808
Grapevine, TX 76099-1808

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) performed on an outpatient basis within seven days before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable at 80% for In-Network services and 60% for Out-of-Network services even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Acupuncture means the practice of insertion of needles into specific exterior body locations to relieve pain, to induce surgical anesthesia or for therapeutic purposes.

For all eligible active ordained and all active ordained Employees **Active Employment or Actively Employed** means an Employee for whom the Diocesan Bishop has Canonical responsibility and is Actively Working for Us 30 or more hours per week.

For all eligible religious order and all eligible lay Employees **Active Employment or Actively Employed** means Actively Working on a regular and consistent basis for Us 30 or more hours each week. For lay Employees, this term further means an Employee who receives compensation in the form of W-2 reportable wages at least the minimum set by federal or state standards.

Actively Working or **Active Work** means performing the normal duties of a regular job for Us at:

(a) Our usual place of business;

(b) an alternative work site at the direction of Us; or

(c) a location to which one must travel to perform the job.

An Employee will be considered Actively Working on any day that is:

(a) a regular paid holiday or day of vacation;
(b) a regular or scheduled non-working day; or
(c) a day on which the Employee is on a qualified family or medical leave of absence as defined by the Family and Medical Leave Act of 1993; provided the Employee was Actively Working on the last preceding regular work day.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician or a registered nurse (R.N.); and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

Caregiver means a person not associated with the Hospice Agency who resides in the Covered Person's home and provides nonmedical services and companionship. This may not be a family member.

Continuation of Benefits Coverage means coverage available to eligible former Employees through this Plan.

Cosmetic Surgery or Service means any surgical procedure or service performed primarily:

(a) to improve physical appearance without materially correcting a bodily malfunction; or
(b) to prevent or treat a Mental and Nervous Disorder through a change in bodily form.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee, Retiree or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dental Injury means and accidental Injury to Sound Natural Teeth which is the direct result of a sudden, unexpected and unintended external force, such as a blow or fall that requires treatment by a Physician or Dentist. It must be independent of Sickness or any other cause. It does not include tooth breakage while biting or chewing.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Developmental Care means services or supplies, regardless or where or by whom they are provided which:

(a) are provided to a Covered Person who has not previously reached the level of development expected for the Covered Person's age in the following areas of major life activity:

1. intellectual;
2. physical;
3. receptive and expressive language
4. learning;
5. mobility;
6. self-direction;
7. capacity for independent living; or
8. economic self-sufficiency;

(b) are not primarily rehabilitative (restoring skills that were lost or impaired due to Injury or Sickness); or

(c) are primarily educational.

Diabetic Supply or **Diabetic Supplies** include needles, syringes, test tablets, sticks, tapes, strips, lancets and alcohol swabs.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee means a person who receives compensation from Us for work performed for Us. An Employee will not include a person who is unauthorized to work in the united States pursuant to the Immigration and Nationality Act and related rules and regulations.

The term Employee does not include any person performing services for Us:

1. pursuant to an independent contractor relationship with Us;
2. subject to the terms of a leasing agreement between us and a leasing organization;
3. who receives income which is reported by us on IRS form 1099;
4. on a seasonal basis; or
5. on a temporary basis.

Employer is Catholic Employee Benefit Group.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Essential Health Benefits include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital means any of the following facilities that are licensed by the proper authority in the jurisdiction in which they are located:

(a) a facility which:
  (1) provides inpatient services for the care and treatment of patients;
  (2) has a registered graduate nurse (RN) always on duty;
  (3) has a laboratory and X-ray facility;
  (4) as a regular practice, charges the patient for its services; and
  (5) has a resident Physician on duty or call at all times; or

(b) a facility which is accredited by the Joint Commission on the Accreditation of Healthcare Organizations, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities, if the function of such facility is primarily to provide rehabilitation specifically for treatment of a physical disability. Rehabilitative facilities need not have major surgical facilities. A hospital does not include a

facility or institution or units within a facility or institution, which is licensed or used principally as a clinic, convalescent home, rest home, nursing home, home for the aged, halfway house, board and care facility, residential treatment center, “wilderness” program, treatment group home or “boot camp”.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition or behavioral condition of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(a) placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
(b) serious impairment to bodily functions;
(c) serious disfigurement of the Covered Person;
(d) serious impairment of any bodily organ or part of the Covered Person; or
(c) in the case of a behavioral condition, placing the health of the Covered Person or other persons in serious jeopardy.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary. However, just because a treatment is deemed Medically Necessary, does not mean it will be covered by the Plan – see Plan Exclusions.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Natural Family Planning Services means counseling, instruction and advice in natural family planning for either procreation or to avoid Pregnancy.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Catholic Employee Benefit Group, which is a benefits plan for certain Employees of Catholic Employee Benefit Group and is described in this document.

Plan Participant is any Employee, Retiree or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Retired Employee is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Sickness is:

For a covered Employee and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy or its complications.

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, Custodial or educational care.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Sound Natural Teeth means teeth which:

(1) are whole or properly restored;

(2) are without impairment or periodontal disease;

(3) are not in need of the treatment provided for reasons other than Dental Injury.

Specialty Drugs and Medicines means injectible drugs or medicines for ongoing treatment of a chronic condition.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Urgent Care Center means a free-standing facility offering ambulatory medical service which:

(1) is not part of a Hospital; and
(2) is licensed by the proper authority in the jurisdiction in which it is located.

Us is the Catholic Employee Benefit Group.

Except as applied to outpatient dialysis claims, **Usual and Reasonable Charge** is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience. For Participating Provider charges, the Usual and Reasonable Charge will be the contracted rate. Outpatient dialysis claims are subject to a definition of "Usual and Reasonable Charge" which include specific terms not available to other claims. Please see the outpatient dialysis claims provisions for the applicable definition.

The Plan will pay benefits on the basis of the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable. Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Plan member is entitled to them.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

NOTE: Services and supplies which may be Medically Necessary are not covered by the Plan if they are specifically excluded or limited in this Plan Exclusions provision.

We do not pay benefits under the Plan for any Expense or loss unless otherwise specifically provided in the Plan:

(a) for an Injury or Sickness:

(1) which arises out of, or in the course of, any employment with any employer; or

(2) for which the Covered Person:

a. is entitled to benefits under any workers' compensation or occupational disease law, employer's liability or similar laws; or

b. receives any settlement from a workers' compensation carrier;

c. arises from work for wage or profit including self-employment.

(b) which is in excess of the Usual and Reasonable Charge, the Facility Charge Allowance or the allowable charge;

(c) for services or supplies that are not Medically Necessary;

(d) incurred before a person was covered under this Plan or after coverage ceased under this Plan;

(e) which is not the result of an Injury or Sickness;

(f) for an Injury or Sickness that occurred while committing a felony or participating in a riot;

(g) incurred by a Covered Person while incarcerated in a jail, penitentiary, correctional facility or Hospital;

(h) which the Covered Person does not have to pay;

(i) for Custodial Care, except as part of a Home Health Care Plan approved by the Plan;

(j) for Developmental Care, (unless otherwise specifically provided in the Plan);

(k) which results from Reconstructive Surgery, except:

(1) for an Injury;

(2) for repair of defects which result from surgery; or

(3) for the reconstructive (not cosmetic) repair of a congenital defect which materially corrects a bodily malfunction;

(l) which results from Cosmetic Surgery;

(m) which relates to appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria, and present significant symptomatic medical problems) or any treatment of obesity (including surgery to treat morbid obesity);

(n) for routine foot care, orthopedic shoes, orthotics or other supportive devices for the feet;

(o) in connection with dental work, dental surgery, or oral surgery (unless otherwise specifically provided in the Plan) including:

(1) treatment or replacement of any tooth or tooth structure, alveolar process, abscess or disease of the periodontal or gingival tissue; or

(2) surgery or splinting to adjust dental occlusion;

(p) for the treatment of Jaw Joint Disorders, including temporomandibular joint (TMJ) syndrome (unless otherwise specifically provided in the Plan);

(q) related to sexual and gender identity disorders, including but not limited to:

(1) sexual dysfunctions;

(2) paraphilias; or

(3) gender transformations;

(r) for services and supplies for the treatment of impotence/erectile dysfunction;

(s) for the diagnosis or treatment of the inability to conceive or become pregnant, or the promotion of fertility including, but not limited to:

(1) fertility tests and procedures;

(2) reversal of surgical sterilization; or
(3) any similar method or treatment which attempts to cause conception or pregnancy by hormone therapy, artificial insemination, in vitro fertilization and/or embryo transfer;

(t) for birth control drugs or devices including, but not limited to, oral contraceptives, IUDs, contraceptive implants and any similar drugs, devices or other birth control methods and all related expenses;

(u) for chelation therapy, except for acute arsenic, gold, mercury or lead poisoning;

(v) for services or supplies which are not provided in accordance with generally accepted professional standards and/or practice;

(w) for services or supplies which:
(1) are considered an Experimental or Investigational Drug or Treatment; or
(2) result from or relate to the application of an Experimental or Investigational Drug or Treatment;

(x) for services or supplies which are primarily for the Covered Person's education, training or development of skills needed to cope with an Injury or Sickness; unless otherwise specifically provided by the Plan;

(y) related to smoking cessation or treatment for nicotine addiction;

(z) for Acupuncture Treatment (except when used in lieu of an anesthetic agent for surgery);

(aa) which is primarily for the Covered Person's convenience or comfort or that of the Covered Person's family, Caregiver, companion, sitter, Physician or other person;

(bb) for bills for telephone calls, mailings, faxes, e-mails or any other communications to or from a Physician, Hospital or other medical provider;

(cc) which results from breast augmentation or reduction, whether or not Medically Necessary, except for breast reconstruction following a mastectomy as required under state or federal law/regulation;

(dd) which results from:
(1) pervasive developmental disorders;
(2) mental retardation;
(3) conduct disorders; or
(4) developmental disorders (unless otherwise specifically provided in the Plan);

(ee) for educational testing or educational remediation (unless otherwise specifically provided in the Plan);

(ff) for therapies designed to promote personal growth or enhancement;

(gg) for exercise equipment;

(hh) for services or supplies which are provided or paid for by the federal government or its agencies, except for:
(1) the Veterans Administration, when services are provided to a veteran for a disability which is not service-connected;
(2) a military Hospital or facility, when services are provided to a retiree (or dependent of a retiree) from the armed services;
(3) a group health plan established by a government or its agencies for its own civilian employees and their dependents; or
(4) Medicaid, if required by a Medicaid assignment of benefits;

(ii) which results from an act of declared or undeclared war or armed aggression;

(jj) which:
(1) is incurred while the Covered Person is on active duty or training in the Armed Forces, National Guard or Reserves of a state or country; and
(2) for which any governmental body or its agencies are liable;

(kk) for contact lenses, except as provided under the Medical Benefits section;

(ll) for routine eye refractions or the fitting or cost of visual aids, vision therapy, radial keratotomy or similar surgery done for the correction of any refraction error or astigmatism, except for corneal graft;

(mm) for the fitting or cost of hearing aids and related supplies;

(nn) for professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law;

(oo) for Substance Abuse treatment, except as provided in the Plan;

(pp) for Mental and Nervous Disorders treatment, except as specifically provided in the Plan;

(qq) for Nonsurgical Spinal Treatment, except as specifically provided in the Plan;

(rr) for body organ(s)/tissue transplants, except as specifically provided in the Plan;

(ss) for Specialty Drugs and Medicines which exceed a Usual and Customary maximum allowable charge of 115% of Average Wholesale Price (AWP);

(tt) for any treatment, service or supply unless it is shown under Covered Services in the Plan;

(uu) any Expense which is paid under any other provision of the Plan;

(vv) for Dependent child Pregnancy or complications of Pregnancy of Dependent child;

(ww) for abortions, terminations of Pregnancy, or complications resulting from abortions or terminations of Pregnancy;

(xx) for direct sterilization procedures, unless required for treatment of an Injury or Illness; or

(yy) for any services not in keeping with Ethical and Religious Directives for Catholic Health Care Services.

(zz) Alcohol. Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(aaa) Biofeedback.

(bbb) Foreign travel. Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(ccc) Hair loss. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.

(ddd) Hazardous Hobby or Activity. Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies or activities are skydiving, auto racing, hang gliding, jet ski operating or bungee jumping.

(eee) Hospital employees. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(fff) Illegal acts. Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(ggg) Illegal drugs or medications. Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(hhh) Marital or pre-marital counseling. Care and treatment for marital or pre-marital counseling.

(iii) Massage therapy.

(jjj) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(kkk) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

(lll) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(mmm) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(nnn) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(ooo) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(ppp) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

(qqq) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(rrr) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

(sss) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Express Scripts is the administrator of the pharmacy drug plan.

Copayments

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

Coinsurance

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, coinsurance is applicable.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, Express Scripts, the mail order pharmacy, is able to offer Covered Persons significant savings on their prescriptions.

This Plan has a restricted Generic program. This means that if the Covered Person requests a Brand Name drug that has a Generic equivalent, when your Physician allows substitution, the Covered Person will be responsible for the Brand Name copayment and the cost difference between the Brand Name drug and its Generic equivalent.

A formulary is a list of preferred medications that have been clinically reviewed by the Plan. To find if a medication is on the formulary, call Express Scripts, Inc. at 1-800-233-8065.

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. Oral contraceptives are excluded.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other Diabetic Supplies when prescribed by a Physician. Other injectables are not covered.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.

(9) **Immunization.** Immunization agents or biological sera.

(10) **Impotence.** A charge for impotence medication.

(11) **Infertility.** A charge for infertility medication.

(12) **Injectable.** A charge for hypodermic syringes and/or needles, injectables or any prescription directing administration by injection (other than for insulin).

(13) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(14) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(15) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(16) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(17) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(18) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(19) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(20) **Smoking cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent products, for smoking cessation.

HOW TO SUBMIT A MEDICAL CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

Normally Participating Provider will file their claims directly to the Claims Administrator. When a Covered Person has a Claim to submit for payment an itemized bill is required:

For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

Send the above to the Claims Administrator at this address:

WebTPA
P.O. Box 99906
Grapevine, Texas 76099-9706

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 365 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

it's not reasonably possible to submit the claim in that time.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

PROCESSING CLAIMS AND APPEALS

CLAIMS AND APPEAL PROCEDURES

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a written notice of this denial. This written notice will be provided within 90 days after receipt of the claim. The written notice will contain the following information:

(a) the specific reason or reasons for the denial;

(b) specific reference to those Plan provisions on which the denial is based;

(c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

(d) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

In cases where a claim for benefits payment is denied in whole or in part, the Plan Participant may appeal the denial. This appeal provision will allow the Plan Participant to:

(a) Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.

(b) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Administrator within 60 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Plan Participant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for review.

The Plan Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits. If a lawsuit is brought, it must be filed within two years after the final determination of an appeal.

Appeals should be sent to the Claims Administrator at the following address:

WebTPA
Appeals and Grievance
P.O. Box 1808
Grapevine, Texas 76099-1808

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an

Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situations in which a person who is covered as a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the

amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer, including but not limited to the Covered Person's insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. This provision expressly abrogates the "make whole" and "common fund" doctrines and similar defenses to the Plan's claims. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's

100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person, or his or her designee, by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION OF BENEFITS COVERAGE

Because the Plan is a "church plan" it is not subject to the Consolidates Omnibus Budget Reconciliation Act of 1985 (COBRA). However, the Plan nonetheless offers continuation of coverage with the provisions described in this section. The extended health coverage is referred to as "Continuation of Benefits Coverage".

If a "Qualified Beneficiary" (as described below) loses his/her coverage under the benefit programs of the group health plan as a result of a qualifying event (as described below), he/she has the opportunity for Continuation of Benefits Coverage for up to 18 months. The benefit programs that are included in the CEBG group health plan include the Medical and Dental programs.

Only Qualified Beneficiaries are eligible for Continuation of Benefits Coverage. A "Qualified Beneficiary" is an employee and any eligible dependents that is covered by a CEBG group health plan on the day before coverage would otherwise end. This employee must have been on the CEBG group health plan at least 6 months. A "Qualified Beneficiary" also includes (1) any child who is born or placed for adoption with you during your Continuation of Benefits Coverage period. Each Qualified Beneficiary has a separate election right and may choose to continue the coverage offered below.

The ***initial*** Continuation of Benefits Coverage premium/payment that is due will include ***both*** the premium for the coverage that is retroactive to the date of the Qualifying event and in accordance with normal benefit plan billing procedures, the next month's premium. Subsequent payments for coverage must be received by the ***First of the Month*** in order for coverage to remain in place. Failure to make payments prior to the first of the month shall result in termination of benefits. ***Once coverage is terminated, Continuation of Benefits Coverage cannot be reinstated.***

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Catholic Employee Benefit Group is the benefit plan of Catholic Employee Benefit Group, the Plan Administrator, also called the Plan Sponsor. An individual or committee may be appointed by Catholic Employee Benefit Group to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Catholic Employee Benefit Group shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean

activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Catholic Employee Benefit Group’s workforce are designated as authorized to receive Protected Health Information from Catholic Employee Benefit Group ("the Plan") in order to perform their duties with respect to the Plan: Human Resources, Advanced Plan for Health.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Catholic Employee Benefit Group

GROUP IDENTIFICATION NUMBER: 2008CEBG

TAX ID NUMBER: 205069782

PLAN YEAR EFFECTIVE DATE: July 1st

PLAN YEAR ENDS: December 31st, 2015

EMPLOYER INFORMATION

Catholic Employee Benefit Group
1320 Greenway, Suite 170
Irving, Texas 75038
972-714-0004

PLAN ADMINISTRATOR

Catholic Employee Benefit Group
1320 Greenway, Suite 170
Irving, Texas 75038
972-714-0004

CLAIMS ADMINISTRATOR

WebTPA
P.O. Box 99906
Grapevine, Texas 76099-9706
800-953-2024

BY THIS AGREEMENT, Catholic Employee Benefit Group is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Catholic Employee Benefit Group on or as of the day and year first below written.

By _____
Catholic Employee Benefit Group

Date June 24, 2015

Witness _____

Date 6/24/2015