Your Employee Benefits

provided through

Christian Brothers Employee Benefit Trust

For

Jesuit Volunteer Corps

Effective 1-1-12

CHRISTIAN BROTHERS SERVICES

Benefits Administered by:
Employee Benefit Services
1205 Windham Parkway
Romeoville, IL 60446-1679
800.807.0400
mycbs.org/health

IMPORTANT NUMBERS

PREFERRED PROVIDER ORGANIZATION (PPO)

Your Member (Employer) has agreed to utilize
PHCS Network
as your Preferred Provider Organization (PPO). Your provider verification number is:

Nationwide: 1-800-545-2958
Website: www.phcs.com

COST CONTAINMENT ADMINISTRATOR

Cost Containment Administrator for Utilization Management Requirements:
Pre-approval required for hospital admissions, physical & speech therapy,
home healthcare, and durable medical equipment.

Nationwide: 1-866-458-4002

BENEFIT ADVICE

Please give us a call if you have any questions about your health care benefits.

1-800-807-0400

You may refer to the claim procedures section of the booklet for more detailed information.

PRESCRIPTION DRUG BENEFITS MANAGER

Your Member (Employer) has agreed to provide prescription drug benefits through the Christian Brothers Employee Benefit Trust. These benefits are administered by **Medco**. Medco's Member Services telephone number is:

Nationwide: 1-800-718-6601

Website: www.medco.com

Maintaining Your Health Programs & Services

The Christian Brothers Employee Benefit Trust (CBEBT) has had a long tradition of including a variety of utilization and disease management services as part of its benefits package at no cost to participants. **Maintaining Your Health** is a suite of value added programs and services. We believe that **Maintaining Your Health** includes all aspects of your health from wellness initiatives to managing chronic diseases as well as providing assistance in those acute health care situations. CBEBT has partnered with a variety of vendors to bring you the highest quality programs and services available.

Pre-Certification & Utilization Review

Pre-approval is required by your Plan. Please refer to the back of your ID card for the requirements of your Plan and for the telephone number to call.

Care Management Program

American Health Holding Inc (AHH) is one of the leading providers of URAC-accredited chronic disease and case management programs. Their main objective is improving the overall health and quality of life for each enrolled member. Care Management can be reached at 800.641.3224.

Our integrated systems provide triggers that automatically refer both large complex cases and small cases that may benefit from care management intervention. The **Maintaining Your Health *Care Management Program*** offers access to centers of excellence, specialty care facilities, education on alternatives to costly inpatient care, and direction toward in-network discounts. AHH Registered Nurse Case Managers function as advocates, facilitators and educators, ensuring that members choose the best care options, find resources or providers for needed treatment, and assist in obtaining the care needed to facilitate a quick recovery. AHH provides individuals with a better understanding of their specialized care needs.

In less complex cases when home treatment could be provided in lieu of hospitalization, e.g., at home wound care, dressing changes, or IV antibiotic infusions a Nurse Case Manager will contact the participant directly to help identify needed care and to guide the participant in locating quality care providers at the best cost possible to maximize benefits.

AHH also provides specialty care management services for high risk maternity, neonatal, pediatric, oncology, transplant and renal cases.

Disease Management Program

The **Maintaining Your Health *Disease Management Program*** is designed to focus on common prevalent chronic conditions that impact health and measure improvements. These include Asthma, Chronic Obstructive Pulmonary Disease, Chronic Pain, Congestive Heart Failure, Coronary Artery Disease, and Diabetes. This program utilizes clinically proven behavioral assessments and modification tools to provide individuals with chronic conditions the best opportunity for achieving optimal health. AHH Nurse Coaches provide support in developing and achieving realistic personal health improvement goals. Population Health Management can be reached at 800.488.2704

In addition to providing support for common chronic conditions, CBEBT has partnered with **Accordant Health Services** to bring you the **Maintaining Your Health *AccordantCare™ Program.*** This program is designed to meet unique healthcare needs and support members with rare chronic conditions, including Seizure Disorders, Rheumatoid Arthritis, Multiple Sclerosis, Crohn's, Ulcerative Colitis, Parkinson's, Myasthenia Gravis, Cystic Fibrosis, Hemophilia, Scleroderma, Dermatomyositis, and Gaucher Disease. The ***AccordantCare™ Program*** can be reached at 866.655.7490 or by visiting www.accordant.com.

Healthy Pregnancy Program

CBEBT also offers a **Maintaining Your Health *Healthy Pregnancy Program*** through AHH. All expectant mothers covered by the Plan are encouraged to enroll in this voluntary program. Experienced nurses work with expectant mothers to emphasize early prenatal care and consistent physician contacts. Nurses are available to answer questions and provide support throughout the pregnancy. Call 800.641.3224 to speak to a nurse or enroll in the ***Healthy Pregnancy Program***.

Wellness Initiatives

All plans offered through the CBEBT cover some preventive care before co-payments and/or deductibles when using an in-network provider. Preventive Care benefits will be based upon the Health Care Reform guidelines and, as such, may be amended from time to time. Benefits will include such services as Annual Routine Physical Exam, Annual Routine Gynecological Exam, Well Child Care, Immunizations, Preventive X-Ray and Lab Services provided during the Exam, Routine Preventive Colonoscopy / Sigmoidoscopy, and Preventive Mammogram. For a complete list visit ***http://www.healthcare.gov/center/regulations/prevention/recommendations.html.***

If offered by your Member Employer, CBEBT has available the **Maintaining Your Health *Wellness Screening and Personal Health Coach Program*** through **Wellness Inc.** This program is designed to alert and educate members on health issues. Screenings provide early detection to many diseases, disorders, and illnesses long before any symptoms are present. Participation in the wellness screening and health coaching programs gives the guidance needed to ensure a healthier, happier life.

The **Free & Clear *Quit for Life*® Program** is a telephone-based program brought to you in partnership with the American Cancer Society that has helped thousands of people double their chances of giving up smoking for good. This clinically-proven counseling program provides support and helps participants stay focused on their personal reasons for quitting. This program also offers Nicotine Replacement Therapy, which includes patches, gum, and lozenges, and can be provided in conjunction with the counseling program. This program is available 24/7 by calling 866.quit.4.life or 866.784.8454.

Discount Programs

A ***Vision Discount Program*** applies to all members enrolled in the medical plan. This program through **Vision Service Plan (VSP)** offers discounts up to 20% off exams, lenses and more. To find a VSP provider, visit their website at www.vsp.com or call 800.877.7195.

Through **American Hearing Benefits, Inc. (AHB)** the Hearing Discount Program offers significant savings on all styles of digital hearing aids at over 1,800 provider locations. This program is available at no charge, and offers free hearing screenings for participants, their spouse, children, parents, and grandparents. Eligible participants and non-CBEBT members may be responsible for any testing performed during the hearing screenings. To take advantage of this discount program, please call 866.925.1287 or visit www.americanhearingbenefits.com.

The ***Lab Card Program*** and ***Lab Card Select Program*** are voluntary programs that allow members enrolled in standard CBEBT PPO Plans to obtain 100% coverage for outpatient laboratory testing with no co-pays and/or deductibles and members enrolled in HSA Qualified High Deductible Health Plans to obtain significantly reduced fees for outpatient laboratory tests. Refer to the back of the participant ID Card to see which program applies. To take advantage of these programs contact Lab Card Client Services at 800.646.7788 or visit their site at www.labcard.com or www.labcardselect.com.

More Information

For more information about these programs and services, please visit mycbs.org/health or contact customer service at the number on the back of your ID card.

MEDICAL AND PRESCRIPTION DRUG

BENEFIT BOOKLET

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I. INTRODUCTION

Christian Brothers Employee Benefit Trust is a self-funded church plan which serves employers of the Catholic Church by providing medical benefits to Plan participants for treatment of covered illnesses or injuries. It is understood that the Trust works within the framework of the tenets of the Catholic Church. It is for that reason the Trust does not provide benefits for services which are not consistent with the position of the Church; such as, contraception, sterilization, abortion, etc.

A. Plan Benefits

Plan Benefits are governed by this benefit description booklet.

B. Plan Interpretation

This benefit description booklet has been prepared with as much information as is reasonable to help you understand your benefits. However, some terms in the Plan may require interpretation as they apply to any specific situation.

The Plan Administrator has been given the authority and discretion by the Plan Trustees to interpret the terms of the Plan where the Plan's terms need interpretation and to approve certain services in catastrophic cases.

The Plan Administrator reserves the right to employ experts in the disability, medical and dental fields in order to be guided by the terms of the entire Plan and by commonly accepted industry practices. In the event of a dispute, final authority for interpretation and construction rests with the Plan Trustees.

C. Conformity with State Mandates

The Christian Brothers Employee Benefit Trust is a "church plan" as designated by the Internal Revenue Service and Department of Labor. It is not a group insurance contract within the meaning of state group insurance laws. Therefore, the Christian Brothers Employee Benefit Trust is not subject to the mandated benefit requirements imposed by state group insurance laws. To the extent that state laws other than those applicable to group insurance contracts may legally require the Christian Brothers Employee Benefit Trust to provide a particular benefit, the Christian Brothers Employee Benefit Trust will conform to the state mandate, unless the mandated benefit would conflict with the doctrine or tenets of the Roman Catholic Church.

D. Conformity with Federal Mandates

The Christian Brothers Employee Benefit Trust is generally subject to the provisions of the Patient Protection and Affordable Care Act. Accordingly, to the extent that Act would legally require the Christian Brothers Employee Benefit Trust to provide a particular benefit, the Christian Brothers Employee Benefit Trust will do so, unless providing the benefit would conflict with the doctrine or tenets of the Roman Catholic Church.

II. YOUR ROLE IN CONTROLLING HEALTH CARE COSTS

Making choices about your health can sometimes be difficult. When you seek health care, take the same approach you use for buying anything else. Ask questions. Make sure you get the most appropriate care for your condition. Use the following guidelines to help you be a wise health care consumer.

Practice Good Health Habits. Staying healthy is the best way to control your medical costs. Eat a balanced diet, exercise regularly, and get enough sleep. Learn how to handle stress. Stop smoking and avoid excessive use of alcohol.

See Your Doctor Early. Don't let a minor problem become a major one. This makes treatment more difficult and expensive.

Be Certain You Need Surgery. If you need surgery, ask about same day surgery. Many procedures can be performed safely without a Hospital stay. You may have these surgeries as an outpatient or at a place other than a Hospital and go home the same day.

If you are not sure surgery is necessary, you may wish to get a second opinion.

Use Outpatient Services for X-ray or Laboratory Tests. Outpatient preadmission and diagnostic tests can save costly room and board charges.

Compare Prescription Drug Prices. Discuss the use of generic drugs with your doctor or pharmacist. Generic drugs are often cheaper than brand name drugs for the same quality.

Consider Hospital Stay Alternatives. Home Health Care, Skilled Nursing Facilities, and Hospice Care services offer quality care in comfortable surroundings for less cost than staying in the Hospital.

Review Medical Bills Carefully. Make sure you understand all charges and receive bills only for services you receive. Keep your medical records up-to-date.

Talk to Your Doctor. Discuss the need for treatment with your doctor. It is your body. To make wise health care decisions, you must understand the treatment and any risks or complications involved. Ask about treatment costs too. With today's health care costs, your doctor will understand your concern about your medical expenses.

Be a wise health care consumer. Review your benefits carefully so you can make informed health care decisions. You can help control health care costs while getting the most your health care plan has to offer.

III. SUMMARY OF MEDICAL BENEFITS

Benefits will be payable during a Plan Year as shown below and will vary depending upon whether or not needed care is received from a Hospital, Physician, or other provider who has contracted with the Preferred Provider Organization network. Refer to the remainder of this book for a complete description of covered services.

Medical Benefit Summary		
	PPO IN-NETWORK	**OUT-OF-NETWORK**
Deductible (1)	$100 per Individual $300 per Family	$100 per Individual $300 per Family
Out-of-Pocket Limit (1)	$100 per Individual $300 per Family	$3,000 per Individual $6,000 per Family
Lifetime Maximum	Unlimited	
Preventive Care	100%, No Deductible	Out-of-Network Benefits Paid
	Preventive Care benefits will be based upon the Health Care Reform guidelines and, as such, may be amended from time to time. Benefits will include such services as Annual Routine Physical Exam, Annual Routine Gynecological Exam, Well Child Care, Immunizations, Preventive X-Ray and Lab Services provided during the Exam, Routine Preventive Colonoscopy / Sigmoidoscopy, and Preventive Mammogram. For a complete list visit http://www.healthcare.gov/center/regulations/prevention/recommendations.html	
Charges By Physician For		
Office Visits - (Primary Care Physician)	100% after $20 Co-Pay (2)	50% after Deductible
Office Visits - (Specialty Physician including Chiropractor and Speech & Physical Therapy)	100% after $20 Co-Pay (2)	50% after Deductible
Allergy Injection	100% after $5 Co-Pay (2)	50% after Deductible
Inpatient or Outpatient Hospital Visits and Surgery	100% after Deductible	50% after Deductible
Emergency Room Visits	100% after Deductible	Same as In-Network
Reading of X-Ray and Lab Tests Performed at Another Location	100% after Deductible	50% after Deductible
	100% for lab tests with Lab Card	
Charges By Hospital	**Hospital admissions require Pre-Certification. Please call the number on the back of your Identification Card. Failure to call may reduce benefits.**	
Inpatient	100% after Deductible	50% after Deductible
Outpatient	100% after Deductible	50% after Deductible
Emergency Room Care	100% after $50 Co-Pay (2)	Same as In-Network
Other Charges For		
Ambulatory Surgery Center / Birthing Center / Free Standing Facility	100% after Deductible	50% after Deductible
Durable Medical Equipment, Prosthetic Appliances, Ambulance, and/or Supplies	100% after Deductible	50% after Deductible
Mental Health, Behavioral, Alcohol, or Drug Abuse Related Services	In-Network PPO Benefits Paid	Out-of-Network Benefits Paid

(1) Medical Deductibles and Out-Of-Pockets reduce each other. (2) Co-Pay does not apply toward Deductible or Out-of-Pocket Limit.

Special Limited Benefits		
Skilled Nursing Facility	100% after Deductible	50% after Deductible
	120 Day Maximum for all Skilled Nursing Facility confinements that result from the same or a related sickness or injury.	
Home Health Care	100% after Deductible	50% after Deductible
	100 Home Health Care visit maximum per Plan Year	
Hospice Care	100% after Deductible	50% after Deductible
	$10,000 maximum benefit for any one Hospice Care Episode	
Other State Licensed Practitioners Includes acupuncture and massage therapists	100% after Deductible (3)	50% after Deductible (3)
	12-visit maximum per year (All providers combined.)	
Natural Family Planning	100%, No Deductible	100%, No Deductible
	Maximum Yearly Benefit of $200. Reimbursement of counseling services.	
Orthotics	In-Network PPO Benefits Paid	Out-of-Network Benefits Paid
	Maximum Lifetime Benefit of $500 - All services related to purchase of orthotics.	
Transplants	**Transplant Network Provider**	**Non-Transplant Network Provider**
	In-Network PPO Benefits Paid Travel/Lodging Benefit of $10,000 if pre-approved and distance to Center is greater than 100 miles one-way	Out-of-Network Benefits Paid Individual Transplant Maximums Lifetime Maximum Benefit of $150,000 for all Transplants
All Other Covered Charges	100% after Deductible	50% after Deductible

(1) Medical Deductibles and Out-Of-Pockets reduce each other. (2) Co-Pay does not apply toward Deductible or Out-of-Pocket Limit.
(3) The percentage members pay for these services (Coinsurance) does not apply toward Out-of-Pocket Limit.

A. Preferred Provider Organization (PPO)

Your Member (Employer) has agreed to participate in a Preferred Provider Organization (PPO) network.

As you may know, Preferred Provider Organizations are arrangements whereby Hospitals, Physicians, and other providers are contracted to furnish, at negotiated costs, medical care for you and your Dependents.

It is expected that your Member's (Employer's) participation in the PPO will result in significant savings of funds needed to maintain your plan. These savings are to be passed on to you in the form of higher plan benefits payable for services received by you or a Dependent from Preferred Providers.

A listing of participating Hospitals, Physicians, and other providers are available to you via the network's website. Please note that your Member's (Employer's) participation in the PPO does not mean that your choice of provider will be restricted. You may still seek needed medical care from any Hospital, Physician, or other provider you wish. However, in order to avoid higher charges and reduced benefit payments, you are urged to obtain such care from Preferred Providers whenever possible.

Please remember, the Plan does not pay PPO benefits to a non-PPO provider even when a PPO provider refers or requests the assistance of a non-PPO provider.

The Cost Containment Administrator will assume responsibility for assisting you and your Dependents with Utilization Management Requirements.

We have the right to terminate the PPO portion of this plan if We or the PPO terminate the arrangement. In the event of termination, We will pay the level of benefits as described for medical care received from "Other Than Preferred Providers."

B. Comprehensive Medical Benefits (Subject to Utilization Management Requirements)

If you or one of your Dependents are sick or injured, Scheduled Benefits then in force will be payable for Covered Charges. Scheduled Benefits are based on your class:

Class	Scheduled Benefit
All Enrolled Employees and Dependents	Comprehensive Medical

C. Co-Pay Requirement Amount(s)

Any Medical or Prescription Drug Co-Pay amount required will not count toward satisfaction of the Plan Year deductible.

Any Medical or Prescription Drug Co-Pay amount required will continue to apply after the Out-of-Pocket Expense Maximum is reached.

D. Medical Deductible Requirement Amount(s)

All Medical Covered Charges (unless otherwise specified) are subject to the Deductible Requirement Amount(s) before benefits are payable for each Covered Person. (See Page 3 in this Summary of Medical Benefits for the amount of your deductibles.)

Any Co-Pays specifically indicated in your Summary of Medical Benefits or Summary of Prescription Benefits will not apply toward satisfaction of the Deductible Requirement.

Family Limit

The maximum family deductible will be the amount listed on Page 3 in this Summary of Medical Benefits but not counting more than one individual deductible for any one person in your family.

E. Medical Out-of-Pocket Expense Maximum per Plan Year

If the amount you pay for Covered Charges in any one Plan Year reaches the Out-of-Pocket Expense Maximum shown on Page 3, We will pay 100% of additional Covered Charges (except as described below).

The percent you pay in excess of the Co-Pay amount will be counted toward satisfaction of the Out-of-Pocket Expense Maximum shown, but will not be counted toward satisfaction of the Plan Year deductible.

The amounts that are not payable after you reach your Out-of-Pocket Expense Maximum or DO NOT apply toward your Out-of-Pocket Expense Maximum are:

- Any Co-Pay amount required; and
- The percent you pay under “Other Covered State Licensed Practitioners Benefits”; and
- Penalties incurred for failure to comply with any Utilization Management Requirements; and
- Co-Pays required from you under the Prescription Drug Benefit.

F. Medical Emergency

If you or one of your Dependents require treatment for a Medical Emergency Service and cannot reasonably reach a Preferred Provider, benefits for such treatment by the hospital, emergency room physician, and other charges incurred while being treated in the emergency room will be paid at the same level as a PPO Provider.

G. Uncontrollable Providers

For services provided by a non-PPO emergency room Physician, anesthesiologist, radiologist, or pathologist, benefits will be payable at the PPO level when such services are provided at a PPO Hospital (inpatient, outpatient, and Hospital emergency room) or a licensed PPO freestanding surgical center.

H. Hospital Benefit Reduction

Comprehensive Medical Benefits payable for Hospital Inpatient Confinement Charges will be reduced by 25%, unless:

- a Hospital Admission Review is requested by you, or a family member, or a Physician and approved by the Cost Containment Administrator; and

- for confinement beyond the initial period, the Hospital Admission Review is extended and approved by the Cost Containment Administrator.

The request must be prior to, but no later than, the day of admission to a Hospital (for other than a Medical Emergency); and for a Medical Emergency, within two business days following a Hospital admission. Certain exceptions apply to Hospital Inpatient Confinement Charges for maternity; see the section entitled Utilization Management Requirements - Hospital

> (If a Hospital Admission Review is not requested in a timely manner as specified above, the 25% reduction in benefits payable will be applied, but only to the charges incurred up to the date a Hospital Admission Review is completed. Benefits will be payable only for that part of the Hospital Inpatient Confinement Charges that have been approved by the Cost Containment Administrator and that We determine to be Covered Charges.)

The 25% reduction in benefits payable is a penalty for failure to comply with the requirements listed in the section entitled Utilization Management Requirements - Hospital. Any such reductions:

- will not count toward satisfaction of the Out-of-Pocket Expense limits; and

- will not exceed $2,000 per individual each Plan Year.

Your medical identification card gives you a telephone number to call your Cost Containment Administrator for Hospital reviews. You must follow all of the requirements discussed in the section entitled Utilization Management Requirements – Hospital or your benefits will be reduced as described above.

SEE THE CLAIMS PROCEDURES SECTION OF THIS BOOKLET FOR IMPORTANT CLAIM PROCEDURES INFORMATION ON FILING YOUR MEDICAL CLAIMS.

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IV. SUMMARY OF PRESCRIPTION BENEFITS

PRESCRIPTION DRUG SUMMARY	
Retail Prescriptions for Short-Term Medications	$10 Co-Pay Generic $25 Co-Pay Preferred Brand $40 Co-Pay Non-Preferred Brand per 30-day supply at any participating pharmacy (2)
Retail purchases for maintenance prescriptions are limited to an initial fill and two subsequent refills. Members who continue to use Retail will pay the Home Delivery Co-Pay, however, only up to a 30-day supply will be dispensed.	
Home Delivery Prescriptions for Long-Term Maintenance Medications	$25 Co-Pay Generic $60 Co-Pay Preferred Brand $100 Co-Pay Non-Preferred Brand per 90-day supply through the home delivery program (2)
• Certain drugs are not covered by the Plan, such as over-the-counter medications, contraceptives, cosmetics, anabolic steroids, appetite suppressants, medications that are not medically necessary, experimental drugs, etc. • Some drugs may require a review of medical necessity and preauthorization before benefits will be applied. • Tobacco Cessation Medications are limited to 180 days supply per year and 540 days supply per lifetime.	
(2) Co-Pay does not apply toward Deductible or Out-of-Pocket Limit.	

A. Retail Network Pharmacy (Up to 30-Day Supply)

Retail Network Pharmacy benefits are designed for short-term drugs, such as antibiotics, or for the first few fills of a long-term maintenance drug while you request a fill through the Home Delivery Pharmacy for up to a 90-day supply. Retail Network Pharmacy prescription drug benefits payable will be 100% of Covered Charges in excess of the copayment or percentage described above.

B. Non-Network Pharmacy

If you or one of your dependents uses a non-Retail Network Pharmacy, the allowable charge for prescription drugs will be 80% of the Retail Network Pharmacy price. Benefits paid will be determined based upon this allowable charge less the appropriate copayment or percentage indicated above.

C. Home Delivery Pharmacy (Up to 90-Day Supply)

Home Delivery Pharmacy Benefits are designed for long-term maintenance prescription drugs that will be taken for more than 90 days. Home Delivery Pharmacy prescription drug benefits payable will be 100% of Covered Charges in excess of the copayment or percentage described above.

D. Generic Drug Substitution

When a Physician allows a generic substitution and you choose the Brand-Name Prescription Drug, you will be responsible for the additional difference in the copayment plus the difference in cost between the Brand Name Prescription Drug and its Generic Prescription Drug equivalent.

E. Your Preferred Prescriptions ® Formulary

Your prescription drug plan includes a formulary, which is a list of drugs that are preferred by your plan. This list includes a wide selection of drugs and is preferred because it offers you a choice while helping to keep the cost of your prescription drug benefits affordable. Each drug is approved by the Food and Drug Administration (FDA) and reviewed by an independent group of doctors and pharmacists for safety and effectiveness. Your plan may encourage the use of the preferred drugs on this list to help control rising drug costs. The Prescription Drug Benefits Manager may remind your doctor when a Formulary Drug is available as a possible alternative for a drug that is not on your Formulary. This may result in a change in your prescription. However, your doctor will always make the final decision on your medication.

To verify if a drug is considered a Preferred Brand-Name Prescription Drug (Formulary) or a long-term maintenance prescription drug, contact Medco at www.medco.com or by calling 1-800-718-6601.

V. HOW TO BE COVERED

A. Eligibility for Enrollment

1. When You are Eligible for Coverage

If you are an Employee, as defined, you are eligible for coverage the day the Plan goes into effect at your Member's (Employer's) location. If your employment commences after such date, you are eligible for coverage on the date selected by your Member (Employer) following the commencement of your employment. (See "Employee" in the Definitions section for eligibility.)

2. When Your Dependents are Eligible for Coverage

Your Dependents are eligible for coverage the same day as you, provided you have eligible Dependents on that date. If you later acquire an eligible Dependent, you will be eligible for Dependent coverage on the date you first acquire an eligible Dependent.

3. Newborns - 31-Day Coverage

Under this Plan, your newborn child will be automatically covered until the child attains 31 days of age. If you do not enroll this child for Dependent coverage before the 31 days end, the "Late Enrollment" provision will apply.

B. How You Enroll for Coverage

To enroll for coverage, obtain an enrollment form from your Member (Employer). Complete the form giving all requested information applicable to you and your Dependents. Sign the form and return to your Member (Employer) on a timely basis.

C. When You Become Enrolled for Coverage

1. Noncontributory Coverage

- If no contributions are required from you for the coverage, you are covered the first day you are eligible.

- If no contributions are required from you for Dependent coverage, your Dependents will be covered on the first day you are eligible for Dependent coverage.

2. Contributory Coverage

- Coverage begins on the first of the month following proper enrollment. If you delay your enrollment more than 31 days beyond the date you were first eligible and other than during a Special Enrollment Period described below, your coverage will be subject to "Late Enrollment Provisions," as described below.

- Coverage begins on the first of the month following proper enrollment . If you delay your enrollment more than 31 days beyond the date you were first eligible but during a Special Enrollment Period described below, your coverage will be subject to "Special Enrollment Provisions," as described below.

3. Late Enrollment Provisions

a. Definitions

Late Enrollee. Late Enrollee means, with respect to coverage under a Member's (Employer's) Group Health Plan, an Employee or Dependent who enrolls under the Plan other than during:

- the first period in which the individual is eligible to enroll under the Group Health Plan; or
- a Special Enrollment Period described below.

For the purpose of the first item listed above, only the most recent period of eligibility will be considered in determining whether an individual is a Late Enrollee if:

- the individual loses eligibility under the Group Health Plan due to termination of employment or due to a general suspension of the Group Health Plan; and
- the individual later becomes eligible again under the Group Health Plan due to resumption of employment or due to resumption of the Group Health Plan's coverage.

The term "Late Enrollee" also means an Employee or Dependent who:

- was previously covered under the Plan but elected to terminate the coverage; and
- reapplies for coverage more than 31 days after the termination date; and
- does not qualify for one of the Special Enrollment Periods described below.

b. Effective Date for Late Enrollees

A Late Enrollee can request coverage at any time, provided on such date:

- the Employee continues to meet the Plan's definition of an Employee; and
- for Dependent coverage, the Dependents continue to meet the Plan's definition of Dependent.

Coverage for a Late Enrollee will become effective the first of the month following a six-month deferral period from the date the enrollment form is received by Us.

The individual will be subject to the Plan's Preexisting Condition Exclusion provisions, as described under Section XI, when his or her coverage becomes effective.

D. Special Enrollment Periods

If you or your Dependent requests enrollment after the first period in which you or your Dependent was eligible to enroll but during a Special Enrollment Period as described below, you or your Dependent will be a Special Enrollee and will not be considered a Late Enrollee.

If the Member (Employer) offers different benefit options, a benefit option transfer may also be made if your request is due to a Special Enrollment Period and you complete the appropriate enrollment form within the time specified for a Special Enrollment Period as described below. The effective date of the benefit option transfer will coincide with the effective date of your applicable Special Enrollment.

The Special Enrollment Periods are:

- Loss of Other Coverage: A Special Enrollment Period will apply to you or your Dependent if all of the following conditions are met:

  - You or your Dependent were covered under another Group Health Plan or had other Health Insurance Coverage at the time of initial eligibility, and declined enrollment solely due to the other coverage; and

  - The other coverage terminated due to loss of eligibility (including loss due to legal separation, divorce, death, cessation of Dependent status, termination of employment or reduction in work hours, incurring a claim that meets or exceeds the other coverage lifetime limit on all benefits, when the individual no longer resides, lives, or works in a service area and there is no other benefit package available under the other Group Health Plan, or when the other Group Health Plan no longer offers any benefits to a class of similarly situated individuals), or due to termination of employer contributions (or, if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation); and

  - Request for enrollment is made within 31 days after the other coverage terminates or after a claim is denied due to reaching the lifetime limit of all benefits under the other health coverage.

  The effective date of coverage will be the first of the calendar month that next follows the date of the request for enrollment.

  NOTE: For the purpose of the second item listed above:

  - "Loss of eligibility" does not include a loss due to failure of the individual to pay contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the health coverage); and

  - "Employer contributions" include contributions by any current or former employer (of the individual or another person) who was contributing to the coverage of the individual.

- Newly Acquired Dependents: A Special Enrollment Period will apply to you or your Dependent if:

  - You are enrolled (or are eligible to be enrolled but have failed to enroll during a previous enrollment period); and

  - A person becomes your Dependent through marriage, birth, adoption or Placement for Adoption; and

  - Request for enrollment is made within 31 days after the date of the marriage, birth, adoption, or Placement for Adoption.

  The effective date of your or your Dependent's coverage will be:

  - In the event of marriage, the date of the request for enrollment; or

  - In the event of a Dependent child's birth, the date of such birth; or

- In the event of a Dependent child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.

- Court-Ordered Coverage: A Special Enrollment Period will apply to your Dependent child if:

  - You are enrolled but have failed to enroll the Dependent child during a previous enrollment period; and

  - You are required by a court or administrative order to provide health coverage for the Dependent child; and

  - Request for enrollment is made within 31 days after the issue date of the court or administrative order.

  The effective date of the Dependent child's coverage will be the date of the request for enrollment.

  A copy of the procedures governing Qualified Medical Child Support Orders (QMCSO) can be obtained from the plan administrator without charge.

- Loss of Medicaid or CHIP Coverage: A Special Enrollment Period may apply to you or your Dependent if:

  - You or your Dependent is covered under Medicaid or a Children's Health Insurance Program ("CHIP") and Medicaid or CHIP coverage is terminated as the result of loss of eligibility; and

  - You request special enrollment on an appropriately completed enrollment application within 60 days after the loss of such coverage.

- Eligibility for Employment Assistance Under Medicaid or CHIP: A Special Enrollment Period may apply to you or your Dependent if:

  - You or your Dependent become eligible for a Medicaid or CHIP premiums assistance subsidy; and

  - You request special enrollment on an appropriately completed enrollment application within 60 days after you or your dependent is determined to be eligible for assistance.

E. Certificate of Creditable Coverage Required by HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires a certificate of Creditable Coverage be issued to individuals losing health coverage. A Certificate of Creditable Coverage will be issued automatically when you or your Dependent's coverage under the plan terminates or when continued coverage terminates. You may also request a Certificate of Creditable Coverage at any time while covered and up to 24 months after the date coverage terminates. For further information contact:

Christian Brothers Employee Benefit Trust
c/o Christian Brothers Services
1205 Windham Parkway
Romeoville, IL 60446-1679
Phone: 800-807-9460

F. Transfer Provision (For Newly Enrolled Employers)

When this Plan replaces the coverage of another group carrier for a newly enrolled Member/Employer, benefits payable will be the lesser of:

- the amount which would have been paid by the previous carrier had their coverage been continued; or

- the amount payable under this Plan.

Conditions for coverage under this Transfer Provision are subject to those stated in the plan document.

VI. ELIGIBLE DEPENDENTS

For Comprehensive Medical and Prescription Drug Benefits, Dependent means:

- your Spouse, if not in the Armed Forces and not covered as an Employee; and
- your natural or legally adopted child less than 26 years of age; and
- a child of your Spouse less than 26 years of age.

In no event may a Dependent child be covered by more than one Employee. If more than one Employee would otherwise cover the Dependent child, the child may only be covered by the Employee with the longest period of continuous service, unless otherwise determined by a mutual written agreement.

Dependent will include a child less than 26 years of age for whom you have legal guardianship if the child is the employee's tax dependent and We approve in writing. To be the employee's tax dependent, the child must be claimed as an exemption, as defined by the I.R.S. Code of the U.S., on your Federal income tax return.

Dependent will include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to this plan, provided the child meets this plan's definition of a Dependent.

A covered child, who attains the age at which his status as an eligible Dependent would otherwise terminate, may retain eligibility if the Dependent is chiefly dependent upon the Employee for support and maintenance and incapable of self-sustaining employment by reason of Physical Handicap. Such condition must start before reaching the age when Dependent status otherwise would terminate. We may ask for proof of incapacity from time to time. If proof is requested and We do not receive an answer within 90 days, the child will no longer be considered an eligible Dependent.

A non-covered child who is ineligible due to age may be eligible for coverage under this handicapped provision if the child meets the requirements above and provides us with proof of "Creditable Coverage" as defined under HIPAA.

A. Change in Family Status

Once you are in the Plan, it is necessary that you promptly enroll your eligible Dependent(s). Also, please notify your Member (Employer) when you no longer have any eligible Dependents.

If you have one or more covered children, you must report the names and dates of birth of any additional children to your Employer. If only children are covered and a spouse becomes eligible, you must also report this to your Employer.

VII. WHEN YOUR COVERAGE TERMINATES

A. Termination of Coverage

Coverage for you and your Dependents terminates when:

- your employment terminates; or
- you no longer qualify as an Employee; or
- coverage terminates on the class of employees to which you belong; or
- you discontinue required contributions; or
- you cease to be actively employed; or
- your Member (Employer) no longer is a participant in the Trust; or
- the Plan terminates.

Coverage for a Dependent terminates when:

- your Dependent is no longer eligible for coverage; or
- your Dependent's coverage under the Plan terminates; or
- your coverage as an Employee terminates; or
- the Plan terminates.

B. Continuation Privilege

Any continuation privileges below are subject to terms and conditions established by your Member (Employer) and the Plan Administrator.

1. Employee and Dependent Continuation Privilege – General

If you or your Dependent(s) lose coverage due to:

- termination of employment; or
- leave of absence; or
- ineligibility as an Employee; or
- ineligibility as a Dependent; or
- retirement; or
- death of an Employee or Retiree; or
- disability; or
- divorce;

you may be eligible to continue your medical and prescription drug coverage for a limited period of time by paying the required contribution.

You should contact your Member (Employer) to verify if continuation is available and to obtain the necessary forms required for continuation.

2. Retiree Continuation Privilege

Your Employer may offer a Retiree Continuation Privilege. Please contact your Employer to verify if continuation is available.

If your Employer allows continuation for retirees, you and your eligible Covered Dependents may be eligible to continue your Medical and Prescription coverage by paying the required contribution. You would be eligible if:

- you retire at age 55 or older with at least five consecutive years of Medical coverage under the Plan prior to retirement, and

- you are receiving a Social Security retirement benefit or a retirement benefit from your Member's (Employer's) retirement plan.

Contact your Employer immediately to obtain the necessary forms for continuation.

If you die while under Retiree Medical and Prescription continuation, your eligible Covered Dependents may be eligible to continue their coverage for a limited period of time by paying the required contribution.

Note: If a retiree, or Spouse, is eligible for Medicare and chooses not to purchase Medicare A or B, benefits from this Plan will be reduced. The Plan only provides benefits under the Integration with Medicare provision discussed later in this booklet at page 53.

3. Federal Family and Medical Leave Act (FMLA)

Continuation

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects your group plan. See your employer for details on this continuation provision.

FMLA and Other Continuation Provisions

If your employer is an Eligible Employer and if the continuation portion of the FMLA applies to your coverage, these FMLA continuation provisions:

- are in addition to any other continuation provision of this plan, if any; and

- will run concurrently with any other continuation provisions of this plan for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

Eligible Employee

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and
- at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- The birth of a child of an Eligible Employee and in order to care for the child.
- The placement of a child with the Eligible Employee for adoption or foster care.
- To care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition."
- A "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job.

Reinstatement

An Eligible Employee's terminated coverage may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

See your employer for details on this reinstatement provision.

Servicemember Family Leave

Eligible Employers are now required to allow unpaid leave to certain family members of military personnel:

- up to 12 weeks for “qualifying exigencies” related to a call to active service in support of a contingency operation; and
- up to 26 weeks to care for a covered family member who has incurred a serious injury or illness in the line of duty.

4. Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Federal law requires that if your coverage would otherwise end because you enter into active military duty, you may elect to continue coverage (including Dependents coverage) in accordance with the provisions of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation

If active employment ends because you enter active military duty, coverage may be continued until the earliest of:

- for you and your Dependents:
    - the date the group plan is terminated; or
    - the end of the contribution period for which contributions are paid if you fail to make timely payment of a required contribution; or
    - the date 24 months after the date you enter active military duty; or
    - the date after the day on which you fail to return to active employment or apply for reemployment with the Member (Employer).
- for your Dependents:
    - the date Dependent Coverage would otherwise cease; or
    - any date desired, if requested by you before that date.

The continuation provision will be in addition to any other continuation provisions described in this plan for sickness, injury, layoff, or approved leave of absence, if any. If you qualify for both state and USERRA continuation, the election of one means the rejection of the other.

Reinstatement

The reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA.

This is a general summary of the USERRA and how it affects your group plan. See your employer for details on this continuation provision.

C. Rescission

Coverage may be cancelled or discontinued retroactively if an individual (or an individual seeking coverage on behalf of an individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact. A cancellation or discontinuance of coverage is not a rescission to the extent it is attributable to a failure to timely pay required contributions toward the cost of coverage.

VIII. COMPREHENSIVE MEDICAL COVERAGE

Comprehensive Medical Benefits are designed to help pay expenses for Covered Charges which you would otherwise have to pay in full.

A. Lifetime Benefit Maximum

The Plan has no overall Lifetime Medical and/or Prescription Drug Benefit Maximum.

The Plan incorporates other yearly or lifetime benefit maximums for each Covered Person. These maximums or limitations are outlined in the description of the specific benefit.

B. Comprehensive Medical Payment Qualification

To qualify for payment of the benefits provided by your Comprehensive Medical Plan, you and your enrolled Dependents must:

- be covered in that class on the date medical Treatment or Service is received; and
- satisfy the requirements listed in the CLAIM PROCEDURES Section.

C. Medical Benefits Payable

Benefits payable are for Covered Charges, described in this section, and are subject to:

- utilization management requirements, as detailed in the section entitled Utilization Management Requirements - Hospital; and
- all listed limitations; and
- the terms and conditions of:
    - Coordination with Other Benefits; and
    - Reimbursement/Subrogation.

D. Medical Payment Conditions

If you or one of your Dependents has a medical condition resulting from a sickness or injury, Comprehenseive Medical Benefits will be paid for Covered Charges:

- in excess of the Deductible Requirement;
- in excess of the Co-Pay requirement;
- at the payment percentage indicated;
- to the applicable Maximum Payment Limit; and
- with any modifications as described in Special Benefit Provisions - Limited.

E. Covered Charges

Covered Charges, as defined, will be the actual cost charged to you or one of your Dependents, but only to the extent that the actual cost charged does not exceed Prevailing Charges for:

- Hospital room and board (but not more than the Private Room Maximum, if confinement is in a private room);
- Hospital services other than room and board;
- Birthing Center services;
- Ambulatory Surgery Center services;
- the services of a Physician, including Physician Visits;
- the services of an assistant to a surgeon if it is determined the skill level of a Physician is required for such services. Covered Charges for such services will be paid at up to 20% of Prevailing Charges of the covered surgical procedure if the procedure is performed by a Physician or a Health Care Extender;
- the services of a licensed practical nurse (L.P.N.) or a licensed registered nurse (R.N.), but only when such services are provided during confinement in a Hospital or Skilled Nursing Facility, or when such services are provided as part of Home Health Care or Hospice Care;
- the services of a licensed physiotherapist;
- the services of a qualified speech therapist to restore or rehabilitate any speech loss or impairment caused by injury or sickness, except a mental, psychoneurotic, or personality disorder or by surgery for that injury or sickness. In the case of congenital defect, speech therapy expenses will be considered only if incurred after corrective surgery for the defect;
- anesthesia, blood, blood plasma, and oxygen;
- x-ray and laboratory examinations;
- the services for genetic testing if the testing meets the Plan's criteria and is pre-approved by Us;
- x-ray, radium, and radioactive isotope therapy;
- surgical dressings, casts, splints, braces, crutches, artificial limbs, and artificial eyes;
- preventive care as shown in your Summary of Benefits beginning on Page 3;
- infertility treatment but limited to initial lab tests, hysterosalpingogram, hysteroscopy, pelvic ultrasound, and transvaginal ultrasound for the restoration of fertility or the promotion of conception. Covered Charges may also include corrective surgery if documentation is provided verifying abnormal or non-functioning body processes;
- services for a diabetic self-management program for a Covered Person who has been newly diagnosed with Diabetes Mellitus, or has new complications thereof. Such program should be pre-approved by Us and the program must be well defined or have received American Diabetes Association approval;

- the services of a Registered Nurse, but only when such services are provided by:

  - an advanced practice Registered Nurse in lieu of a Physician; i.e., Certified Nurse Anesthetist, Certified Nurse Midwife, Certified Registered Nurse Practitioner;

- Dental Services to repair damage to the jaw and sound natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and the Dental Services are completed within twelve months after the accident, and not covered by your dental plan. Covered Charges are limited to the least expensive procedure that would provide professionally acceptable results;

- the services of a Health Care Extender. Health Care Extender means a member of a covered provider's staff or allied health practitioner. Medical services must be billed by and delivered under the Direction and Supervision of a provider covered by the Plan;

- Federal Legend drugs and medicines requiring a Physician's prescription which are not eligible under the Prescription Drug Coverage for Retail Network Pharmacy and Home Delivery Pharmacy;

- transportation services by ambulance provided by a Hospital or licensed service to a local Hospital, to the nearest Hospital equipped to furnish needed treatment not available in a local Hospital, or when needed to transition to a more cost effective level of care as determined by Us;

- rental or purchase of Durable Medical Equipment (DME). The maximum charges eligible for consideration for rental of DME will be limited to the purchase price. When We determine whether to purchase or rent the equipment, We will consider the type of equipment requested, and the condition and length of time for which it will be used. Eligible equipment is a nebulizer, commode, walker, manual wheelchair, or standard hospital-type bed. Other DME may be eligible after Our review, but We must pre-approve the requested equipment;

- repair, adjustment, or replacement of covered purchased Durable Medical Equipment, unless damage results from your or your dependent's negligence or abuse of such equipment;

- convalescent care in a Skilled Nursing Facility only as described under the Special Benefit Provisions - Limited section; Skilled Nursing Facility Confinement Benefits at page 28;

- Home Health Care only as described under the Special Benefit Provisions – Limited section; Home Health Care Benefits at page 29;

- Hospice Care only as described under the Special Benefit Provisions – Limited section; Hospice Care Benefits at page 30;

- the services of a State Licensed Practitioner as limited under the Special Benefit Provisions - Limited section; Other Covered State Licensed Practitioners Benefits at page 31;

- counseling services or visits performed by a covered provider or an individual trained and certified in natural family planning as limited under the Special Benefit Provisions - Limited section; Natural Family Planning Benefit at page 31;

- orthotics provided by a covered provider as limited under the Special Benefit Provisions - Limited section; Orthotic Benefit at page 31;

- Transplant services only as described under the Special Benefit Provisions – Limited section; Organ and Tissue Transplant Benefits at page 32;

1. Miscellaneous

Covered Charges for services provided for anesthesiology, radiology, and pathology by Other Than Preferred Providers (non-PPO): The Plan will pay Preferred Provider (PPO) benefits for Treatment or Services by a non-PPO provider when such services are provided at a PPO Hospital, PPO facility or PPO doctor's office.

Covered Charges for ambulance services: The Plan will pay Preferred Provider (PPO) benefits under Category D for transportation by ambulance regardless of whether such service is provided by a PPO or non-PPO provider.

2. Quest Diagnostics Lab Card Program – Outpatient Laboratory Services

Quest Diagnostics is a laboratory provider that conducts outpatient testing. An agreement has been established with Quest Diagnostics to provide these services at a negotiated rate.

"Laboratory Services" means Covered Charges for testing of materials, fluids, or tissues obtained from patients for the purpose of screening, diagnosing a condition and for determining appropriate treatment.

When you or your Dependent requires outpatient Laboratory Services, you or your Physician may choose any laboratory you wish. However, if you use Quest Diagnostics, the benefits will be more favorable.

When utilizing Quest Diagnostics, there are two ways in which laboratory work is completed:

- Specimens are drawn at the Physician's office and are sent to Quest Diagnostics for testing; or

- The covered individual visits a contracted Quest Diagnostics collection site with a Physician's directive and has the specimen drawn. The specimen is then sent to Quest Diagnostics for testing.

If you or your Dependent goes to a Physician's office or clinic and the Physician sends the laboratory work to Quest Diagnostics for processing, benefits will be paid at 100% of Covered Charges for the Laboratory Services.

If you or your Dependent goes to a Physician's office or clinic and the Physician sends the laboratory work to a facility other than Quest Diagnostics, regular benefits will apply, including any applicable Deductibles or Copays.

If you or your Dependent goes to a Quest Diagnostics contracted collection site with a Physician's directive, benefits will be paid at 100% of Covered Charges for the Laboratory Services. If the laboratory facility is not Quest Diagnostics, regular benefits will apply including any applicable Deductibles or Copays.

If you have questions about the Quest Diagnostics Lab Card program or need to find a participating lab, please call Quest Diagnostic's Client Services at:

1-800-646-7788
www.labcard.com

3. Maternity Benefit

Normal Plan benefits will apply for charges related to pregnancy. The mother and newborn are considered separate dependents under the Plan and separate deductibles and out-of-pockets will apply.

Maternity benefits include services which are considered to be the Generally Accepted standard of care as well as benefits for three routine obstetrical ultrasounds. Any additional ultrasounds must be reviewed to determine if they will be considered Covered Charges.

4. Benefits Payable – Compliance With Federal Law

Subject to the provisions as described above, benefits under this group plan will be payable for:

Newborns' and Mothers' Health Protection Act of 1996

Under Federal law, group health plans generally may not 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 Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, a group health plan may not, under Federal law, require that a provider obtain authorization from the group health plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

Under Federal law, group health plans and health insurance issuers providing benefits for a mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

- all stages of reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema;

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

These benefits are subject to all Plan provisions including the applicable Deductible and Coinsurance based upon where and by whom services are rendered. Please refer to your Summary of Benefits, beginning on Page 3, for a full description of Deductibles and Coinsurance percentages.

5. Prenatal Care Program

A Prenatal Care Program is offered by the Plan. All expectant mothers covered by the Plan are encouraged to enroll in this voluntary program within the first 16 weeks of pregnancy. There is no cost to you for the program and experienced nurses will work with the expectant mother to emphasize early prenatal care, consistent physician contacts, and will be available for questions and provide support throughout the pregnancy.

6. Care Management Program for Newborns

The Plan provides a care management program for newborns admitted to neonatal intensive care units (NICU.) The program promotes high quality of NICU care for each infant through on-site and telephonic care management by physicians and nurse care managers with extensive NICU experience. The goals of this program are to improve infant outcomes and to provide education and support for family members.

Newborns will be identified by a case manager. There is no cost to you for this program, but a written or verbal consent will be needed for the infant to receive the case management services.

7. Prevailing Charges for Multiple Surgical Procedures

If two or more surgical procedures are performed during any one time, Covered Charges for the services of the Physician for each procedure that is clearly identified and defined as a separate procedure will be based on:

- 100% of Prevailing Charges for the first or primary surgical procedures; and
- 50% of Prevailing Charges for the second surgical procedures; and
- 25% of Prevailing Charges for each of the other surgical procedures.

8. Covered Charges for an Assistant during Surgical Procedures

Benefits will be payable for the services of an assistant to a surgeon if the skill level of an M.D. or D.O. is required to assist the primary surgeon. Covered Charges for such services will be paid at up to 20% of the Prevailing Charge of the covered surgical procedure if the procedure is performed by a Physician or a Health Care Extender.

In addition, the multiple surgical procedures percentiles, as described above, will be applied.

IX. SPECIAL BENEFIT PROVISIONS - LIMITED

In order to give you and your Dependent(s) a balanced Comprehensive Medical Plan, certain benefit provisions have been added. These special benefit provisions modify payments to providers and are described on the following pages.

Covered Charges exceeding Prevailing Charges are not eligible for payment.

A. Skilled Nursing Facility Confinement Benefits

Comprehensive Medical Covered Charges will include charges by a Skilled Nursing Facility for room, board, and other services required for treatment, provided the confinement:

- is certified by a Physician as necessary for recovery from a sickness or injury;
- follows three or more consecutive days of Hospital confinement for which Comprehensive Medical Benefits were paid;
- results from the sickness or injury that was the cause of the Hospital confinement;
- begins not later than 14 days after the end of the Hospital confinement or not later than 14 days after the end of a prior Skilled Nursing Facility confinement for which Comprehensive Medical Benefits were paid.

Covered Charges for each day will not be more than 50% of the Private Room Maximum of the Hospital in which the Covered Person was confined before the Skilled Nursing Facility confinement. In addition, Covered Charges will not include any charges after the date the attending Physician stops treatment or withdraws certification.

Refer to your Summary of Medical Benefits beginning on Page 3 under Special Limited Benefits for the:

- percentage payable by the Plan for Covered Charges, and
- maximum number of days payable by the Plan for all Skilled Nursing Facility confinements that result from the same or a related sickness or injury.

B. Home Health Care Benefits

Comprehensive Medical Covered Charges will include charges by a Home Health Care Agency, as defined, for:

- part-time or intermittent home nursing care by or under the supervision of a Registered Nurse; and
- part-time or intermittent home care by a Home Health Aide, as defined; and
- physical, occupational, or speech therapy; and
- drugs and medicines (requiring a physician's prescription), and other supplies prescribed by the attending physician, if the cost of these items would have been Covered Charges had the Employee or Dependent remained as an inpatient in the hospital; and
- laboratory services by or for a hospital if the cost of these services would have been Covered Charges had the Employee or Dependent remained as an inpatient in the hospital.

The above services and supplies must be provided under the terms of a Home Health Care Plan, as defined.

The Comprehensive Medical Benefit Limitations will apply to Home Health Care Benefits. In addition, Comprehensive Medical Covered Charges will not include charges for:

- services or supplies not included in the Home Health Care Plan, as defined; or
- the services of any person who normally lives in the Employee or Dependent's home; or
- custodial care (assistance with meeting personal needs or the activities of daily living that does not require the services of a Physician, Registered Nurse, licensed practical nurse, chiropractor, physical therapist, occupational therapist, speech therapist, or other health care professional and includes bathing, dressing, getting in and out of bed, feeding, walking, elimination, and taking of medications); or
- transportation services; or
- more than the maximum Home Health Care visits in a calendar year as indicated in the Summary of Medical Benefits beginning on Page 3. For this purpose, one visit will be counted for up to four hours of service (in a 24-hour period) by a Home Health Aide and one visit will be counted for each visit by any other person.

Refer to your Summary of Medical Benefits beginning on Page 3 under Special Limited Benefits for the:

- percentage payable by the Plan for Covered Charges, and
- maximum number of Home Health Care visits payable in a Calendar Year.

C. Hospice Care Benefits

Comprehensive Medical Covered Charges will include charges for Hospice Care Services provided by a Hospice, Hospice Care Team, Hospital, Home Health Care Agency, or Skilled Nursing Facility for:

- any sick or injured Employee or Dependent who, in the opinion of the attending physician, has no reasonable prospect of cure and is expected to live no longer than six months; and

- the family (Employee and Dependents) of any such Employee or Dependent;

but only to the extent that such Hospice Care Services are provided under the terms of a Hospice Care Program and are billed through the Hospice that manages that program.

All terms are defined under "Definitions."

The Comprehensive Medical Benefit Limitations listed in this section will apply to Hospice Care Benefits. In addition, Comprehensive Medical Covered Charges will not include Hospice Care Charges that:

- exceed the maximum in Plan benefits for any one Hospice Care Episode as indicated in the Summary of Medical Benefits beginning on Page 3; or

- exceed six months for all Hospice benefits due to the same or a related injury or sickness; or

- are for Hospice Care Services not approved by the attending Physician and Us; or

- are for transportation services; or

- are for custodial care (services or supplies provided to assist a person in daily living--e.g., meals and personal grooming); or

- are for Hospice Care Services provided at a time other than during a Hospice Care Episode.

Two or more Hospice Care Episodes for the same Employee or Dependent will be considered one Hospice Care Episode, unless separated by a period of at least three months during which no Hospice Care Program is in effect for the Employee or Dependent.

Refer to your Summary of Medical Benefits beginning on Page 3 under Special Limited Benefits for the:

- percentage payable by the Plan for Covered Charges, and

- maximum Plan benefit payable for any one Hospice Care Episode.

D. Other Covered State Licensed Practitioners Benefits

Covered Charges include services by State Licensed Practitioners unless specifically mentioned elsewhere.

Note: All charges for acupressure and acupuncture services are eligible under this benefit only.

This benefit includes charges from a state licensed dietician to assist Covered Persons with their nutritional needs for the treatment of a covered illness if such treatment meets Plan criteria and is ordered by a Physician.

Refer to your Summary of Medical Benefits beginning on Page 3 under Special Limited Benefits for the:

- percentage payable by the Plan for Covered Charges, and
- maximum number of visits payable in a Calendar Year.

The yearly maximum benefit is combined for all covered providers. The percent you pay does not apply toward the Calendar Year Deductible and Out-of-Pocket Expense Maximum.

E. Natural Family Planning Benefit

Comprehensive Medical Coverage will be limited to charges for counseling services or visits performed by a covered provider or an individual trained and certified in natural family planning. Charges will be reimbursed to you at 100% up to a $200 yearly maximum. We will require proof of payment and an itemized billing with a diagnosis code confirming treatment for natural family planning.

Maximum Benefit Payable..... $200 per Covered Person per Calendar Year

F. Orthotic Benefit

Comprehensive Medical Coverage is provided for the purchase of orthotics when they are prescribed for a specific diagnosed medical condition, such as, but not limited to: bone spurs, heel spurs or plantar fasciitis. Covered Charges will include testing and casting related to the purchase of the orthotics.

Refer to your Summary of Medical Benefits beginning on Page 3 under Special Limited Benefits for the:

- percentage payable by the Plan for Covered Charges, and
- maximum benefit payable for orthotics.

G. Organ and Tissue Transplant Benefits

1. Payment Conditions - Transplant Services

"Transplant Services" means Covered Charges incurred in connection with the Covered Transplants listed below that are necessary and required for treatment and not considered to be an Experimental or Investigational Measure. The following benefits will be payable for Treatment or Service for Transplant Services. These benefits will be payable instead of any other benefits described in this Plan, except as otherwise provided in this section.

2. Covered Transplants

The following human-to-human organ or bone marrow transplant procedures will be considered Covered Charges, subject to all limitations and maximums described in this section and booklet, for a Covered Person under this Plan.

- Heart;
- Heart/lung (simultaneous);
- Lung;
- Liver;
- Kidney;
- Pancreas;
- Kidney-pancreas;
- Small Bowel;
- Bone marrow transplant or peripheral stem cell infusion when a positive response to standard medical treatment or chemotherapy has been documented. Coverage is for one transplant or infusion only within a 12-month period, unless a tandem transplant or infusion meets the Plan's definition of Covered Charge and is not an Experimental and Investigational Measure.

Cornea and skin transplants are not Covered Transplants for the purpose of this Transplant Services section. Instead, cornea and skin transplants are covered under the normal provisions of the Plan, and are not subject to any conditions set forth in this Transplant Services section.

3. Covered Charges

Transplant Services will include all services listed in the Comprehensive Medical Covered Charges section, including, but not limited to, services by a Home Health Agency, Skilled Nursing Facility, or Hospice.

4. Benefits Payable; Within the Transplant Network

Benefits for Treatment or Service received will be paid at the PPO level of benefits if the Transplant Services are provided by a provider in the Transplant Network and the services are not considered to be Experimental or Investigational.

Covered Charges will also include charges incurred by the organ donor for a Covered Transplant if the charges are not covered by any other medical expense coverage. If the donor charges are incurred through a provider in the Transplant Network, Benefits Payable will be determined under this section. If the donor charges are incurred at a provider not in the Transplant Network and the Covered Person is eligible under this section, benefits for the donor charges will be limited as described under "Benefits Payable; Outside the Transplant Network."

Travel / Lodging Benefit: If transplant related services are provided by a provider in the Transplant Network, travel and lodging expenses for the recipient and one companion will be covered if the treating facility is greater than 100 miles one way from the recipient's home (excluding travel and lodging provided by a family member or friend). This would include ambulance expenses that would otherwise be excluded under the Comprehensive Medical ambulance benefit if such expenses are incurred solely to meet timing requirements imposed by the transplant. Benefits payable cannot be used to satisfy any Deductible or Co-Pay amount under the ambulance benefit in the normal provisions of the Comprehensive Medical section.

Travel and lodging benefits will be payable at 100% without application of any Deductible Amount, up to a lifetime maximum benefit of $10,000 for each approved transplant. All travel and lodging benefits must be approved in advance by Us.

5. Benefits Payable; Outside the Transplant Network

For Transplant Services provided by any covered provider not in the Transplant Network, benefits will be payable on the same basis as for any other sickness up to the following maximum benefits for each surgery listed below, and up to a lifetime maximum benefit of $150,000 for each Covered Person.

- Liver $110,000
- Kidney $50,000
- Heart $95,000
- Lung $110,000
- Heart/Lung (simultaneous) $145,000
- Bone Marrow:
  - Autologous $60,000
  - Allogeneic $100,000
- Pancreas $65,000
- Kidney-Pancreas $84,000
- Small Bowel $150,000

Services subject to the transplant episode and lifetime maximums above will include Covered Charges as specified in this section, including but not limited to: evaluation; pre-transplant, transplant, and post-transplant care (not including out-patient immunosuppressant drugs); cadaver organ donor procurement; complications related to the procedure and follow-up care for services received during the 12-month period from the date of transplant.

Services by a Home Health Care Agency, Hospice, or Skilled Nursing Facility will reduce those provision maximums as described under the Special Benefit Provisions - Limited section which begins on page 27.

The cost of securing an organ from a cadaver, including standard procurement charges for removal of the organ and transportation of the organ, will be considered a Covered Charge.

The cost of organ or tissue procurement from a living person (living donor) is covered if the charges are not covered by any other medical expense coverage.

Covered Charges will include cryopreservation and storage of bone marrow or peripheral stem cells when the cryopreservation and storage is part of a protocol of high dose chemotherapy, which has been determined by the Claims Administrator to be medically necessary care, not to exceed $10,000 per approved transplant.

No benefits will be payable for travel and lodging expenses if services are provided outside the Transplant Network.

6. Limitations: Applicable Within and Outside the Transplant Network

The Comprehensive Medical limitations listed in this section will apply to Transplant Services. In addition, limitations specific to Home Health Care, Skilled Nursing Facility and Hospice provisions will apply to Transplant Services if those benefits are used in connection with a Covered Transplant.

For each transplant episode, Covered Charges will include:

a. Transplant evaluations from no more than two transplant providers; and

b. No more than one listing with a provider in the Transplant Network.

If the transplant is not a Covered Transplant under this Plan, all charges related to the transplant will be excluded from payment under this Plan, including but not limited to, dose-intensive chemotherapy.

Benefits paid for Transplant Services will be applied to the Lifetime Medical and Prescription Drug Benefit Maximum and this maximum will be reduced by the benefits paid.

Comprehensive Medical Benefits will not be paid for confinement, treatment, service or materials for:

- animal-to-human organ or tissue transplants; or
- any Treatment or Service related to the use of embryonic stem cells;
- implantation within the human body of artificial or mechanical devices designed to replace human organ(s); or
- transportation, lodging, or any other expenses not specifically indicated as a Covered Charge related to a living donor or the recipient.

NOTE: In order for you to receive the maximum plan benefits, you must contact your Cost Containment Administrator, who will have a transplant coordinator contact you or your provider.

X. LIMITATIONS OF COMPREHENSIVE MEDICAL BENEFITS

Comprehensive Medical Benefits will not be paid for:

a. Treatment or Service that is not a Covered Charge, as defined, for treatment of an illness or injury;

b. Treatment or Service that is an Experimental or Investigational Measure;

c. any part of a charge for Treatment or Service that exceeds Prevailing Charges;

d. charges that are billed incorrectly or separately for Treatment or Services that are an integral part of another billed Treatment or Service as determined by Us;

e. charges for Physician overhead, including but not limited to surgical rooms or suites or for equipment used to perform a particular Treatment or Service (i.e. laser equipment);

f. Treatment or Service for foot care with respect to: corns, calluses, trimming of toe nails, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

g. Treatment or Service for foot care with respect to: casting, testing, fitting or purchase of orthotics, or any appliance (including orthotics), except as covered under Special Benefit Provisions – Limited, Orthotic Benefit at page 31;

h. charges for shoes or shoe lifts;

i. the surgical treatment of obesity including any and all surgical revisions related to this non-covered surgery, even if the Covered Person has other health conditions which might be helped by weight loss or reduction of obesity;

j. Treatment or Service related to the restoration of fertility or promotion of conception (except as described under Covered Charges);

k. molecular genetic testing (specific gene identification) for the purposes of health screening or if not part of a treatment regimen for a specific sickness;

l. charges for storage of blood or blood products;

m. Treatment or Service for voluntary sterilization or reversal of sterilization;

n. Treatment or Service for abortion;

o. Treatment or Service for contraception;

p. Treatment or Service for sexual dysfunction, except when related to an illness and approved by Us;

q. Treatment or Service for transsexualism;

r. charges incurred to improve general physical condition, including, but not limited to programs such as counseling and monitored exercise to improve or maintain general health;

s. Treatment or Service for behavior modification;

t. Treatment or Service for marital counseling or social counseling;

u. Treatment or Service for tobacco cessation or nicotine addiction, except for physician office visits or as provided under Prescription Drug Benefits;

v. Treatment or Service for gambling addiction, or stress management;

w. Treatment or Service for educational or instructional purposes (except as described under Covered Charges);

x. Treatment or Service for educational, training or developmental problems, learning disorders;

y. Treatment or Service eligible under your Dental Plan;

z. Dental Services (except as described under Covered Charges);

aa. Treatment or Service for any form of temporomandibular joint disorder (malfunction, degeneration, or disease related to the joint that connects the jaw to the skull), including but not limited to braces, splints, appliances, or surgery of any type;

ab. drugs and medicines eligible under the Prescription Drug Coverage for Retail Network Pharmacy and Home Delivery Pharmacy, except as listed under Covered Charges;

ac. drugs and medicines dispensed by a nursing home or rest home (Note: such drugs are eligible under the Prescription Plan if purchased at a Retail Network Pharmacy or the Home Delivery Pharmacy);

ad. Treatment or Service for DESI (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness);

ae. charges for non-prescription drugs; non-prescription vitamins and minerals;

af. charges for nutritional supplements, special diets, special formulas;

ag. charges for eye examinations for correction of vision or fitting of glasses, vision materials (frames or lenses);

ah. Treatment or Service for Kerato-Refractive Eye Surgery (surgery to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including but not limited to radial keratotomy and keratomileusis surgery);

ai. acupuncture or acupressure treatment (except as limited under the Special Benefit Provisions – Limited, Other Covered State Licensed Practitioners Benefits at page 31);

aj. Treatment or Service for Cosmetic Surgery (except when the surgery results from an accidental injury and is performed within 18 months of that injury);

ak. Treatment or Service for:

- human-to-human organ or bone marrow transplants, except as provided under the Special Benefits Provisions- Limited, Organ and Tissue Transplant Benefits beginning on page 32;

- animal-to-human organ or tissue transplants; or

- implantation within the human body of artificial or mechanical devices designed to replace human organs;

al. Treatment or Service for unattended home sleep studies;

am. any nursing services (except as described under Covered Charges);

an. Treatment or Service for custodial care;

ao. Treatment or Service for maintenance therapy or supportive care or when maximum therapeutic benefit (no further objective improvement) has been attained (except as described under Covered Charges);

ap. charges for sports, employment or immigration physicals;

aq. charges for transportation or ambulance services except as described under Covered Charges;

ar. Durable Medical Equipment:

- used for personal hygiene, comfort, or convenience, whether or not recommended by a Physician, including, but not limited to, air conditioners, humidifiers, diapers, underpads, bed tables, tub bench, shower chair, hoyer lift, gait belts, bedpans, physical fitness equipment, stair glides, elevators, or lift;

- used for "barrier free" home modifications, whether or not recommended by a Physician, including, but not limited to, ramps, grab bars, or railings;

- used for non-implantable communication-assist devices, including, but not limited to, communications boards, and computers;

- which are in excess of the purchase price of the equipment; or

- which are provided during rental for repair, adjustment, or replacement of components and accessories necessary for the functioning and maintenance of covered equipment, as this is the responsibility of the DME supplier;

as. charges for comfort or convenience services and supplies;

at. charges for prone standers, Amigo-type carts, motorized carts, scooters, strollers, etc.;

au. charges for heating pads, heating and cooling units, ice bags or cold therapy units;

av. charges for devices used specifically as safety items or to affect performance in sport-related activities;

aw. charges for hearing aids and related charges;

ax. charges for wigs or hair prostheses;

ay. delivery charges or taxes;

az. charges for telephone calls or telephone consultations or missed appointments;

ba. charges for e-mail communication or e-mail consultation;

bb. additional charges incurred because care was provided after hours, on a Sunday, holidays or week-end;

bc. Weekend Admission Charges;

bd. charges for travel and lodging (except as limited under the Special Benefit Provisions - Limited, Organ and Tissue Transplant Benefits beginning on page 32);

be. charges for which the Covered Person is not legally obligated to pay or which are for medical or dental care furnished without charge, paid for or reimbursable by or through the government of a nation, state, province, county, municipality, or other political subdivision, or any instrumentality or agency of such a government;

bf. Treatment or Service rendered in a hospital owned or operated by the United States Government, either by the hospital or a physician/dentist employed by it (a) unless the treatment is of an emergency nature, and (b) unless the Covered Person is not entitled to such treatment by reason of his status as a veteran or otherwise;

bg. Treatment or Service for an injury or sickness which results from war, act of war, or voluntary participation in criminal activities while a Covered Person;

bh. Treatment or Service for an injury or sickness which arise out of or in the course of employment, and which either entitles the Covered Person to benefits under a Worker's Compensation Act or similar legislation, or would have entitled him to benefits if coverage under such a statute could have been in force on a voluntary or elective basis;

bi. Treatment or Service provided by any person, hospital, or entity whose charges for medical/dental care, depend on the patients' financial ability to pay or availability of coverage;

bj. Treatment or Service for the purpose of duplicating or replacing equipment, brace, or supply that is lost or stolen;

bk. charges which are eligible to be paid by a previous group plan which was replaced by enrollment in the Christian Brothers Employee Benefit Trust;

bl. Treatment or Service provided outside the United States unless the Covered Person is outside the United States for one of the following reasons:

- travel, provided the travel is for a reason other than securing medical or dental care diagnosis or treatment;
- a business assignment by a covered Member (Employer);
- the Employee is employed by a covered Member (Employer) and working outside the United States; or
- an eligible Dependent child attending school outside the United States.

bm. the services of any person in your Immediate Family or any person in your Dependent's Immediate Family;

bn. Treatment or Service provided by any type of health care practitioner not otherwise provided for in this Plan;

bo. charges in excess of 100% of the Medicare allowance for incurred expenses due to renal dialysis;

bp. Treatment or Service that is subject to the Preexisting Conditions Exclusion, except as provided under that section; or

bq. Treatment or Service incurred after termination of coverage under this Plan.

XI. PREEXISTING CONDITIONS EXCLUSION

The Preexisting Conditions Exclusion provisions described in this section will not apply to any covered person under 19 years of age.

Definition

A Preexisting Condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the three-month period ending on that individual's Enrollment Date under the plan.

However, pregnancy will not be considered a Preexisting Condition.

Genetic information will not be considered a Preexisting Condition in the absence of a diagnosis of the condition related to such information.

Exclusion Period

Benefits for Treatment or Service of an individual's Preexisting Condition will be excluded for a period of 12 consecutive months after the individual's Enrollment Date, and then benefits will be payable only with respect to confinement occurring after that date or to Treatment or Service received after that date.

The Preexisting Conditions Exclusion will not apply if the individual has not received medical advice, diagnosis, care, or treatment for such condition, or any complication therefrom, for 90 consecutive days from the individual's Enrollment Date.

The Preexisting Conditions Exclusion will also not apply to the first $3,000 of Comprehensive Medical Covered Charges in the first 12 consecutive months that coverage is in force.

Credit for Previous Creditable Coverage

The Preexisting Condition Exclusion period will be reduced by days of continuous Creditable Coverage, if any, applicable to the individual as of the effective date of his or her coverage under the group plan.

In determining days of continuous Creditable Coverage, any period of Creditable Coverage which occurs before a significant break in coverage will not be counted. For this purpose, "significant break in coverage" means a period of 63 days during all of which a person is not covered under any Creditable Coverage. However, a Waiting Period or an HMO Affiliation Period will not be considered a break in coverage.

With respect to an individual becoming covered under the group plan, a period of Creditable Coverage will not be considered continuous if, after such period and before the effective date of the individual's coverage, there was a 63-day period during all of which the individual was not covered under any Creditable Coverage.

XII. EXTENSION OF MEDICAL BENEFITS AFTER TERMINATION OF COVERAGE

If a Covered Employee is Totally Disabled or a Covered Dependent is in a Period of Limited Activity on the date the Comprehensive Medical Benefit terminates, benefits will continue to be available during the uninterrupted existence of such Disability or Period of Limited Activity qualification, subject to the following conditions:

- The provisions of the Plan will be applicable to such benefits just as if coverage had not terminated.

- Benefits will be paid for only those Covered Charges which are due to care and treatment of such total disability.

- Charges incurred after termination of coverage will be applied toward satisfaction of the deductible only if they are incurred for care and treatment of such total disability.

- Benefits will normally be payable for all such Covered Charges incurred within the three month period immediately following termination of coverage.

- This extension of benefits will not apply to any charges which are incurred after the occurrence of the first of the following events: (1) the expiration of a number of months equal to the number of months the Covered Person has been covered by the Comprehensive Medical Plan before such termination of coverage; (2) the expiration of three months immediately following termination of coverage; (3) the date the Covered Person becomes covered under any other group, franchise, Blue Cross Blue Shield, other service or prepayment plan, or Medicare.

XIII. UTILIZATION MANAGEMENT REQUIREMENTS - HOSPITAL

A. Utilization Management Requirements

A Hospital Admission Review by the Cost Containment Administrator is required for all Hospital Inpatient Confinements (scheduled or emergency). The benefits payable for Hospital Inpatient Confinement Charges will be reduced 25% up to $2,000 per Calendar Year unless:

- For Hospital Inpatient Confinement Charges, a Hospital Admission Review is requested from the Cost Containment Administrator by you, a Dependent, or a designated patient representative as soon as a Hospital Inpatient Confinement is scheduled, but no later than the day of a Hospital Inpatient Confinement, for other than a Medical Emergency; and for a Medical Emergency within two business days of a Hospital Inpatient Confinement.

  If a Hospital Admission Review is not requested in a timely manner as specified above, the 25% reduction in benefits payable will be applied to all Hospital Inpatient Confinement Charges, but only to the charges incurred up to the date a Hospital Admission Review is obtained.

  For Hospital Inpatient Confinement Charges for confinement beyond the initial period, the Hospital Admission Review must be extended and approved by the Cost Containment Administrator.

  Benefits will be payable only for that part of the Hospital Inpatient Confinement Charges the Cost Containment Administrator determines to be medically necessary.

- Certain exceptions apply to Hospital Inpatient Confinement for childbirth as described below.

The 25% reduction in benefits payable is a penalty for failure to comply with the Utilization Management Requirements listed. The reduction:

- will not count toward satisfaction of the Out-of-Pocket Expense limits described in the Summary of Benefits section; and

- will not exceed $2,000 per Calendar Year for any one person.

B. Hospital Admission Review

A Hospital Admission Review by the Cost Containment Administrator is required for all Hospital Inpatient confinements (scheduled or emergency.)

The following exception applies to Hospital Inpatient Confinement for childbirth.

Medically Necessary Care requirements are waived and a Hospital Admission Review is not required for mother and baby for:

- A 48-hour Hospital Inpatient Confinement following vaginal delivery; or

- A 96-hour Hospital Inpatient Confinement following cesarean section.

A request for review by the Cost Containment Administrator of the need for continued Hospital Inpatient Confinement for mother or baby beyond the automatically approved time period stated

above must be made by you, a Dependent, or a designated patient representative before the end of that time period.

If you, a Dependent, or a designated patient representative fail to request a Hospital Admission Review as specified in this section, benefits will be reduced as described above. Exception: For all Hospital Inpatient Confinement Charges incurred beyond the 48-hour or 96-hour automatically approved Hospital Inpatient Confinement for childbirth, the penalty will be applied beginning the date the automatically approved time period ends. Except as waived above, no benefits will be payable for any Treatment or Service that is not for Medically Necessary Care.

For the purpose of these requirements, "Hospital Admission Review" means review by the Cost Containment Administrator of a Physician's report of the need for a Hospital Inpatient Confinement, scheduled or emergency, (unless it is for an automatically approved Hospital Inpatient Confinement for childbirth).

The report (verbal or written) must include the:

- reason(s) for the Hospital Inpatient Confinement;
- significant symptoms, physical findings, and treatment plan;
- procedures performed or to be performed during the Hospital Inpatient Confinement; and
- estimated length of the Hospital Inpatient Confinement.

If a Hospital Inpatient Confinement will exceed the approved number of days, the Cost Containment Administrator will initiate a Continued Stay Review. For the purpose of these requirements, "Continued Stay Review" means a review by the Cost Containment Administrator of a Physician's report of the need for continued Hospital Inpatient Confinement.

The report (verbal or written) must include the:

- reason(s) for requesting continued Hospital Inpatient Confinement;
- significant symptoms, physical findings, and treatment plan;
- procedures performed or to be performed during the Hospital Inpatient Confinement; and
- estimated length of the continued Hospital Inpatient Confinement.

Notification of the number of Hospital days authorized will be sent to you, your Physician, and the Hospital. If you or your Physician has any questions, please call the toll-free number of the Cost Containment Administrator.

C. Utilization Review Program

1. Notice of Utilization Review

For purposes of satisfying the claims processing requirements, receipt of claim will be considered to be met when the Cost Containment Administrator receives notification of utilization review services.

If you, your Dependent, or designated patient representative fails to follow the Cost Containment Administrator's procedures for filing a claim for Hospital Admission Review, a Prospective Review or an Urgent Review, the Cost Containment Administrator will notify you, your Dependent, or designated patient representative of the failure and the proper procedures to be followed.

2. Prospective Review

For an initial Prospective Review, a decision and notification of the decision will be made within 15 calendar days of the date the Cost Containment Administrator receives Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, the Cost Containment Administrator will either issue a Noncertification or send an explanation of the information needed to complete the review prior to expiration of the 15 calendar days. If the Cost Containment Administrator does not issue a Noncertification and requests additional information to complete the review, you, the patient, the attending Physician, or the facility rendering the service is permitted up to 45 calendar days to provide the necessary information. The Cost Containment Administrator will render a decision within 15 calendar days of either receiving the necessary information or the expiration of 45 calendar days, if no additional information is received. For certification, the Cost Containment Administrator will provide notification to the attending Physician, the facility rendering service, and you or the patient. Upon request, the Cost Containment Administrator will provide written notification of the certification. For Noncertifications, notification will be made in writing to the attending Physician, the facility rendering service, and you or the patient.

3. Urgent Prospective Review

For Urgent Review of a Prospective Review, a decision and notification of the decision will be made within 24 hours of the date the Cost Containment Administrator receives Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, the Cost Containment Administrator will either issue a Noncertification or send an explanation of the information needed to complete the review within 24 hours of receipt of Notification of Utilization Review Services. If the Cost Containment Administrator does not issue a Noncertification and requests additional information to complete the review, you, the patient, the attending Physician, or the facility rendering the service is permitted up to 48 hours to provide the necessary information. The Cost Containment Administrator will render a decision within 48 hours of either receiving the necessary information or, if no additional information is received, the expiration of the 48 hours to provide the specified additional information. For certifications, the Cost Containment Administrator will provide notification to the attending Physician, the facility rendering service, and you or the patient. Upon request, the Cost Containment Administrator will provide written notification of the certification. For Noncertifications, notification will be made in writing to the attending Physician, the facility rendering service, and you or the patient.

4. Concurrent Review

For a Concurrent Review that does not involve an Urgent Concurrent Review, a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the Cost Containment Administrator will be decided within the timeframes and according to the requirements for Prospective Review.

For an Urgent Concurrent Review, a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the Cost Containment Administrator will be decided and notification of the decision will be made within 24 hours of receipt of the Notification of Utilization Review Services if the request is made at least 24 hours prior to the expiration of the previously approved period or number of treatments. If a request is made less than 24 hours prior to the expiration of the previously approved period of number of treatments, a decision and notification of the decision will be made within 72 hours of receipt of the Notification of Utilization Review Services.

5. Retrospective Review

For a Retrospective Review, a decision and notification of the decision will be made within 30 calendar days after the date the Cost Containment Administrator receives Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, the Cost Containment Administrator will either issue a Noncertification or send an explanation of the information needed to complete the review prior to the expiration of the 30 calendar days. If the Cost Containment Administrator does not issue a Noncertification and requests additional information to complete the review, you, the patient, the attending Physician, or the facility rendering the service is permitted up to 45 days to provide the necessary information. The Cost Containment Administrator will render a decision within 15 calendar days of either receiving the necessary information or the expiration of 45 calendar days, if no additional information is received. For certifications, the Cost Containment Administrator will provide notification to the attending Physician, the facility rendering service, and you or the patient. Upon request, the Cost Containment Administrator will provide written notification of the certification. For Noncertifications, notification will be made in writing to the attending Physician, the facility rendering service, and you or the patient.

6. Request for Reconsideration

When an initial decision is made not to certify an admission or other service and no peer-to-peer conversation has occurred, the Peer Clinical Reviewer that made the initial decision will be made available within one business day to discuss the Noncertification decision with the attending Physician upon their request. If the original Peer Clinical Reviewer is not available, another Peer Clinical Reviewer will be made available to discuss the review.

At the time of the conversation, if the reconsideration process is unable to resolve the difference of opinion regarding a decision not to certify, the attending Physician will be informed of his or her right to initiate an appeal and the procedure to do so. For certifications, the Cost Containment Administrator will provide notification to the attending Physician, the facility rendering service, and you or the patient. Upon request the Cost Containment Administrator will provide written notification of the certification. For Noncertifications, notification will be made in writing to the attending Physician, the facility rendering service, and you or the patient.

7. Expedited Appeal Review and Voluntary Appeal Review

An Expedited Appeal Review is a request, usually by telephone but can be written, for a review of a decision not to certify an Urgent Review. An Expedited Appeal Review must be requested within 180 calendar days of the receipt of a Noncertification. A decision and notification of the decision on the expedited appeal of an Urgent Review decision will be made within 72 hours from request of an expedited appeal review. Written or electronic notification of the appeal review outcome will be made to the attending Physician and you or the patient.

If the Noncertification is affirmed on the appeal review, you, the patient, or attending Physician can request a voluntary appeal. The appeal may be requested by telephone, fax, or in writing. You, the patient or the attending Physician may submit written comments, documents, records, and other information relating to the request for appeal. An independent review agency will make a decision within 30 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, the independent review agency will send a written explanation of the additional information that is required or an authorization for you or the patient's signature so information can be obtained from the attending Physician. This information must be sent to the independent review agency within 45 calendar days of the date of the written request for information. Failure to comply with the request for additional information could result in declination of the appeal. A decision will be made and notification of the outcome will be provided within 30 calendar days of the receipt of all necessary information to properly review the appeal request.

Note: The expedited appeal process does not apply to Retrospective Reviews.

8. Standard Appeal Review and Voluntary Appeal Review

A standard appeal may be requested either in writing or verbally. It must be requested within 180 calendar days of the receipt of a Noncertification.

A decision and notification of the decision will be made in writing to you or the patient and the attending Physician within two business days (but not later than 30 calendar days from receiving the request for an appeal review.)

If the Noncertification is affirmed on the appeal review, you, the patient, or attending Physician can request a voluntary appeal. The appeal may be requested by telephone, fax, or in writing. You, the patient or the attending Physician may submit written comments, documents, records, and other information relating to the request for appeal. A determination will be made by an independent review agency within 30 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, the independent review agency will send a written explanation of the additional information that is required or an authorization for you or the patient's signature so information can be obtained from the attending Physician. This information must be sent to the independent review agency within 45 calendar days of the date of the written request for information. Failure to comply with the request for additional information could result in declination of the appeal. A decision will be made and notification of the outcome will be provided within 30 calendar days of the receipt of all necessary information to properly review the appeal request.

XIV. MEDICAL CLAIM PROCEDURES

Claim Forms

Special claim forms are not required to file a claim with Us. Standard industry computerized forms may be used by your providers to submit a claim. When you become covered, you will be issued an identification card. This card should be presented to each provider at the time you or a Dependent receives needed medical care. The Cost Containment Administrator will assist you with the Hospital Pre-Admission Authorization in accordance with the terms of your coverage under the Plan.

Prompt Filing

Completed claims, and other information needed to prove loss, should be filed promptly. Written proof of loss should be sent to Us within 90 calendar days.

All Claims Must Be Received By Us Within One Year From The Date Of Loss To Be Eligible For Benefit Consideration.

Proof of loss sent later will be accepted only if there is reasonable cause for the delay and if the claim is received no later than two years after date of loss.

For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when we receive proof of loss. Proof of loss includes the patient's name, your name (if different from the patient's name) and identification number, provider of services, dates of services, diagnosis, description of Treatment or Service provided and extent of loss. We may request additional information to substantiate your loss or require a signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim.

Payment and Denial

We will process your claim as quickly as possible after We have received all the required information. In actual practice, claims may be processed and paid within a few days after We receive completed proof of loss. If a claim cannot be paid, We will promptly explain why.

If a claim cannot be processed due to incomplete information, We will either deny the claim or send a written explanation requesting additional information. If additional information is requested and it is not received at the end of 45 calendar days, a decision will be made without it.

Physical Examinations

We may have the person whose loss is the basis for claim examined by a Physician. We will pay for these examinations and will choose the Physician to perform them.

Release of Medical Information

As a condition of receiving benefits under this Plan, you and your Dependents authorize:

- any provider to disclose to Us any medical information We request;
- Us to examine your medical records at the office of any provider;
- Us to release to or obtain from any person or organization any information necessary to administer your benefits; and
- Us to examine your employment records in order to verify your eligibility.

XV. MEDICAL APPEAL PROCEDURES

Internal Appeal

Initial Appeal: You or your authorized representative may request an appeal of an adverse benefit determination, a claim denied in whole or in part, within 180 calendar days of receipt of notice of the adverse benefit determination. Any such written request for review must state the reason or reasons why you believe that the original decision was incorrect. You or your authorized representative is entitled to review any pertinent Plan documents for this purpose.

We will make a full and fair review of the adverse benefit determination. If more information is needed, We will send a written request for the additional information. Failure to receive the additional information could result in declination of the appeal. We will notify you in writing of the appeal decision within 30 calendar days of receiving the appeal request.

Plan Committee appeal: If the initial appeal was denied in whole or in part, you may appeal that adverse benefit determination to the Plan Committee. Your appeal must be in writing and must be received within 90 days after your receipt of the notice of denial. You may submit written comments, documents, records, and other information relating to the claim. The Plan Committee will make a determination within 30 calendar days unless the appeal cannot be processed due to incomplete information. If additional information is required, the Plan Committee will request that information to complete the review. You, the patient, the attending Physician, or the facility rendering the service is permitted up to 45 days to provide the necessary information. Failure to receive the additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 30 calendar days of the receipt of all necessary information to properly review the appeal request.

External Appeal

When the Plan Administrator has denied, reduced, or terminated a required service or payment for the service based on a judgment as to the:

- medical necessity;
- appropriateness;
- health care setting;
- level of care; or
- effectiveness of the health care service;

you or someone you name to act for you (your authorized representative) has the right to have the Plan Administrator's decision reviewed by an independent review organization not associated with the Plan Administrator. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination.

The Plan already provides you with right to appeal procedures described above under Internal Appeal and under the Utilization Management Program beginning on Page 42.

An external review does not apply to a denial of coverage for any Treatment or Service specifically excluded under the Plan.

If you request an external review, an independent organization will review the claim decision and provide you with a written determination. Any decision made during the external review by the independent organization will be binding for both the Plan and the claimant.

XVI. COORDINATION WITH OTHER BENEFITS – MEDICAL

The intent of this Coordination with Other Benefits – Medical section is to provide that the sum of benefits paid under this Plan (except the benefits provided under the Prescription Drug Benefits) plus benefits paid under all other Plans will not exceed the actual cost charged for a Treatment or Service.

A. Definitions

As used in this section, the term "This Plan" will mean the medical, dental, and vision expense benefits described in this booklet.

The term "Plan" will mean This Plan and any medical or dental expense benefits provided under:

- any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or employee benefit or other association; and

- any program required or established by state or Federal law, including Medicare Parts A and B (see Medicare rules below); and

- any program sponsored by or arranged through a school or other educational agency; and

- the first-party medical expense provisions of any automobile policy issued under a no-fault insurance statute including the self-insured equivalent of any minimum benefits required by law;

except that the term Plan will not include benefits provided under a student accident policy, nor will the term Plan include benefits provided under a state medical assistance program where eligibility is based on financial need.

Also, the term Plan will apply separately to those parts of any program that contain provisions for coordination of benefits with other Plans and separately to those parts of any program which do not contain such provisions.

The term Allowable Expense will mean all Prevailing Charges for Treatment or Service when at least a part of those charges are covered under at least one of the Plans then in force for the person for whom benefits are claimed. If a Plan provides benefits in a form other than cash payments, the cash value of those benefits will be both an Allowable Expense and a benefit paid.

The term Claim Determination Period will mean the part of a calendar year during which you or a Dependent(s) would receive benefit payments under This Plan if this section were not in force.

B. Effect on Benefits

Benefits otherwise payable under This Plan for Allowable Expenses during a Claim Determination Period may be reduced if:

- benefits are payable under any other Plan for the same Allowable Expenses; and

- the rules listed below provide that benefits payable under the other Plan are to be determined before the benefits payable under This Plan.

The reduction will be the amount needed to provide that the sum of payments under This Plan plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses. Each benefit that would be payable in the absence of this section will be reduced proportionately; such reduced amount will be charged against any applicable benefit limit of This Plan.

C. Order of Benefit Determination

Except as described under Medicare Exception below, the benefits payable of a Plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

- Nondependent/Dependent. The benefits of a Plan which covers the person for whom benefits are claimed as an Employee, Member, or subscriber (that is, other than as a Dependent) are determined before the benefits of a Plan which covers the person as a Dependent.

- Dependent Child--Parents Not Separated or Divorced. When This Plan and another Plan cover the same child as a Dependent of different persons called "parents," the benefits of the Plan of the parent whose birthday falls earlier in a calendar year are determined before those of the Plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

  However, if another Plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- Dependent Child--Separated or Divorced Parents. If two or more Plans cover a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

  - first, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child; and
  - finally, the Plan of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first.

- Joint Custody. If the specific terms of a 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 for Dependent children of parents who are not separated or divorced.

- Active/Inactive Employee. The benefits of a Plan which covers a person as an Employee who is neither laid off nor retired, or as that Employee's Dependent, are determined before the benefits of a Plan which covers that person as a laid-off or retired Employee or as that Employee's Dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an Employee, Member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

- Automatic Coverage for a Newborn Child. When This Plan and another Plan both provide benefits, the benefits of the other Plan will be determined before the benefits payable under the Automatic Coverage for a Newborn Child provision of This Plan.

- Continuation/Extension of Benefits. When This Plan and another Plan both provide benefits, the benefits of the plan covering the person as an employee, member or subscriber, or as that person's dependent, will be determined before the benefits payable under This Plan's Extension of Benefits.

D. Medicare Rules

(There are limited instances where these rules apply to a full time employee, such as, but not limited to, Chronic Renal Failure.)

Medicare rules apply to any Covered Person under Part A and Part B of Title XVIII of the Social Security Act, as amended (Medicare).

For all Covered Persons, benefits payable under Medicare will normally be determined before the benefit payable under This Plan. It is important for a Covered Person to be enrolled for both Medicare A and B coverages. If not enrolled for both, the Covered Person will not have complete coverage for eligible charges. Please refer to the Integration With Medicare provision.

E. Medicare Exception

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under This Plan.

Federal law will usually apply in such instances if:

- the benefits are applicable to an active Covered Employee (rather than a Retiree) or to that Covered Employee's spouse; or

- the Covered Employee's Member (Employer) has 20 or more employees.

F. Integration With Medicare

(For all Covered Persons where permitted by Law)

The payments under This Plan are reduced by the benefits available under Medicare.

Note: Any balance owed to a provider after Medicare payment may not be paid by the Plan unless your Out-of-Pocket Expense Maximum has been reached for the year.

It works this way:

- In determining a claim payment under This Plan, the first step is to calculate the amount that would be paid if the person had no Medicare coverage. The Covered Charges under This Plan will be limited to the amounts approved by Medicare or no more than the limiting charges as determined by Medicare.

- The above amount is reduced by the Medicare benefits for the expenses upon which the claim under This Plan is based. In determining the Medicare benefits, the person will be assumed to have full Medicare coverage (that is, both Part A and Part B) whether or not the person has enrolled for the full coverage.

- If a provider has chosen not to apply to Medicare to become a participating provider, This Plan will estimate Medicare benefits as if application has been made and was approved. Any benefit payable by the Plan will then be calculated as if Medicare had been paid.

If Medicare benefits are paid for expenses not covered under This Plan, they will not be used to reduce our benefits. In the case of services and supplies for which Medicare makes direct reimbursement to the provider, the amount of expenses and Medicare benefits will be determined on the basis of the prevailing charges for the services and supplies.

G. Coordination with HMOs

If a Covered Dependent is covered under an HMO and the HMO should provide benefits before This Plan, the Dependent is required to access benefits available under the HMO.

If the Covered Dependent does not access benefits available under the HMO, This Plan will only consider 50% of This Plan's Covered Charges applicable to such Covered Dependent.

H. Coordination with Excess Only or Secondary Only Plans

If a Covered Person is covered by another plan containing a provision, either:

- excess only of other available benefits; or

- secondary only of other available benefits;

This Plan will coordinate to consider benefits payable on a 50%/50% basis, This Plan and the other plan.

I. Secondary Coverage Under Automatic Coverage for Newborn Child Provision

Benefits available for a newborn child under any other medical plan for which you or your Dependents are eligible, will be determined before benefits under the Automatic Coverage for a Newborn Child provision of This Plan.

J. Exchange of Information

Any person who claims benefits under This Plan must, upon request, provide all information We believe is needed to coordinate benefits.

In addition, all information We believe is needed to coordinate benefits may be exchanged with other companies, organizations or persons.

K. Facility of Payment

We may reimburse any other plan if:

- benefits were paid by that other plan; but
- should have been paid under This Plan in accordance with this section.

In such instances, the reimbursement amounts will be considered benefits paid under This Plan and, to the extent of those amounts, will discharge Us from liability.

L. Right of Recovery

If it is determined that benefits paid under This Plan should have been paid by any other plan, We will have the right to recover those payments from:

- the person to or for whom the benefits were paid; and/or
- the other companies or organizations liable for the benefit payments.

M. Transfer of Rights

(Applicable in California)

1. Applicability

Where allowed by law, this section will apply to Covered Persons who:

- receive benefit payment under This Plan as the result of a sickness or injury; and
- have a lawful claim against another party or parties for compensation, damages, or other payment because of that same sickness or injury; and
- recover payment from such party or parties which includes an amount (or part of an amount) previously paid under This Plan for the Treatment or Service.

2. Transfer of Rights

In those instances where this section applies, the rights of the Covered Person to claim or receive compensation, damages, or other payment from the other party or parties will be transferred to the Trust, but only to the extent of benefit payments made under This Plan.

N. Covered Person Obligations

To secure the rights of the Trust under this section, a Covered Person must:

- complete any claim applications or other instruments the Trust might reasonably require; and
- if payment from the other party or parties has been received, reimburse the Trust for benefit payment made under This Plan (but not more than the amount paid by the other party or parties).

XVII. PRESCRIPTION DRUG COVERAGE

A. Description of Benefits

1. Retail Network Pharmacy - Payment Conditions

If drugs and medicines are prescribed to treat you or one of your Dependents, We will pay Retail Network Pharmacy benefits for Covered Charges:

- in excess of the copayment; and
- at the payment percentage indicated;

as described in your Summary of Prescription Benefits beginning on Page 9.

Benefit payments will be restricted to:

- Covered Charges as described below; and
- up to a 30 day supply for each prescription and each refill at a Retail Network Pharmacy.

2. Home Delivery Pharmacy - Payment Conditions

If maintenance drugs and medicines are prescribed to treat you or one of your Dependents, We will pay Home Delivery Pharmacy drug benefits for charges:

- in excess of the copayment amount; and
- at the payment percentage indicated;

as described in your Summary of Prescription Benefits beginning on Page 9.

Maintenance drugs are those taken on a regular or long term basis to treat such conditions as high blood pressure, ulcers, arthritis, heart or thyroid conditions, emphysema or diabetes, etc.

Benefit Payment will be restricted to:

- prescribed maintenance medications which are necessary to treat a chronic or long term sickness or injury; and
- up to a 90 day supply for each prescription and each refill; and
- prescriptions which are filled through the pharmacy designated to administer the Home Delivery Pharmacy prescription drug program.

B. Covered Charges

Covered Charges will be the actual cost charged to you or one of your Dependents for:

- Federal Legend Drugs, including vitamins and minerals which may be legally dispensed only upon the written prescription of a Physician; and
- Insulin and supplies for injection of insulin; and
- Federal Legend Drugs for tobacco cessation; benefit is limited to 180 days supply per year and 540 days supply per lifetime.

C. Payment of Prescription Drug Benefits

If you buy your prescription drugs from a Retail Network Pharmacy, you should:

- present your identification card to the pharmacist with your prescription each time you need to have a prescription filled or refilled;
- sign the pharmacy claims voucher (the pharmacist will have this voucher); and
- pay the pharmacist the applicable payment amount as described in the Summary of Prescription Benefits beginning on Page 9.

If you buy your prescription drugs from a non-Retail Network Pharmacy, you should:

- pay the pharmacist the entire cost of the prescription;
- call Medco at the telephone number listed on your identification card to obtain a special claim form; and
- complete the claim form, attach your prescription receipt, and mail the completed form to the address shown on the form. Although reduced benefits are payable because you used a non-Retail Network Pharmacy, the appropriate prescription drug benefits will be paid directly to you.

D. Pre-Authorization of Certain Prescription Drugs

For certain drugs and classes of drugs designated by Us, We reserve the right to:

- require prior authorization for dispensing;
- limit payment of benefits to specified quantities; and
- require the dispensing of certain drugs before paying benefits for another drug within a given class, as established by Us.

There are certain categories of drugs which may require pre-authorization to be eligible for Prescription Drug Coverage under the Plan. Due to specific Plan limitations, either our nursing staff or Medco's pharmacy staff will review pertinent information from the prescribing physician to determine eligibility. Some categories or conditions are listed below. We cannot guarantee this list is all inclusive. Therefore,

to confirm if your specific drug will require pre-authorization, you may call Medco directly at the telephone number listed on your identification card.

- Contraceptives for medical illnesses; such as, but not limited to: Ortho Tri-Cyclen, Lo-Ovral
- CNS Stimulants/Amphetamines; such as, but not limited to: Provigil, Strattera
- Growth Hormones/Receptor Antagonists; such as, but not limited to: Genotropin, Somavert
- Dermatology Agents; such as, but not limited to: Raptiva, Tazorac Cream
- Pulmonary Agents; such as, but not limited to: Xolair, Pulmozyme
- Red/White Blood Cell Stimulants; such as, but not limited to: Epogen, Neupogen
- Interferons; such as, but not limited to: Betaseron, Actimmune
- Hormone Altering Medications; such as, but not limited to: Lupron, Depo-Provera
- Cancer Medications
- Diabetic Agents; such as, but not limited to: Byetta
- Anticonvulsant Agents; such as, but not limited to: Topamax
- Long Acting Calcium Channel Blockers; such as, but not limited to: Cardene SR, Procardia XL
- Rheumatoid Arthritis Medications; such as, but not limited to: Enbrel, Humira, Remicade
- Narcotic Pain Medications; such as, but not limited to: Actiq, Fentora
- Ribavirin Therapy medications; such as, but not limited to: Rebetol
- Pulmonary Arterial Hypertension Therapy medications; such as, but not limited to: Flolan

E. Limitations for Prescription Drug Coverage

Prescription Drug benefits will not include and no benefits will be paid for:

a. drugs or medicines that are not for a covered illness or injury or which are not approved by the FDA for the treatment of that illness or injury;

b. drugs or medicines that are an Experimental or Investigational Measure;

c. drugs or medicines that can be purchased without a Physician's prescription (except those listed under Covered Charges);

d. any prescription or refill in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date;

e. any part of a charge for drugs or medicines that exceed the Retail Network Pharmacy price (Retail Network Pharmacy coverage);

f. drugs or medicines for DESI (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness);

g. drugs labeled "Caution—limited by Federal law to investigational use";

h. infertility medications;

i. immunization agents, biological sera, blood, blood plasma, or any prescription directing parenteral administration or use;

j. drugs or medicines covered under the Medical Plan; i.e., Home Health Care Agency, etc.;

k. drugs or medicines dispensed by a Hospital, Skilled Nursing Facility, rest home, or other institution in which you or one of your Dependents is confined;

l. drugs or medicines, or any other method, to restore fertilization or promote conception;

m. drugs or medicines to induce abortion;

n. drugs or medicines provided for cosmetic purposes;

o. vitamins and minerals, unless as specified under Covered Charges;

p. over-the-counter drugs;

q. nutritional and diet supplements;

r. diet or appetite suppressants, except when related to an illness and approved by Us;

s. contraceptives, except when related to an illness and approved by Us;

t. sexual dysfunction, except when related to an illness and approved by Us;

u. drugs or medicines prescribed for treatment leading to, in connection with or resulting from sexual transformation, intersex surgery, or transsexualism;

v. anabolic steroids, except when related to an illness and approved by Us;

w. any drug or medicine to promote hair growth;

x. any drug containing nicotine or other tobacco deterrent medication, except as specifically covered by the Plan;

y. devices or appliances, support garments, and other non-medicinal substances, regardless of intended use;

z. drugs or medicines prescribed or dispensed by any person in your Immediate Family or any person in your Dependent's Immediate Family;

aa. drugs or medicines purchased outside the United States unless the Covered Person is outside the United States for one of the following reasons:

- travel, provided the travel is for a reason other than securing medical or dental care diagnosis or treatment;

- a business assignment by a covered Member (Employer);

- the Employee is employed by a covered Member (Employer) and working outside the United States; or

- an eligible Dependent child attending school outside the United States.

ab. drugs or medicines for which you or your Dependent have no financial liability or that would be provided at no charge in the absence of coverage or that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law) unless charges are imposed against the Covered Person for such drugs or medicines;

ac. drugs or medicines provided as the result of an injury arising out of or in the course of any self-employment for wage or profit;

ad. drugs or medicines provided as the result of a sickness covered by a Workers' Compensation Act or other similar law;

ae. drugs or medicines provided as the result of a sickness or injury that is due to war or act of war or to voluntary participation in criminal activities; or

af. drugs or medicines purchased after termination of coverage under this Plan.

F. Brand Name versus Generic

Most maintenance drugs come in two forms, Brand Name Prescription Drug and Generic Prescription Drug. Both brand name and generic drugs are covered under the program.

The Home Delivery Pharmacy will automatically fill your prescription with a generic drug (if available) if the prescribing Physician has indicated that a generic substitution is acceptable. If the prescribing Physician indicates that generic substitution is not acceptable (even though available), the Home Delivery Pharmacy will use the brand name drug.

G. 90 Day Supplies

Typically, prescriptions submitted to the Home Delivery Pharmacy will be filled up to a 90 day supply. Please have your Physician contact the Home Delivery Pharmacy at the toll-free number shown on your order form if there are any questions.

H. How to Order From the Home Delivery Pharmacy

Your initial order consists of three parts: the written prescription from your Physician; a Patient/Profile Order form with pre-addressed envelope; and a copayment. These are described below. You should allow 14 days for your order to be completed and shipped to you. All orders are mailed either by UPS or First Class U.S. Mail.

1. The Written Prescription

When obtaining your prescription, be sure to ask your Physician to specify the following information:

- patient name;
- 90 day supply of medication (the Physician should indicate the total number of pills required for that period of time. For example, 270 tablets would be needed for medication that must be taken three times a day.);
- refills (Many maintenance drugs can be prescribed for up to one year; therefore, a prescription for a 90 day supply may specify up to three refills.);
- Physician's signature.

Also it is very important to include your name, address, and member identification number in the prescription form, so that eligibility for the program can be verified when the Home Delivery Pharmacy receives the order.

2. Patient Profile/Order Form

Included in the installation package you will receive, as well as with each order shipped, is the Patient Profile/Order Form. This form is to be completed and sent to the Home Delivery Pharmacy with each order. The Patient Profile/Order Form provides information concerning eligibility in addition to health and allergy conditions pertaining to each covered person.

3. Copayment

A check or money order for the correct amount of copayment must accompany each order. The copayment amount is described in your Summary of Prescription Benefits beginning on Page 9. You may also be able to charge your copayment as explained in the Patient Profile/Order Form.

I. Refills or Follow-up Orders

Each filled order you receive includes Refill Ordering Instructions, a Patient/Profile Order Form, and a pre-addressed envelope. Orders for refills should be placed approximately two weeks before the current supply or medication is expected to run out.

J. Special Situations

If a maintenance medication is prescribed for immediate use, you should obtain two prescriptions--one for a 30 day supply to be filled immediately at a local pharmacy, and a second one for a 90 day supply with refills, to be filled by the Home Delivery Pharmacy if and when the medication proves satisfactory.

K. Questions

If you have a question concerning your prescriptions, you can call the Customer Service Department. The toll-free number is shown on your order form.

Also included with each order filled by the Home Delivery Pharmacy is a Patient Counseling information sheet which has specific information about the medication included with the order.

XVIII. PRESCRIPTION APPEAL PROCEDURES

If you or the pharmacist has a question about a prescription which cannot be filled at the pharmacy, either you or the pharmacist should contact Medco Customer Service at the telephone number listed on your identification card.

If the prescription cannot be filled because pre-authorization is required, you should have the ordering Physician contact Medco at 800-753-2851.

Internal Appeal – Home Delivery Pharmacy

Initial Appeal: In the event you receive an adverse benefit determination following a request for coverage of a prescription drug claim, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of the notice of the initial decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate a written appeal, you must provide your name, member ID, telephone number, the prescription drug for which an adverse benefit determination was made, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to:

Medco Health Solutions, Inc.
8111 Royal Ridge Parkway
Irving, TX 75063

A decision regarding your initial appeal will be sent to you within 15 days of receipt of your written request.

Second Level Appeal: If the initial appeal was denied in whole or in part, you may request a second level appeal. Such appeal must be in writing and must be received within 90 days after your receipt of the notice of the initial appeal decision. To initiate a second level appeal, you must provide your name, member ID, telephone number, the prescription drug for which an adverse benefit determination was made, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This appeal should be mailed to the address provided above. You have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim. A decision regarding your second level appeal will be sent to you within 15 days of receipt of your written request for an appeal.

You have a right to receive, upon request and at no charge, the information used to review your second level appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance of any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

Urgent Care: In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 24 hours of receipt of the claim. An urgent care claim is any claim for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision

with 24 hours of receipt of the information. If you do not provide the needed information within the 48 hour period, your claim will be deemed denied.

Urgent Appeal: You have the right to request an urgent appeal of an adverse benefit determination if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or your physician may call 800-864-1135 or send a written request to the above address. In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have a right to receive, upon request and at no charge, the information used to review your urgent appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond prior to issuance of any final adverse determination of this appeal.

Internal Appeal – Retail Pharmacy

Your Plan provides for reimbursement of prescription drugs when you pay 100% of the prescription price at the time of purchase. The claim will be processed based on your Plan benefit in effect at the time of purchase. If your claim was denied in whole or in part, you will receive a written notice within 30 days of receipt of the claim or you will be advised additional information is needed. You will have 30 days to provide the additional information and, once received, you will be notified of the benefit determination within 15 days.

Initial Appeal: In the event you receive an adverse benefit determination of a request for reimbursement, you have the right to appeal this decision within 180 days of receipt of the notice of the initial decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate a written appeal, you must provide your name, member ID, telephone number, the prescription drug for which an adverse benefit determination was made, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to:

Medco Health Solutions, Inc.
8111 Royal Ridge Parkway
Irving, TX 75063

A decision regarding your initial appeal will be sent to you within 30 days of receipt of your written request.

Second Level Appeal: If the initial appeal was denied in whole or in part, you may request a second level appeal. Such appeal must be in writing and must be received within 90 days after your receipt of the notice of the initial appeal decision. To initiate a second level appeal, you must provide your name, member ID, telephone number, the prescription drug for which an adverse benefit determination was made, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This appeal should be mailed to the address provided above. You have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim. A decision regarding your second level appeal will be sent to you within 30 days of receipt of your written request for an appeal.

You have a right to receive, upon request and at no charge, the information used to review your second level appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance of any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

External Appeal

When Medco has denied a prescription based on a judgment as to the:

- medical necessity;
- appropriateness;
- effectiveness of the prescription drug;

you or someone you name to act for you (your authorized representative) has the right to have Medco's decision reviewed by an independent review organization not associated with Medco. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination.

An external review does not apply to a denial of coverage for any Treatment or Service specifically excluded under the Plan or to decisions relating to eligibility.

If you request an external review, an independent organization will review the claim decision and provide you with a written determination.

Any decision made during the external review by the independent organization will be binding for both Medco and the claimant.

XIX. COORDINATION WITH OTHER BENEFITS - PRESCRIPTION DRUGS

Your Prescription Drug program does not coordinate benefits with any other plan or program nor will reimbursements be made for drugs purchased through other coverage, except where applicable by law.

XX. REIMBURSEMENT/SUBROGATION - MEDICAL AND PRESCRIPTION DRUG

If the Plan provides any benefits in connection with a Claim by a Covered Person, the Covered Person shall reimburse the Plan, to the extent of all amounts that the Plan has paid, out of any amounts that the Covered Person recovers from any source other than the Plan in connection with the Claim. The Covered Person's recovery from a source other than the Plan shall not be reduced by the amount of the Covered Person's attorney fees or for any other reason whatsoever, until the Plan has been repaid in full.

In addition, the Plan shall be subrogated to any legal rights which the Covered Person may have to recover against any party in connection with the Claim.

This reimbursement/subrogation provision applies to recoveries available to minor children from sources other than the Plan.

By accepting benefits hereunder, the Covered Person hereby grants a lien and assigns to the Plan an amount equal to the benefits paid against any recovery made by or on behalf of the Covered Person. The assignment is binding on any attorney who represents the Covered Person whether or not an agent of the Covered Person and on any insurance company or other financially responsible party against whom a Covered Person may have a claim provided said attorney, insurance carriers or others have been notified by the Plan or its agents.

The Covered Person shall timely notify the Plan of any litigation, settlement discussions, or other efforts to recover amounts from sources other than the Plan in connection with the Claim. A Covered Person shall obtain approval from the Plan before releasing any rights to recover medical and/or prescription drug expenses from sources other than the Plan.

If the Plan establishes that a Covered Person, personally or through the acts of an agent or attorney, breaches obligations under this provision, the Plan shall be entitled to pursue and recover to all available remedies together with any and all costs, including reasonable attorney fees, that the Plan may incur in establishing the breach and in obtaining remedies for the breach.

Covered Persons shall comply with all of the requirements within this reimbursement/subrogation provision in order to continue receiving benefits under the Plan.

XXI. DEFINITIONS

Several words and phrases used to describe your plan are capitalized whenever they are used in this booklet. These words and phrases have special meanings as explained in this section.

Ambulatory Surgery Center means a facility designed to provide surgical care which does not require Hospital Inpatient Confinement but is at a level above what is available in a Physician's office or clinic. An Ambulatory Surgery Center:

- is licensed by the proper authority of the state in which it is located, has an organized Physician staff, and has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; and
- provides Physician services and full-time skilled nursing services directed by a licensed Registered Nurse whenever a patient is in the facility; and
- does not provide the services or other accommodations for Hospital Inpatient Confinement; and
- is not a facility used as an office or clinic for the private practice of a Physician or other professional providers.

Birthing Center means a freestanding facility that is licensed by the proper authority of the state in which it is located and that:

- operates within the scope of all required licenses; and
- provides prenatal care, delivery, and immediate postpartum care; and
- operates under the direction of a Physician who is a specialist in obstetrics and gynecology; and
- has a Physician or certified nurse midwife present at all births and during the immediate postpartum period; and
- provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a licensed Registered Nurse or certified nurse midwife; and
- has a written agreement with a Hospital in the area for emergency transfer of a patient or a newborn child, with written procedures for such transfer being displayed and staff members being aware of such procedures; and
- maintains written medical records for each patient.

Brand Name Prescription Drug; Brand Name Drug means a drug that is customarily recognized throughout the pharmaceutical profession as the original or trademarked preparation of a drug entity and for which the Food and Drug Administration (FDA) has given general marketing approval.

Calendar Year means the calendar year January 1, up to and including the following December 31.

Coinsurance is the percentage that a Plan participant must pay for services covered at less than 100%. Coinsurance does not include Deductibles, Co-Pays, charges for services not covered by the Plan, or charges for services already eligible for payment at 100%.

Concurrent Review means a Utilization Review conducted during a patient's Hospital stay or course of treatment.

Co-Pay means the initial amount you owe the provider/supplier for the visit. This amount does not apply to the Covered Person's Deductible Requirement or Out-of-Pocket Expense Maximum Requirement.

Cosmetic Surgery means treatment, procedure, or surgery to change:

- the texture or appearance of the skin; or
- the relative size or position of any part of the body;

when such treatment, procedure, or surgery is performed primarily for psychological purposes or is not needed to correct or improve a bodily function.

Cost Containment Administrator means the entity responsible for administration of your Utilization Management Requirements as shown on your Summary of Medical Benefits beginning on Page 3.

Covered Charge means treatment or service which is:

- prescribed by a Physician and required for the screening, diagnosis or treatment of a medical condition;
- consistent with the diagnosis or symptoms;
- not excessive in scope, duration, intensity or quantity;
- the most appropriate level of services or supplies that can safely be provided; and
- determined by Us to be Generally Accepted.

Covered Person means a Covered Employee, Covered Dependent, or Covered Retiree.

Creditable Coverage means, with respect to an individual, coverage of the individual under any of the following:

- Another group health plan;
- Health Insurance Coverage, as defined in this section;
- Medicare (Part A or Part B of Title XVIII of the Social Security Act);
- Medicaid (Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928);
- TRICARE (Chapter 55 of Title 10, United States Code);
- A medical care program of the Indian Health Service or of a tribal organization;
- A state health benefits risk pool;
- A health benefit plan for government employees (Chapter 89 of Title 5, United States Code);
- A public health plan established or maintained by a State, the United States, a foreign country, or any political subdivision thereof;

- A health benefit plan provided under the Peace Corps Act;

- Any other similar coverage permitted under state or federal law or regulations;

- A health benefit plan provided under a State Children's Health Insurance Program (Title XXI of the Social Security Act).

Creditable Coverage does not include coverage consisting solely of coverage of Excepted Benefits.

Custodial Care means assistance with meeting personal needs or the Activities of Daily Living.

For this purpose, "Activities of Daily Living" means activities that do not require the services of a Physician, licensed registered nurse (R.N.), licensed practical nurse (L.P.N.), or other health care professional including, but not limited to, bathing, dressing, getting in and out of bed, feeding, walking, elimination, and taking medications.

Deductible; Deductible Amount means a specified dollar amount of Covered Charges that must be incurred by you or one of your Dependents before benefits will be payable under this Plan for all or part of the remaining Covered Charges during the year.

Dental Services means any confinement, treatment, or service to diagnose, prevent, or correct:

- periodontal disease (disease of the surrounding and supplemental tissues of the teeth, including deformities of the bone surrounding the teeth); and/or

- malocclusion (abnormal positioning and/or relationship of the teeth); and/or

- craniomandibular or temporomandibular joint disorders; and/or

- ailments or defects of the teeth and supporting tissues and bone (excluding appliances used to close an acquired or congenital opening). However, the term Dental Services will include treatment performed to replace or restore any natural teeth in conjunction with the use of any such appliance.

Dependent means:

- your Spouse, if not in the Armed Forces and not covered as an Employee; and

- your natural or legally adopted child less than 26 years of age; and

- a child of your Spouse less than 26 years of age.

Dependent will include a child less than 26 years of age for whom you have legal guardianship if the child is the employee's tax dependent and We approve in writing. To be the employee's tax dependent, the child must be claimed as an exemption, as defined by the I.R.S. Code of the U.S., on your Federal income tax return.

Dependent will include any child covered under a Qualified Medical Child Support Order (QMCSO) or national Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to this plan, provided the child meets this plan's definition of a Dependent.

Durable Medical Equipment means equipment that:

- can withstand repeated use; and
- is primarily and customarily used to serve a medical purpose; and
- is generally not useful to a person who is not sick or injured, or used by other family members; and
- is appropriate for home use; and
- improves bodily function caused by sickness or injury, or further prevents deterioration of the medical condition.

Employee means an employee of a Participating Member (Employer):

- whose work week meets the minimum requirements as determined by the Member (Employer). In no event can an employee be eligible for the Plan who works less than 20 hours in a normal work week.
- For a teacher, Employee means a teacher who meets the requirements as determined by the Member (Employer). In no event can a teacher be eligible for the Plan who teaches less than ½ of a normal work load.
- Employee may include members of religious orders and secular priests.
- Employee does not include independent contractors, volunteers, etc., whose income from the Member (Employer) is not subject to Federal Withholding for wages or FICA.

Employer refer to **Member (Employer)**.

Enrollment Date means the first day of coverage under this Plan or, if earlier, the first day of any Waiting Period.

Excepted Benefits means benefits or coverage under one or more (or any combination thereof) of the following:

- Coverage only for accident (including accidental death and dismemberment);
- Disability income insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Coverage issued as a supplement to liability insurance;
- Workers' Compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance (for example, mortgage insurance);
- Coverage for on-site medical clinics;

- Other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits;

- The following benefits if offered separately from medical expense benefits (provided under a separate policy, certificate, or contract of insurance, or otherwise not an integral part of the plan);

    - limited scope dental or vision benefits;

    - benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

    - other similar limited benefits;

- The following benefits if offered as independent, non-coordinated benefits:

    - coverage only for a specified disease or illness;

    - hospital indemnity or other fixed indemnity insurance;

- The following benefits if offered as a separate insurance policy:

    - Medicare Supplement Insurance;

    - coverage supplemental to TRICARE;

    - similar supplemental coverage provided to coverage under a Group Health Plan;

- Health flexible spending arrangement, if the following are satisfied:

    - the maximum benefit from employee and employer contributions for the year does not exceed two times the employee's annual salary reduction;

    - the employee has other group health coverage available that is not limited to Excepted Benefits.

Experimental or Investigational Measures means any Treatment or Service, regardless of any claimed therapeutic value, not Generally Accepted by specialists in that particular field of medicine or dentistry, as determined by Us.

Formulary – See Preferred Brand Prescription Drug

Generally Accepted means Treatment or Service for the particular sickness or injury which is the subject of the claim that:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature; and

- is in general use in the relevant medical community; and

- is not under scientific testing or research.

Generic Prescription Drug(s) means biologically equivalent pharmaceutical products manufactured and sold under their chemical, common or non-proprietary official name.

Health Care Extender means a member of a covered provider's staff or allied health practitioner. Medical services must be billed by and delivered under the Direction and Supervision of a provider covered by the Plan.

Direction and supervision means:

- the covered provider bills for and co-signs any progress notes written by the Health Care Extender; or

- there is a legal agreement that places overall responsibility for the Health Care Extender's services on the provider.

Health Insurance Coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health Insurance Coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

Home Delivery Pharmacy means the Prescription Drug Benefits Manager designated by The Plan.

Home Health Aide means a person, other than a Registered Nurse, certified by the State to provide medical or therapeutic care under the supervision of a Home Health Care Agency.

Home Health Care Agency means a Hospital, agency, or other service that is certified by the proper authority of the state in which it is located to provide home health care.

Home Health Care Plan means a program of home care that:

- is required as a result of a sickness or injury; and

- follows a period of Hospital confinement; and

- is a result of the sickness or injury that was the cause of the Hospital confinement; and

- is established in writing by the attending Physician within seven days after Hospital confinement ends; and

- is certified by the attending Physician as a replacement for Hospital confinement that would otherwise be necessary.

Hospice means a facility, agency, or service that:

- is licensed, accredited, or approved by the proper regulatory authority to establish and manage Hospice Care Programs; and

- arranges, coordinates, and/or provides Hospice Care Services for a dying Employee or Dependent and their families; and

- maintains records of Hospice Care Services provided and bills for such services on a consolidated basis.

Hospice Care Episode means the period of time:

- beginning on the date a Hospice Care Program is established for a dying Employee or Dependent; and

- ending on the earlier of the date six months after the date the Hospice Care Program is established, the date the attending physician withdraws approval of the Hospice Care Program, the date the Employee or Dependent recovers, or the date the Employee or Dependent dies.

Hospice Care Program means a coordinated, interdisciplinary program that provides services that consist of:

- inpatient and outpatient care, home care, nursing care, counseling, and other supportive services and supplies provided to meet the physical, psychological, spiritual, and social needs of the dying Employee or Dependent; and

- drugs and medicines (requiring a Physician's prescription) and other supplies prescribed for the dying Employee or Dependent by any Physician who is a part of the Hospice Care Team; and

- instructions for care of the patient, counseling, and other supportive services for the family of the dying Employee or Dependent.

Hospice Care Team means a group that provides coordinated Hospice Care Services and normally includes:

- a physician;

- a patient care coordinator (physician or nurse who serves as an intermediary between the program and the attending physician);

- a nurse;

- a mental health specialist;

- a social worker;

- a chaplain; and

- lay volunteers.

Hospital means an institution that is licensed as a Hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center. Hospital shall also include an Inpatient Alcohol or Drug Abuse Treatment Facility and a Birthing Center.

Hospital Admission Review means a review by the Cost Containment Administrator of a Physician's report of the need for Hospital Inpatient Confinement (scheduled or emergency) to determine if the confinement is for medically necessary care.

Hospital Inpatient Confined; Hospital Inpatient Confinement means any period of Treatment or Service in a hospital in excess of 23 consecutive hours for any cause. A Hospital Admission Review is required for all Hospital Inpatient Confinements.

Hospital Inpatient Confinement Charges means Covered Charges by a Hospital for room, board, and other usual services and by a Physician for pathology, radiology, or the administration of anesthesia while a person is Hospital Inpatient Confined.

Immediate Family means an Employee's or Dependent's husband or wife, natural or adoptive parent, child or sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or spouse of grandparent or grandchild.

Initial Clinical Review(er) means a clinical review conducted by appropriate licensed or certified health professionals. Initial Clinical Review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to a Peer Clinical Reviewer for certification or Noncertification.

Inpatient Alcohol or Drug Abuse Treatment Facility means an institution that:

- is licensed by the proper authority of the state in which it is located; and
- is primarily engaged in providing alcohol or drug detoxification or rehabilitation treatment services; and
- is supervised on a full-time basis by a Doctor of Medicine (MD) or Doctor of Osteopathy (DO); and
- provides 24-hour a day on-site nursing care by licensed Registered Nurses.

Maintenance Prescription Drugs or Medications means drugs taken on a regular long-term basis.

Medical Emergency means the sudden onset of severe medical symptoms that:

- may be life threatening; and
- could not have been reasonably anticipated; and
- requires immediate medical treatment.

Medically Necessary Care means any Treatment or Service that is:

- prescribed by a Physician and required for the screening, diagnosis or treatment of a medical condition;
- consistent with the diagnosis or symptoms;
- not excessive in scope, duration, intensity or quantity;
- the most appropriate level of services or supplies that can safely be provided; and
- determined by Us to be Generally Accepted.

Member (Employer) means any corporation, establishment, or institution that has fulfilled participation requirements of the Trust and which:

- is operated under the auspices of the Roman Catholic Church, in good standing thereof, and is currently listed, or approved for listing, in The Official Catholic Directory, published by P.J. Kenedy & Sons; and
- is exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986, as amended; and
- is organized as a not-for-profit corporation, if the organization is a corporation.

Noncertification means a decision by the Cost Containment Administrator that an admission, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the Cost Containment Administrator's requirements for Medically Necessary Care, appropriateness, health care setting level of care or effectiveness, and the request is therefore denied, reduced, or terminated.

Notification of Utilization Review Services means receipt of necessary information to initiate review of a request for Utilization Review services to include the patient's name and your name (if different from patient's name), attending Physician's name, treating facility's name, diagnosis, and date of service.

Out-of-Pocket Limit; Out-of-Pocket Expenses means Covered Charges for Treatment or Service for which no benefits are payable because of the Deductible and Coinsurance; the amount you pay on Covered Charges.

Peer Clinical Review(er) means a clinical review conducted by a Physician or other health professional when a request for an admission, procedure, or service was not approved during the Initial Clinical Review.

In the case of an appeal review, the Peer Clinical Reviewer is a Physician or other health professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the ordering provider.

Period of Limited Activity means any period of time during which a Covered Dependent:

- is confined in a Hospital or Skilled Nursing Facility; or
- whether confined or not, is unable to carry on the regular and usual activities of a healthy person of the same age and sex.

Physical Handicap means a Dependent child's substantial physical or mental impairment which:

- results from injury, accident, congenital defect, or sickness; and
- is diagnosed by a Physician as a permanent or long term dysfunction or malformation of the body.

Physician means Doctor of Medicine; Doctor of Osteopathy; Certified Registered Nurse Anesthetist; Dentist; Certified Midwife; Physician's Assistant; Podiatrist, Chiropractor, Psychologist, State Licensed Mental Health Provider, and Social Worker.

Physician Visit or Visit means a face-to-face meeting between a Physician, Physician's staff, or State Licensed Practitioner, and a patient for the purpose of medical Treatment or Service.

Plan Administrator means, Christian Brothers Services, the entity retained to perform certain administrative services for the Plan, and who is appointed by the Trustees.

Plan Sponsor means the Trustees of the Christian Brothers Employee Benefit Trust, as elected.

Preferred Brand Prescription Drug (Formulary) means a list of drugs that are preferred by your plan. This list includes a wide selection of drugs and is preferred because it offers you a choice while helping to keep the cost of your prescription drug benefits affordable. Each drug is approved by the Food and Drug Administration (FDA) and reviewed by an independent group of doctors and pharmacists for safety and effectiveness

Prevailing Charge means the amount, as determined by Us, that most Physicians or other health care providers charge for the same or a similar Treatment or Service in the cost area (or a comparable cost area) where the Treatment or Service is provided.

Primary Care Physician is a family or general practitioner, internist (internal medicine), obstetrician/gynecologist, pediatrician, nurse midwife, urgent care physician, geriatric physician, or a nurse or physician assistant directed and supervised by a Primary Care Physician. The Plan does not require you to select a Primary Care Physician.

Private Room Maximum means Covered Charges by a Hospital for room and board while confined in a private room up to:

- the Hospital's most frequent semiprivate room rate, if the Hospital has semiprivate rooms; or
- the Hospital's most frequent private room rate, if the Hospital has no semiprivate rooms.

Prospective Review means a Utilization Review conducted prior to a patient's stay in a Hospital or other health care facility or course of treatment, including any required preauthorization or precertification.

Registered Nurse means a nurse who is licensed or certified by the State in which he or she practices.

Retail Network Pharmacy means the network of pharmacies elected by the Plan provided through the Prescription Drug Benefits Manager.

Retrospective Review means a Utilization Review conducted after the patient is discharged from a Hospital or other health care facility or has completed a course of treatment.

Skilled Nursing Facility means an institution that is licensed to provide skilled nursing care for persons recovering from sickness or injury and:

- is supervised on a full-time basis by a Physician or a Registered Nurse; and
- has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one Physician; and
- has a contract for the services of a Physician, maintains daily records on each patient and is equipped to dispense and administer drugs; and
- provides 24-hour nursing care and other medical treatment.

Not included are rest homes, homes for the aged, or places for treatment of mental disease, drug addiction, or alcoholism.

Specialty Care Physician is a physician who is not a Primary Care Physician as defined.

Specialty Prescription Drug(s) means drugs designated as Specialty Prescription Drugs per generally accepted industry sources and as adopted by Us.

Spouse means a person of the opposite sex who is the legally married husband or wife of the Employee.

State Licensed Mental Health Provider means a provider who:

- is licensed or certified and practices within the State of the license or certification;
- is treating a mental health, alcohol, or drug abuse condition; and
- is practicing within the scope of his/her license.

State Licensed Practitioner means a provider who:

- is licensed or certified and practices within the State of the license or certification;
- is treating a medical condition;
- is practicing within the scope of his/her license; and
- is not specifically covered under any other provisions of the medical plan.

Totally Disabled (Total Disability) means your inability, because of sickness or injury, to work at any occupation that reasonably fits your background and training.

Transplant Network means any network of providers that the Plan Administrator determines to be an appropriate transplant network and that has contracted to provide Transplant Services subject to a negotiated fee schedule.

Treatment or Service when used in this Plan will be considered to mean 'confinement, treatment, service, substance, material, or device'.

Trust means the funding medium for accumulation of assets and payment of benefits and known as, The Christian Brothers Employee Benefit Trust.

Trustee(s) means the entity elected by the Members (Employers) which has the responsibility for the administration of the Trust and Plan.

Urgent Review means a Utilization Review that must be completed sooner than a Prospective Review in order to prevent serious jeopardy to your or the patient's life or health or the ability to regain maximum function, or in the opinion of a Physician with knowledge of your or the patient's medical condition, would subject you or the patient to severe pain that cannot be adequately managed without treatment. Whether or not there is a need for an Urgent Review is based upon the Cost Containment Administrator's decision using the judgment of a prudent lay-person who possesses an average knowledge of health and medicine.

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities.

We, Us, and Our means The Trustee or Plan Administrator for specific duties which have been delegated to the Administrator by the Trustee.

Weekend Admission Charges means room and board charges by a Hospital for the first Friday and/or Saturday of a confinement if the patient is admitted to the Hospital on one of these days, unless:

- the confinement is for emergency Treatment or Service; or
- a surgical operation is scheduled for the day or the day after the date of admission; or
- medical treatment, requiring Hospital confinement, is scheduled for the day or the day after the date of admission.

XXII. PLAN INFORMATION

Plan Name:

Christian Brothers Employee Benefit Trust

Plan Sponsor:

Trustees of Christian Brothers Employee Benefit Trust

c/o Christian Brothers Services

1205 Windham Parkway

Romeoville, IL 60446-1679

Plan Year:

January 1 thru December 31

Plan Administrator:

Christian Brothers Services (appointed by the Trustees)

1205 Windham Parkway

Romeoville, IL 60446-1679

Telephone No. 800-807-0100

EIN No. 36-3884439

Plan Costs:

Medical and Prescription Drug benefits are paid by the Employee and Member (Employer) as determined by the Member (Employer) at each location.

Agent for Service or Legal Process:

Managing Director, Employee Benefit Services, the Christian Brothers Employee Benefit Trust

1205 Windham Parkway

Romeoville, IL 60446-1679

Legal process may be served on the Plan Administrator or a Trustee

Plan Benefits Provided by:

Medical and Prescription Drug benefits are provided through the Christian Brothers Employee Benefit Trust.

Plan Eligibility and Benefits:

See the Table of Contents and your Summary of Benefits to locate description of medical and prescription drug benefits and eligibility requirements.

How to File a Claim:

See the table of contents in this section of the booklet to locate "Claim Procedures".

Plan Trustees:

The Plan Administrator will provide the names of the current Trustees upon request.

DENTAL
PREFERRED PROVIDER ORGANIZATION (PPO)

Your Plan has made available a
Dental Preferred Provider Organization (PPO)

Aetna Dental Administrators (SM)

You may verify PPO status with your provider or check status on the PPO website.

Please visit www.mycbs.org/health

Click on "Find a PPO Provider."

Utilizing a Dental PPO Provider entitles you to additional savings
due to their discounted fees and reduces your out-of-pocket expenses.

However, if you are unable to find a Dental PPO Provider in your area,
normal dental benefits will apply.

BENEFIT ADVICE

Please give us a call if you have any questions about your dental benefits.

1-800-852-4877

You may refer to the claim procedures section of the booklet for more detailed information.

DENTAL BENEFIT BOOKLET

TABLE OF CONTENTS

I. INTRODUCTION

Christian Brothers Employee Benefit Trust is a self-funded church plan which serves employers of the Catholic Church by providing certain dental and other benefits to Plan participants.

A. Plan Benefits

Plan Benefits are governed by this benefit description booklet.

B. Plan Interpretation

This benefit description booklet has been prepared with as much information as is reasonable to help you understand your benefits. However, some terms in the Plan may require interpretation as they apply to any specific situation.

The Plan Administrator has been given the authority and discretion by the Plan Trustees to interpret the terms of the Plan where the Plan's terms need interpretation and to approve certain services in catastrophic cases.

The Plan Administrator reserves the right to employ experts in the disability, medical and dental fields in order to be guided by the terms of the entire Plan and by commonly accepted industry practices. In the event of a dispute, final authority for interpretation and construction rests with the Plan Trustees.

C. Conformity With State Mandates

The Christian Brothers Employee Benefit Trust is a “church plan” as designated by the Internal Revenue Service and Department of Labor. It is not a group insurance contract within the meaning of state group insurance laws. Therefore, the Christian Brothers Employee Benefit Trust is not subject to the mandated benefit requirements imposed by state group insurance laws. To the extent that state laws other than those applicable to group insurance contracts may legally require the Christian Brothers Employee Benefit Trust to provide a particular benefit, the Christian Brothers Employee Benefit Trust will conform to the state mandate, unless the mandated benefit would conflict with the doctrine or tenets of the Roman Catholic Church.

II. HOW TO BE COVERED

A. Eligibility For Enrollment

1. When You are Eligible for Coverage

If you are an Employee, as defined, you are eligible for coverage the day the Plan goes into effect at your Member's (Employer's) location. If your employment commences after such date, you are eligible for coverage on the date selected by your Member (Employer) following the commencement of your employment. (See “Employee” in the Definitions section for eligibility.)

2. When Your Dependents are Eligible for Coverage

Your Dependents are eligible for coverage the same day as you, provided you have eligible Dependents on that date. If you later acquire an eligible Dependent, you will be eligible for Dependent coverage on the date you first acquire an eligible Dependent.

3. Newborns - 31-Day Coverage

Under this Plan, your newborn child will be automatically covered until the child attains 31 days of age. If you do not enroll this child for Dependent coverage before the 31 days end, the "Late Enrollment" provision will apply.

B. How You Enroll for Coverage

To enroll for coverage, obtain an enrollment form from your Member (Employer). Complete the form giving all requested information applicable to you and your Dependents. Sign the form and return to your Member (Employer) on a timely basis.

C. When You Become Enrolled for Coverage

1. Noncontributory Coverage:

- If no contributions are required from you for the coverage, you are covered the first day you are eligible.

- If no contributions are required from you for Dependent coverage, your Dependents will be covered on the first day you are eligible for Dependent coverage.

2. Contributory Coverage:

- Coverage begins on the first of the month following proper enrollment. If you delay your enrollment more than 31 days beyond the date you were first eligible and other than during a Special Enrollment Period described below, your coverage will be subject to "Late Enrollment Provisions," as described below.

- Coverage begins on the first of the month following proper enrollment . If you delay your enrollment more than 31 days beyond the date you were first eligible but during a Special Enrollment Period described below, your coverage will be subject to "Special Enrollment Provisions," as described below.

3. Late Enrollment Provisions

a. Definitions

Late Enrollee. Late Enrollee means, with respect to coverage under a Member's (Employer's) Group Health Plan, an Employee or Dependent who enrolls under the Plan other than during:

- the first period in which the individual is eligible to enroll under the Group Health Plan; or

- a Special Enrollment Period described below.

For the purpose of the first item listed above, only the most recent period of eligibility will be considered in determining whether an individual is a Late Enrollee if:

- the individual loses eligibility under the Group Health Plan due to termination of employment or due to a general suspension of the Group Health Plan; and

- the individual later becomes eligible again under the Group Health Plan due to resumption of employment or due to resumption of the Group Health Plan's coverage.

The term "Late Enrollee" also means an Employee or Dependent who:

- was previously covered under the Plan but elected to terminate the coverage; and

- reapplies for coverage more than 31 days after the termination date; and

- does not qualify for one of the Special Enrollment Periods described below.

b. Effective Date for Late Enrollees

A Late Enrollee can request coverage at any time, provided on such date:

- the Employee continues to meet the Plan's definition of an Employee; and

- for Dependent coverage, the Dependents continue to meet the Plan's definition of Dependent.

Coverage for a Late Enrollee will become effective the first of the month following a six month deferral period from the date the enrollment form is received by Us.

The individual will be subject to the plan's Deferred Dental Limitation provisions, as described under Section X, when his or her coverage becomes effective.

D. Special Enrollment Periods

If you or your Dependent requests enrollment after the first period in which you or your Dependent was eligible to enroll but during a Special Enrollment Period as described below, you or your Dependent will be a Special Enrollee and will not be considered a Late Enrollee.

If the Member (Employer) offers different benefit options, a benefit option transfer may also be made if your request is due to a Special Enrollment Period and you complete the appropriate enrollment form within the time specified for a Special Enrollment Period as described below. The effective date of the benefit option transfer will coincide with the effective date of your applicable Special Enrollment.

The Special Enrollment Periods are:

- Loss of Other Coverage: A Special Enrollment Period will apply to you or your Dependent if all of the following conditions are met:

  - You or your Dependent were covered under another Group Health Plan or had other Health Insurance Coverage at the time of initial eligibility, and declined enrollment solely due to the other coverage; and

  - The other coverage terminated due to loss of eligibility (including loss due to legal separation, divorce, death, cessation of Dependent status, termination of employment or reduction in work hours, incurring a claim that meets or exceeds the other coverage lifetime limit on all benefits, when the individual no longer resides, lives, or works in a service area and there is no other benefit package available under the other Group Health Plan, or when the other Group Health Plan no longer offers any benefits to a class of similarly situated individuals), or due to termination of employer contributions (or, if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation); and

  - Request for enrollment is made within 31 days after the other coverage terminates or after a claim is denied due to reaching the lifetime limit of all benefits under the other health coverage.

  The effective date of coverage will be the first of the calendar month that next follows the date of the request for enrollment.

NOTE: For the purpose of the second item listed above:

- "Loss of eligibility" does not include a loss due to failure of the individual to pay contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the health coverage); and

- "Employer contributions" include contributions by any current or former employer (of the individual or another person) who was contributing to the coverage of the individual.

- Newly Acquired Dependents: A Special Enrollment Period will apply to you or your Dependent if:

  - You are enrolled (or are eligible to be enrolled but have failed to enroll during a previous enrollment period); and

  - A person becomes your Dependent through marriage, birth, adoption or Placement for Adoption; and

  - Request for enrollment is made within 31 days after the date of the marriage, birth, adoption, or Placement for Adoption.

  The effective date of your or your Dependent's coverage will be:

  - In the event of marriage, the date of the request for enrollment; or

  - In the event of a Dependent child's birth, the date of such birth; or

  - In the event of a Dependent child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.

- Court-Ordered Coverage: A Special Enrollment Period will apply to your Dependent child if:

  - You are enrolled but have failed to enroll the Dependent child during a previous enrollment period; and

  - You are required by a court or administrative order to provide health coverage for the Dependent child; and

  - Request for enrollment is made within 31 days after the issue date of the court or administrative order.

  The effective date of the Dependent child's coverage will be the date of the request for enrollment.

  A copy of the procedures governing Qualified Medical Child Support Orders (QMCSO) can be obtained from the plan administrator without charge.

- Loss of Medicaid or CHIP Coverage: A Special Enrollment Period may apply to you or your Dependent if:

    - You or your Dependent is covered under Medicaid or a Children's Health Insurance Program ("CHIP") and Medicaid or CHIP coverage is terminated as the result of loss of eligibility; and

    - You request special enrollment on an appropriately completed enrollment application within 60 days after the loss of such coverage.

- Eligibility for Employment Assistance Under Medicaid or CHIP: A Special Enrollment Period may apply to you or your Dependent if:
    - You or your Dependent become eligible for a Medicaid or CHIP premiums assistance subsidy; and
    - You request special enrollment on an appropriately completed enrollment application within 60 days after you or your dependent is determined to be eligible for assistance.

E. Certificate of Creditable Coverage Required by HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires a certificate of Creditable Coverage be issued to individuals losing health coverage. A Certificate of Creditable Coverage will be issued automatically when you or your Dependent's coverage under the plan terminates or when continued coverage terminates. You may also request a Certificate of Creditable Coverage at any time while covered and up to 24 months after the date coverage terminates. For further information contact:

Christian Brothers Employee Benefit Trust
c/o Christian Brothers Services
1205 Windham Parkway
Romeoville, IL 60446-1679
Phone: 800-807-9460

F. Transfer Provision (For Newly Enrolled Employers)

When this Plan replaces the coverage of another group carrier for a newly enrolled Member/Employer, benefits payable will be the lesser of:

- the amount which would have been paid by the previous carrier had their coverage been continued; or

- the amount payable under this Plan.

Conditions for coverage under this Transfer Provision are subject to those stated in the plan document.

III. ELIGIBLE DEPENDENTS

For Dental Benefits, Dependent means:

- your spouse, if not in the Armed Forces and not covered as an Employee; and

- your unmarried natural or legally adopted child less than 26 years of age, if not in the Armed Forces and not eligible as an Employee under this Plan, who is chiefly dependent upon you for support; and

- your unmarried stepchild or any child for whom you have legal guardianship, living with you, if they meet all requirements above and We approve in writing.

To be eligible as a Dependent, the Dependent's principal residence must be in the U.S.

In no event may a Dependent child be covered by more than one Employee. If more than one Employee would otherwise cover the Dependent child, the child may only be covered by the Employee with the longest period of continuous service, unless otherwise determined by a mutual written agreement.

Dependent will include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to this plan, provided the child meets this plan's definition of a Dependent.

A covered child, who attains the age at which his status as an eligible Dependent would otherwise terminate, may retain eligibility if the Dependent is chiefly dependent upon the Employee for support and maintenance and incapable of self-sustaining employment by reason of Physical Handicap. Such condition must start before reaching the age when Dependent status otherwise would terminate. We may ask for proof of incapacity from time to time. If proof is requested and We do not receive an answer within 90 days, the child will no longer be considered an eligible Dependent.

A non-covered child who is ineligible due to age may be eligible for coverage under this handicapped provision if the child meets the requirements above and provides us with proof of "Creditable Coverage" as defined under HIPAA.

A. Change in Family Status

Once you are in the Plan, it is necessary that you promptly enroll your eligible Dependent(s). Also, please notify your Member (Employer) when you no longer have any eligible Dependents.

If you have one or more covered children, you must report the names and dates of birth of any additional children to your Employer. If only children are covered and a spouse becomes eligible, you must also report this to your Employer.

IV. WHEN YOUR COVERAGE TERMINATES

A. Termination of Coverage

Coverage for you and your Dependents terminates when:

- your employment terminates; or
- you no longer qualify as an Employee; or
- coverage terminates on the class of employees to which you belong; or
- you discontinue required contributions; or
- you cease to be actively employed; or
- your Member (Employer) no longer is a participant in the Trust; or
- the Plan terminates.

Coverage for a Dependent terminates when:

- your Dependent is no longer eligible for coverage; or
- your Dependent's coverage under the Plan terminates; or
- your coverage as an Employee terminates; or
- the Plan terminates.

B. Continuation Privilege

Any continuation privileges below are subject to terms and conditions established by your Member (Employer) and the Plan Administrator.

1. **Employee and Dependent Continuation Privilege** – General

If you or your Dependent(s) lose coverage due to:

- termination of employment; or
- leave of absence; or
- ineligibility as an Employee; or
- ineligibility as a Dependent; or
- retirement; or
- death of an Employee or Retiree; or
- disability; or
- divorce;

you may be eligible to continue your dental coverage for a limited period of time by paying the required contribution.

You should contact your Member (Employer) to verify if continuation is available and to obtain the necessary forms required for continuation.

2. Retiree Continuation Privilege

Your Employer may offer a Retiree Continuation Privilege. Please contact your employer to verify if continuation is available.

If your Employer allows continuation for retirees, you and your eligible Covered Dependents may be eligible to continue your Dental coverage by paying the required contribution. You would be eligible if:

- you retire at age 55 or older with at least five consecutive years of Dental coverage under the Plan prior to retirement, and

- you are receiving a Social Security retirement benefit or a retirement benefit from your Member's (Employer's) retirement plan.

Contact your Employer immediately to obtain the necessary forms for continuation.

If you die while under Retiree Dental continuation, your eligible Covered Dependents may be eligible to continue their coverage for a limited period of time by paying the required contribution.

Note: If a retiree, or Spouse, is eligible for Medicare and chooses not to purchase Medicare A or B, benefits from this Plan will be reduced. The Plan only provides benefits under the Integration with Medicare provision discussed later in this booklet.

3. Federal Family and Medical Leave Act (FMLA)

Continuation

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects your group plan. See your employer for details on this continuation provision.

FMLA and Other Continuation Provisions

If your employer is an Eligible Employer and if the continuation portion of the FMLA applies to your coverage, these FMLA continuation provisions:

- are in addition to any other continuation provision of this plan, if any; and

- will run concurrently with any other continuation provisions of this plan for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

Eligible Employee

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and

- for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and

- at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- The birth of a child of an Eligible Employee and in order to care for the child.

- The placement of a child with the Eligible Employee for adoption or foster care.

- To care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition."

- A "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job.

Reinstatement

An Eligible Employee's terminated coverage may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

See your employer for details on this reinstatement provision.

Servicemember Family Leave

Eligible Employers are now required to allow unpaid leave to certain family members of military personnel:

- up to 12 weeks for “qualifying exigencies” related to a call to active service in support of a contingency operation; and

- up to 26 weeks to care for a covered family member who has incurred a serious injury or illness in the line of duty.

4. Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Federal law requires that if your coverage would otherwise end because you enter into active military duty, you may elect to continue coverage (including Dependents coverage) in accordance with the provisions of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation

If active employment ends because you enter active military duty, coverage may be continued until the earliest of:

- for you and your Dependents:
    - the date the group plan is terminated; or
    - the end of the contribution period for which contributions are paid if you fail to make timely payment of a required contribution; or
    - the date 24 months after the date you enter active military duty; or
    - the date after the day on which you fail to return to active employment or apply for reemployment with the Member (Employer).
- for your Dependents:
    - the date Dependent Coverage would otherwise cease; or
    - any date desired, if requested by you before that date.
    -

The continuation provision will be in addition to any other continuation provisions described in this plan for sickness, injury, layoff, or approved leave of absence, if any. If you qualify for both state and USERRA continuation, the election of one means the rejection of the other.

Reinstatement

The reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA.

This is a general summary of the USERRA and how it affects your group plan. See your employer for details on this continuation provision.

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V. SUMMARY OF DENTAL BENEFITS

Dental Expense Benefits are designed to help pay expenses which otherwise you would have to pay in full for necessary dental care. Coverage for you and your enrolled Dependents is the same.

A. Maximum Dental Payment Limits

The maximum benefit payable for all Dental Covered Charges under Dental Care Units 1, 2, and 3 incurred by a Covered Person during the Calendar Year is $1,000.

B. Dental Benefits Payable

Dental Care Benefits are payable for Covered Charges incurred in the calendar year after satisfaction of the Deductible Requirement except, Diagnostic and Preventive Covered Charges shall not be subject to the Deductible Requirement. Reimbursement of Covered Charges shall be payable at the following percentages:

Diagnostic and Preventive Covered Charges	100%	Dental Care Unit 1
Basic Covered Charges	80%	Dental Care Unit 2
Major Covered Charges	50%	Dental Care Unit 3

C. Deductible Requirements

There is no deductible requirement under Dental Care Unit 1, Diagnostic and Preventive Covered Charges.

All Dental Covered Charges under Dental Care Units 2 and 3, Basic and Major Covered Charges, are subject to a combined deductible requirement of $50 per Covered Person per calendar year.

D. Family Limit

The maximum family deductible under Dental Care Units 2 and 3, Basic and Major Covered Charges, will be a combined family total of $150 of covered dental charges per calendar year (but not counting more than $50 for any one Covered Person in your family).

NOTE: See the Table of Contents to locate the Claims Procedures section of this booklet for important information on filing your dental claims.

DENTAL BENEFITS ARE NOT PAYABLE FOR DISEASE OR INJURY COVERED BY A WORKERS' COMPENSATION ACT OR SIMILAR LEGISLATION, OR THAT WOULD HAVE BEEN COVERED IF ELECTED.

BENEFIT ADVICE

PLEASE GIVE US A CALL IF YOU HAVE ANY QUESTIONS ABOUT YOUR DENTAL BENEFITS.

1-800-807-0400

YOU MAY REFER TO THE CLAIM PROCEDURES SECTION OF THE BOOKLET FOR MORE DETAILED INFORMATION.

VI. DESCRIPTION OF DENTAL BENEFITS

Dental Expense Benefits are designed to help pay expenses which otherwise you would have to pay in full for necessary dental care. Coverage for you and your enrolled Dependents is the same.

A. Maximum Dental Payment Limit

The maximum benefit payable for all Dental Covered Charges incurred by a Covered Person during the calendar year is shown in the Summary of Benefits.

B. Dental Payment Qualification

To qualify for payment of the benefits provided by your plan you and your Dependents must:

- be covered in that class on the date dental Treatment or Service is received; and
- file a Dental Treatment Plan with Us before treatment begins when charges for a Period of Dental Treatment (other than emergency treatment) are expected to exceed $300; and
- satisfy the requirements listed in the CLAIM PROCEDURES Section.

C. Dental Benefits Payable

Benefits payable will be as described in this section, subject to:

- all listed limitations; and
- the terms and conditions of:
  - Coordination with Other Benefits; and
  - Reimbursement/Subrogation.

D. Deductible Requirement

Dental Care Benefits are payable for charges incurred in the calendar year after satisfaction of the Deductible Requirement except Diagnostic and Preventive Covered Charges shall not be subject to the Deductible Requirement. Reimbursement of Covered Charges shall be payable as shown in the Summary of Benefits.

The Deductible Requirement per person per calendar year is shown in the Summary of Benefits.

E. Family Limit on Deductible

The maximum family deductible is shown in the Summary of Benefits.

VII. DENTAL COVERED CHARGES

A. Dental Payment Conditions

If you or one of your Dependents receive any Treatment or Service that is listed in the Schedule of Dental Procedures, We will pay Dental benefits for Covered Charges:

- in excess of the deductible amount(s); and
- at the payment percentage(s) indicated; and
- to the Maximum Allowances (indicated in the Schedule of Dental Procedures) and Maximum Payment Limits;

as described in the Dental Summary of Benefits section.

B. Deferred Coverage Limits

(for requests (1) more than 31 days after the date eligible; or after (2) the date you elect to terminate coverage)

If you request coverage for you or your Dependent more than 31 days after the date of eligibility, or you elect to terminate coverage and more than 31 days later request to be covered again, during the first 12 months in which coverage is in force, benefits will be limited as follows:

- During the first six months, benefits will be payable only for Dental Care Unit 1 (Preventive Procedures) Covered Charges.
- During the second six months, benefits will be payable only for Dental Care Unit 1 (Preventive Procedures) Covered Charges and Dental Care Unit 2 (Basic Procedures) Covered Charges.

After coverage has been in force for 12 consecutive months, benefits will be payable for charges incurred for Covered Charges under Dental Care Units 1, 2 and 3.

C. Covered Charges

Covered Charges will be the actual cost charged to you or your Dependent for Treatment or Service, but not more than the Maximum Allowances shown in the Schedule of Dental Procedures. Also:

- If We determine that more than one procedure could be performed to correct a dental condition, Covered Charges will be limited to the Maximum Allowance for the least expensive of the procedures that would provide professionally acceptable results.
- Covered Charges will include only those charges for Treatment or Service that begins (see below) while you and your Dependents are covered under this plan.

- Covered Charges will include only those charges for Treatment or Service that is completed while you and your Dependents are covered under the plan (except when the Treatment or Service is covered under the Extended Benefits provision).

D. Beginning Date for Treatment or Service

Treatment or Service will be considered to begin:

- for root canal therapy, on the date the pulp chamber is opened and the pulp canal explored to the apex; and

- for crowns, fixed bridgework, inlays, or onlay restoration, on the date the tooth or teeth are fully prepared; and

- for full or partial dentures, on the date the master impression is made; and

- for all other, on the date the Treatment or Service is performed.

E. Completion Date for Treatment or Service

Treatment or Service will be considered to be completed:

- for crowns, on the date the crown is seated; and

- for fixed bridgework, on the date the bridge is seated; and

- for inlay or onlay restorations, on the date the inlay or onlay is seated; and

- for complete or partial dentures, on the date the complete or partial denture is seated.

VIII. SCHEDULE OF DENTAL PROCEDURES

Unless We agree otherwise, Covered Charges will include only charges for procedures listed in the Schedule of Dental Procedures. If a non-listed procedure is accepted, We will determine its Maximum Allowance based on the Maximum Allowance for a listed procedure of comparable nature.

A. Dental Care Unit 1 - Diagnostic and Preventive Procedures

The Maximum Allowance for each procedure described below will be the actual amount charged to you or your Dependent for Necessary Dental Care, but only to the extent that actual charges do not exceed Prevailing Charges.

Dental Procedure

1. Examinations

Oral Examination (evaluation)
Periodic Examination (evaluation)

Only one of the listed examinations will be covered in any six consecutive months.

2. Emergency Examination

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

3. Radiographs

Full Mouth Survey

Complete series (including bitewings)
Panoramic

Only one of the listed full mouth surveys will be covered in any 36 consecutive months.

Bitewing

For Dependent children under age 18, only one set will be covered in any six consecutive months.

For adults 18 years of age or older, only one set will be covered in any 12 consecutive months.

Occlusal
Periapical

Extraoral X-Rays

Sialography
TMJ
Cephalometric film
Posterior-anterior or lateral skull and facial bone survey
Other extraoral

Only one of the listed extraoral procedures will be covered in any six consecutive months.

Diagnostic x-rays performed in conjunction with root canal therapy or orthodontic treatment will not be considered Unit 1 Covered Charges.

4. Preventive Services

Prophylaxis (cleaning of teeth)

Covered once in any six consecutive months.

Topical application of fluoride

Applicable only to Dependent children under age 16. Only one application will be covered in any six consecutive months.

Space maintainers

Applicable only to Dependent children under age 16.

Topical application of sealants

Applicable only to first and second permanent molars for Dependent children under age 16. Covered once each tooth in any 24 consecutive months.

5. Other Services

Biopsy of oral tissue
Palliative treatment

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Histopathologic examination

B. Dental Care Unit 2 - Basic Procedures

The Maximum Allowance for each procedure described below will be the actual amount charged to you or your Dependent for Necessary Dental Care, but only to the extent that actual charges do not exceed Prevailing Charges.

Dental Procedure

1. Restorations

Fillings (Amalgam, silicate, plastic, or composite, including pin retention when necessary).

Multiple restorations on one surface will be paid as a single filling. Replacement of existing fillings are covered only if at least 24 consecutive months have passed since placement of prior filling, unless required by new decay in an additional tooth surface. Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations.

Stainless steel crown

2. Oral Surgery

Extraction of teeth
Alveoloplasty
Removal of dental cysts and tumors
Surgical incision and drainage of dental abscess

3. Other surgical procedures

Tooth reimplantation
Surgical exposure to aid eruption
Surgical repositioning of teeth
Excision of hyperplastic tissue

4. Periodontic Services

Scaling and root planing (each quadrant)

Covered once each quadrant in any 24 consecutive months.

Periodontal appliance

One appliance is covered in any 36 consecutive months.

Periodontal prophylaxis (including probing, charting, exam, polishing, scaling, root planing and similar maintenance procedures).

Covered only if at least three months have elapsed after completion of active therapeutic scaling and root planing or active surgical periodontal treatment and then not more than once in three consecutive months.

5. Periodontal Surgical Procedures

Gingival flap procedure
Gingivectomy
Gingival curettage
Osseous surgery
Pedicle soft tissue graft
Free soft tissue graft
Osseous Graft

Only one of the listed periodontic surgical procedures is covered for each quadrant in any 24 consecutive months.

6. Endodontic Services

Vital Pulpotomy (for deciduous teeth only)
Root canal therapy including treatment plan, diagnostic x-rays, clinical procedures, and follow-up care.
Apexification
Apicoectomy
Retrograde filling
Root resection
Hemisection

7. Anesthesia

General anesthesia
IV Sedation

General anesthesia or IV Sedation is covered as a separate procedure only when required for complex oral surgical procedures covered under this plan (and only when performed in a dental office).

8. Other Services

Repairs to bridges and complete or partial dentures
Adding tooth to partial denture
Relining or rebasing complete or partial denture (upper or lower)

Covered only if relining or rebasing is done more than 12 months after the initial insertion and then not more than once in any 24 consecutive months.

Tissue Conditioning

Covered only if at least 12 months have elapsed since the insertion of a complete or partial denture and not more than once in any 24 consecutive months.

Denture Adjustment

Covered once in any 12 consecutive months and only if at least 12 months have elapsed since the insertion of the denture.

Recementing

Inlay
Onlay
Crown
Bridge
Space maintainer

Consultation with specialist
Antibiotic drug injection
Pulp vitality test

C. Dental Care Unit 3 - Major Procedures

The Maximum Allowance for each procedure described below will be the actual amount charged to you or your Dependent for Necessary Dental Care, but only to the extent that actual charges do not exceed Prevailing Charges. All procedures listed include one year follow-up care.

Dental Procedure

1. Restorations

Inlays and onlays

Inlays and onlays are covered only if the tooth cannot be restored by a filling and (for replacements) at least five years (60 consecutive months) have elapsed since the last placement.

Labial Veneers

Veneer restorations are covered only if tooth cannot be restored by a filling and (for replacements) at least five years (60 consecutive months) have elapsed since the last placement.

Crowns (single restorations only)

Resin (laboratory)
Resin, prefabricated
Resin with nonprecious metal
Resin with semiprecious metal
Resin with gold
Porcelain
Porcelain with nonprecious metal
Porcelain with semiprecious metal
Porcelain with gold
Gold (3/4 cast)
Gold (full cast)
Nonprecious metal (full cast)
Semiprecious metal (full cast)

Crowns are covered only if the tooth cannot be restored by a filling and (for replacements) at least five years (60 consecutive months) have elapsed since the last placement. Crowns for the primary purpose of periodontal splinting, altering or maintaining vertical dimension, or restoring occlusion are not covered.

Crowns for the replacement of veneer, inlay or onlay are covered only if at least five years (60 consecutive months) have elapsed since the last placement of the restoration. Crowning of implant replacing a tooth missing prior to the effective date is not covered. For persons under 16 years of age, the benefit for crowns on vital teeth is limited to resin or stainless steel crowns.

Cast post and core

Covered only for teeth that have had root canal therapy.

Steel post and composite or amalgam

Covered only for teeth that have had root canal therapy.

2. Prosthodontics, Fixed

Fixed Bridges - initial placement or replacement

Initial placement of fixed bridges to replace teeth which were missing prior to the effective date of the person's coverage will not be covered unless it includes the replacement of a Functioning Natural Tooth extracted while the person is covered under this plan (provided that tooth was not an abutment to an existing partial denture that is less than five years old). In that event, benefits are payable only for the replacement of those teeth which were extracted while covered under the plan.

Replacement of an existing fixed bridge is covered only if the existing bridge is more than five years old (60 consecutive months), and is not serviceable, and cannot be repaired.

3. Prosthodontics, Removable

Complete or partial dentures - initial placement or replacement

Initial placement of complete or partial dentures to replace teeth which were missing prior to the effective date of the person's coverage will not be covered unless it includes the replacement of a Functioning Natural Tooth extracted while covered under this plan.

Replacement of an existing complete or partial denture is covered only if the existing denture is more than five years old (60 consecutive months), and is not serviceable and cannot be repaired.

Covered Charges for complete or partial dentures do not include any additional charges for overdentures or for precision or semi-precision attachments.

4. Temporomandibular Joint Disorders (TMJ)

Treatment, service, or material for TMJ disorder which is not specifically excluded.

IX. LIMITATIONS OF DENTAL BENEFITS

Dental benefits will not be paid for:

a. Treatment or Service that is not for Necessary Dental Care;

b. any part of a charge for Treatment or Service that exceeds Prevailing Charges;

c. the services of any person who is not a Dentist or Dental Hygienist;

d. any charge related to Treatment or Service at a Hospital (except Treatment or Service for Necessary Dental Care eligible under Temporomandibular Joint Disorders (TMJ);

e. the services of any person in your Immediate Family or any person in your Dependent's Immediate Family;

f. personalization of dentures or crowns and any other Treatment or Service that is primarily cosmetic;

g. Treatment or Service that does not meet professionally recognized standards of quality or that is an Experimental or Investigational Measure;

h. implants;

i. Treatment or Service for bone grafts performed in an extraction site;

j. drugs and medicines (except for antibiotic injections);

k. bite registration or occlusal analysis;

l. instruction for plaque control, oral hygiene, or diet;

m. Treatment or Service to alter or maintain vertical dimension or restore or maintain occlusion;

n. Treatment or Service for provisional or permanent splinting;

o. Treatment or Service for the purpose of duplicating or replacing a lost or stolen prosthetic device or appliance;

p. Treatment or Service that is temporary;

q. Treatment or Service excluded under the section Deferred Coverage Limits, or

r. Treatment or Service due to orthodontics;

s. Treatment or Service covered under the Comprehensive Medical Benefits Plan;

t. Treatment or Service provided outside the United States unless the Covered Person is outside the United States for one of the following reasons:

- travel, provided the travel is for a reason other than securing medical or dental care diagnosis or treatment;
- a business assignment by a covered Member (Employer);
- the Employee is employed by a covered Member (Employer) and working outside the United States; or
- Full-Time Student status, provided the dependent is either:
  - enrolled and attending an accredited school in a foreign country; or
  - is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit;

u. charges for which the Covered Person is not legally obligated to pay or which are for medical or dental care furnished without charge, paid for or reimbursable by or through the government of a nation, state, province, county, municipality, or other political subdivision, or any instrumentality or agency of such a government;

v. Treatment or Service rendered in a hospital owned or operated by the United States Government, either by the hospital or a physician/dentist employed by it (a) unless the treatment is of an emergency nature, and (b) unless the Covered Person is not entitled to such treatment by reason of his status as a veteran or otherwise;

w. Treatment or Service for an injury or sickness which results from war, act of war, or voluntary participation in criminal activities while a Covered Person;

x. Treatment or Service for an injury or sickness which arise out of or in the course of employment, and which either entitles the Covered Person to benefits under a Worker's Compensation Act or similar legislation, or would have entitled him to benefits if coverage under such a statute could have been in force on a voluntary or elective basis;

y. Treatment or Service provided by any person, hospital, or entity whose charges for medical/dental care, depend on the patients' financial ability to pay or availability of coverage;

z. charges which are eligible to be paid by a previous group plan which was replaced by enrollment in the Christian Brothers Employee Benefit Trust; or

aa. Treatment or Service incurred after termination of coverage under this Plan, except as provided by the Plan.

X. DEFERRED DENTAL LIMITATION

If you request coverage for you or your Dependent more than 31 days after the date of eligibility, or you elect to terminate coverage and more than 31 days later request to be covered again, during the first 12 months in which coverage is in force, some dental services will be excluded from coverage during an Exclusion Period..

Exclusion Period and Limited Benefits

- During the first six months, benefits will be payable only for Dental Care Unit 1 (Preventive Procedures) Covered Charges.

- During the second six months, benefits will be payable only for Dental Care Unit 1 (Preventive Procedures) Covered Charges and Dental Care Unit 2 (Basic Procedures) Covered Charges.

After coverage has been in force for 12 consecutive months, benefits will be payable for charges incurred for Covered Charges under Dental Care Units 1, 2 and 3.

Exemption for Certain Dependent Children. The Deferred Dental Limitation described will not apply to any Dependent child:

- who is the Member's newborn child, or a child newly adopted by the Member (or Placed for Adoption with the Member) prior to the child's attainment of age 18; and

- whose coverage becomes effective under the Plan within the 31-day period immediately following the date of birth, adoption, or Placement for Adoption.

If a Dependent child becomes covered under the Plan other than as described above, that child will also be exempt from the Deferred Dental Limitation if:

- the child was covered under another Creditable Coverage as of the last day of the 31-day period beginning with the child's date of birth, adoption or Placement for Adoption (provided the adoption or Placement occurred prior to the child's attainment of age 18); and

- the child has subsequently maintained continuous Creditable Coverage, with no gap in coverage exceeding 63 days.

If any such child's coverage under the Plan terminates and the child later becomes covered again under the Plan, the exemption will continue to apply to the child unless there has been a period of at least 63 days during all of which the child was not covered under any Creditable Coverage.

For the purpose of these provisions, a Waiting Period or HMO Affiliation Period will not be considered a break in Creditable Coverage.

Credit for Previous Creditable Coverage

The Deferred Dental Limitation will be reduced by days of continuous Creditable Coverage, if any, applicable to the individual as of the effective date of his or her coverage under the group plan.

In determining days of continuous Creditable Coverage, any period of Creditable Coverage which occurs before a significant break in coverage will not be counted. For this purpose, "significant break in coverage" means a period of 63 days during all of which a person is not covered under any Creditable Coverage. However, a Waiting Period or an HMO Affiliation Period will not be considered a break in coverage.

With respect to an individual becoming covered under the group plan, a period of Creditable Coverage will not be considered continuous if, after such period and before the effective date of the individual's coverage, there was a 63-day period during all of which the individual was not covered under any Creditable Coverage.

XI. EXTENSION OF DENTAL BENEFITS AFTER TERMINATION OF COVERAGE

If Dental Expense Coverage under your plan ceases and if you or your Dependents qualify, the Plan will pay for:

- root canal therapy, but only if the pulp chamber was opened and the pulp canal explored to the apex while you or a Dependent were covered under this plan; and

- crowns, bridges, inlays, or onlay restorations, but only if the tooth or teeth were fully prepared while you or a Dependent were covered under this plan; and

- complete or partial dentures, but only if the master impression was made while you or a Dependent were covered under this plan; and

provided the Treatment or Service is received within 60 days after your or a Dependent's coverage terminates.

You or a Dependent will qualify if:

- you or a Dependent would have qualified for benefit payment under this plan had coverage remained in force; and

- the Treatment or Service began while you or a Dependent were covered under this plan; and

- this plan is in force at the time Treatment or Service is received.

However, no extended benefits will be paid for Treatment or Service received on or after the date you or your Dependents become eligible for other group dental expense coverage.

XII. CLAIM PROCEDURES

Claim Forms

Special claim forms are not required to file a claim with Us. Standard industry computerized forms may be used by your providers to submit a claim. When you become covered, you will be issued an identification card. This card should be presented to each provider at the time you or a Dependent receives needed medical care.

Prompt Filing

Completed claims, and other information needed to prove loss, should be filed promptly. Written proof of loss should be sent to Us within 90 calendar days.

All Claims Must Be Received By Us Within One Year From The Date Of Loss To Be Eligible For Benefit Consideration.

Proof of loss sent later will be accepted only if there is reasonable cause for the delay and if the claim is received no later than two years after date of loss.

For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when we receive proof of loss. Proof of loss includes the patient's name, your name (if different from the patient's name) and identification number, provider of services, dates of services, diagnosis, description of Treatment or Service provided and extent of loss. We may request additional information to substantiate your loss or require a signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim.

Payment, Denial, and Review

We will process your claim as quickly as possible after We have received all the required information. In actual practice, claims may be processed and paid within a few days after We receive completed proof of loss. If a claim cannot be paid, We will promptly explain why.

If a claim cannot be processed due to incomplete information, We will either deny the claim or send a written explanation requesting additional information. If additional information is requested and it is not received at the end of 30 calendar days, a decision will be made without it

Initial appeal: If your claim has been denied in whole or in part, you may request an appeal of the denial. Your appeal must be in writing and must state the reason or reasons why you believe the original decision was incorrect. Such appeal must be received by us within 60 days after your receipt of the notice of denial or at least 60 days from the end of the processing period, if you've heard nothing by that time. Besides having the right to appeal, you or your authorized representative may examine any plan documents related to your claim.

We will make a full and fair review of the claim and notify you in writing of the appeal decision within 60 calendar days of receiving it.

Plan Committee appeal: If the initial appeal was denied in whole or in part, you may appeal that decision to the Plan Committee. Your appeal must be in writing and must be received within 60 days after your receipt of the notice of denial. You may submit written comments, documents, records, and other information relating to the claim. The Plan Committee will make a determination within 60 calendar days unless the appeal cannot be processed due to incomplete information. If more information is needed, the Plan Committee will send a written request for the additional information. Failure to receive the additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request.

Dental Examinations

We may have the person whose loss is the basis for dental claim examined by a Dentist. We will pay for these examinations and will choose the Dentist to perform them.

Release of Dental or Medical Information

As a condition of receiving benefits under this Plan, you and your Dependents authorize:

- any provider to disclose to Us any dental or medical information We request.

- Us to examine your dental or medical records at the office of any provider.

- Us to release to or obtain from any person or organization any information necessary to administer your benefits.

- Us to examine your employment records in order to verify your eligibility.

XIII. COORDINATION WITH OTHER BENEFITS -- DENTAL

Intent

The intent of Coordination with Other Benefits is to provide that the sum of benefits paid under This Plan plus benefits paid under all other Plans will not exceed the actual cost charged for a Treatment or Service.

A. Definitions

As used in this section, the term "This Plan" will mean the medical, dental, and vision expense benefits described in this booklet.

The term "Plan" will mean This Plan and any medical or dental expense benefits provided under:

- any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or employee benefit or other association; and

- any program required or established by state or Federal law, including Medicare Parts A and B (see Medicare rules below); and

- any program sponsored by or arranged through a school or other educational agency; and

- the first-party medical expense provisions of any automobile policy issued under a no-fault insurance statute including the self-insured equivalent of any minimum benefits required by law;

the term Plan will not include benefits provided under a student accident policy, nor will the term Plan include benefits provided under a state medical assistance program where eligibility is based on financial need.

Also, the term Plan will apply separately to those parts of any program that contain provisions for coordination of benefits with other Plans and separately to those parts of any program which do not contain such provisions.

The term Allowable Expense will mean all Prevailing Charges for Treatment or Service when at least a part of those charges are covered under at least one of the Plans then in force for the person for whom benefits are claimed. If a Plan provides benefits in a form other than cash payments, the cash value of those benefits will be both an Allowable Expense and a benefit paid.

The term Claim Determination Period will mean the part of a calendar year during which you or a Dependent(s) would receive benefit payments under This Plan if this section were not in force.

B. Effect on Benefits

Benefits otherwise payable under This Plan for Allowable Expenses during a Claim Determination Period may be reduced if:

- benefits are payable under any other Plan for the same Allowable Expenses; and

- the rules listed below provide that benefits payable under the other Plan are to be determined before the benefits payable under This Plan.

The reduction will be the amount needed to provide that the sum of payments under This Plan plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses. Each benefit that would be payable in the absence of this section will be reduced proportionately; such reduced amount will be charged against any applicable benefit limit of This Plan.

C. Order of Benefit Determination

Except as described under Medicare Exception below, the benefits payable of a Plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

- Nondependent/Dependent. The benefits of a Plan which covers the person for whom benefits are claimed as an Employee, Member, or subscriber (that is, other than as a Dependent) are determined before the benefits of a Plan which covers the person as a Dependent.

- Dependent Child--Parents Not Separated or Divorced. When This Plan and another Plan cover the same child as a Dependent of different persons called "parents," the benefits of the Plan of the parent whose birthday falls earlier in a calendar year are determined before those of the Plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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  However, if another Plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- Dependent Child--Separated or Divorced Parents. If two or more Plans cover a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

  - first, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child; and
  - finally, the Plan of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first.

- Joint Custody. If the specific terms of a 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 for Dependent children of parents who are not separated or divorced.

- Active/Inactive Employee. The benefits of a Plan which covers a person as an Employee who is neither laid off nor retired, or as that Employee's Dependent, are determined before the benefits of a Plan which covers that person as a laid-off or retired Employee or as that Employee's Dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an Employee, Member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

- Automatic Coverage for a Newborn Child. When This Plan and another Plan both provide benefits, the benefits of the other Plan will be determined before the benefits payable under the Automatic Coverage for a Newborn Child provision of This Plan.

- Continuation/Extension of Benefits. When This Plan and another Plan both provide benefits, the benefits of the plan covering the person as an employee, member or subscriber, or as that person's dependent, will be determined before the benefits payable under This Plan's Extension of Benefits.

D. Medicare Rules

(There are limited instances where these rules apply to a full time employee, such as, but not limited to, Chronic Renal Failure.)

Medicare rules apply to any Covered Person under Part A and Part B of Title XVIII of the Social Security Act, as amended (Medicare).

For all Covered Persons, benefits payable under Medicare will normally be determined before the benefit payable under This Plan. It is important for a Covered Person to be enrolled for both Medicare A and B coverages. If not enrolled for both, the Covered Person will not have complete coverage for eligible charges. Please refer to the Integration With Medicare provision.

E. Medicare Exception

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under This Plan.

Federal law will usually apply in such instances if:

- the benefits are applicable to an active Covered Employee (rather than a Retiree) or to that Covered Employee's spouse; or

- the Covered Employee's Member (Employer) has 20 or more employees.

F. Integration With Medicare

(For all Covered Persons where permitted by Law)

The payments under This Plan are reduced by the benefits available under Medicare.

Note: Any balance owed to a provider after Medicare payment may not be paid by the Plan unless your Out-of-Pocket Expense Maximum has been reached for the year.

It works this way:

- In determining a claim payment under This Plan, the first step is to calculate the amount that would be paid if the person had no Medicare coverage. The Covered Charges under This Plan will be limited to the amounts approved by Medicare or no more than the limiting charges as determined by Medicare.

- The above amount is reduced by the Medicare benefits for the expenses upon which the claim under This Plan is based. In determining the Medicare benefits, the person will be assumed to have full Medicare coverage (that is, both Part A and Part B) whether or not the person has enrolled for the full coverage.

- If a provider has chosen not to apply to Medicare to become a participating provider, This Plan will estimate Medicare benefits as if application has been made and was approved. Any benefit payable by the Plan will then be calculated as if Medicare had been paid.

If Medicare benefits are paid for expenses not covered under This Plan, they will not be used to reduce our benefits. In the case of services and supplies for which Medicare makes direct reimbursement to the provider, the amount of expenses and Medicare benefits will be determined on the basis of the prevailing charges for the services and supplies.

G. Coordination with HMOs

If a Covered Dependent is covered under an HMO and the HMO should provide benefits before This Plan, the Dependent is required to access benefits available under the HMO.

If the Covered Dependent does not access benefits available under the HMO, This Plan will only consider 50% of This Plan's Covered Charges applicable to such Covered Dependent.

H. Coordination with Excess Only or Secondary Only Plans

If a Covered Person is covered by another plan containing a provision, either:

- excess only of other available benefits; or

- secondary only of other available benefits;

This Plan will coordinate to consider benefits payable on a 50%/50% basis, This Plan and the other plan.

I. Secondary Coverage Under Automatic Coverage for Newborn Child Provision

Benefits available for a newborn child under any other medical plan for which you or your Dependents are eligible, will be determined before benefits under the Automatic Coverage for a Newborn Child provision of This Plan.

J. Exchange of Information

Any person who claims benefits under This Plan must, upon request, provide all information We believe is needed to coordinate benefits.

In addition, all information We believe is needed to coordinate benefits may be exchanged with other companies, organizations or persons.

K. Facility of Payment

We may reimburse any other plan if:

- benefits were paid by that other plan; but
- should have been paid under This Plan in accordance with this section.

In such instances, the reimbursement amounts will be considered benefits paid under This Plan and, to the extent of those amounts, will discharge Us from liability.

L. Right of Recovery

If it is determined that benefits paid under This Plan should have been paid by any other plan, We will have the right to recover those payments from:

- the person to or for whom the benefits were paid; and/or
- the other companies or organizations liable for the benefit payments.

M. Transfer of Rights

(Applicable in California)

1 Applicability

Where allowed by law, this section will apply to Covered Persons who:

- receive benefit payment under This Plan as the result of a sickness or injury; and
- have a lawful claim against another party or parties for compensation, damages, or other payment because of that same sickness or injury; and
- recover payment from such party or parties which includes an amount (or part of an amount) previously paid under This Plan for the Treatment or Service.

2. Transfer of Rights

In those instances where this section applies, the rights of the Covered Person to claim or receive compensation, damages, or other payment from the other party or parties will be transferred to the Trust, but only to the extent of benefit payments made under This Plan.

N. Covered Person Obligations

To secure the rights of the Trust under this section, a Covered Person must:

- complete any claim applications or other instruments the Trust might reasonably require; and
- if payment from the other party or parties has been received, reimburse the Trust for benefit payment made under This Plan (but not more than the amount paid by the other party or parties).

XIV. REIMBURSEMENT/SUBROGATION - DENTAL

If the Plan provides any benefits in connection with a Claim by a Covered Person, the Covered Person shall reimburse the Plan, to the extent of all amounts that the Plan has paid, out of any amounts that the Covered Person recovers from any source other than the Plan in connection with the Claim. The Covered Person's recovery from a source other than the Plan shall not be reduced by the amount of the Covered Person's attorney fees or for any other reason whatsoever, until the Plan has been repaid in full.

In addition, the Plan shall be subrogated to any legal rights which the Covered Person may have to recover against any party in connection with the Claim.

This reimbursement/subrogation provision applies to recoveries available to minor children from sources other than the Plan.

By accepting benefits hereunder, the Covered Person hereby grants a lien and assigns to the Plan an amount equal to the benefits paid against any recovery made by or on behalf of the Covered Person. The assignment is binding on any attorney who represents the Covered Person whether or not an agent of the Covered Person and on any insurance company or other financially responsible party against whom a Covered Person may have a claim provided said attorney, insurance carriers or others have been notified by the Plan or its agents.

The Covered Person shall timely notify the Plan of any litigation, settlement discussions, or other efforts to recover amounts from sources other than the Plan in connection with the Claim. A Covered Person shall obtain approval from the Plan before releasing any rights to recover medical expenses from sources other than the Plan.

If the Plan establishes that a Covered Person, personally or through the acts of an agent or attorney, breaches obligations under this provision, the Plan shall be entitled to pursue and recover to all available remedies together with any and all costs, including reasonable attorney fees, that the Plan may incur in establishing the breach and in obtaining remedies for the breach.

Covered Persons shall comply with all of the requirements within this reimbursement/subrogation provision in order to continue receiving benefits under the Plan.

XV. DEFINITIONS

Several words and phrases used to describe your plan are capitalized whenever they are used in this booklet. These words and phrases have special meanings as explained in this section.

Calendar Year means the calendar year January 1, up to and including the following December 31.

Covered Person means a Covered Employee, Covered Dependent, or Covered Retiree.

Creditable Coverage means, with respect to an individual, coverage of the individual under any of the following:

- Another group health plan;
- Health Insurance Coverage, as defined in this section;
- Medicare (Part A or Part B of Title XVIII of the Social Security Act);
- Medicaid (Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928);
- TRICARE (Chapter 55 of Title 10, United States Code);
- A medical care program of the Indian Health Service or of a tribal organization;
- A state health benefits risk pool;
- A health benefit plan for government employees (Chapter 89 of Title 5, United States Code);
- A public health plan established or maintained by a State, the United States, a foreign country, or any political subdivision thereof;
- A health benefit plan provided under the Peace Corps Act;
- Any other similar coverage permitted under state or federal law or regulations;
- A health benefit plan provided under a State Children's Health Insurance Program (Title XXI of the Social Security Act).

Creditable Coverage does not include coverage consisting solely of coverage of Excepted Benefits.

Dental Hygienist means a person who works under the supervision of a Dentist and is licensed to practice dental hygiene.

Dental Treatment Plan means the Dentist's report of proposed treatment which:

- is written on a form provided by Us; and
- lists the procedures required for the Period of Dental Treatment; and
- shows the charges for each procedure; and
- is accompanied by any diagnostic materials that We might require.

Dentist means:

- a person licensed to practice dentistry; and
- a licensed Physician who provides dental Treatment or Service.

Dependent means:

- your spouse, if not in the Armed Forces, and not eligible as an Employee; and
- your unmarried natural or legally adopted child less than 26 years of age, if not in the Armed Forces and not eligible as an Employee under this Plan, who is chiefly dependent upon you for support; and
- your unmarried stepchild or any child for whom you have legal guardianship, living with you, if they meet all the requirements above and we approve in writing.

To be eligible as a Dependent, the Dependent's principal residence must be in the U.S.

Dependent will include any child covered under a Qualified Medical Child Support Order (QMCSO) or national Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to this plan, provided the child meets this plan’s definition of a Dependent.

Employee means an employee of a Participating Member (Employer):

- whose work week meets the minimum requirements as determined by the Member (Employer). In no event can an employee be eligible for the Plan who works less than 20 hours in a normal work week.
- For a teacher, Employee means a teacher who meets the requirements as determined by the Member (Employer). In no event can a teacher be eligible for the Plan who teaches less than ½ of a normal work load.
- Employee may include members of religious orders and secular priests.
- Employee does not include independent contractors, volunteers, etc., whose income from the Member (Employer) is not subject to Federal Withholding for wages or FICA.

Employer refer to **Member (Employer)**.

Enrollment Date means the first day of coverage under this Plan or, if earlier, the first day of any Waiting Period.

Excepted Benefits means benefits or coverage under one or more (or any combination thereof) of the following:

- Coverage only for accident (including accidental death and dismemberment);
- Disability income insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Coverage issued as a supplement to liability insurance;
- Workers' Compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance (for example, mortgage insurance);
- Coverage for on-site medical clinics;
- Other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits;
- The following benefits if offered separately from medical expense benefits (provided under a separate policy, certificate, or contract of insurance, or otherwise not an integral part of the plan);
    - limited scope dental or vision benefits;
    - benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
    - other similar limited benefits;
- The following benefits if offered as independent, non-coordinated benefits:
    - coverage only for a specified disease or illness;
    - hospital indemnity or other fixed indemnity insurance;
- The following benefits if offered as a separate insurance policy:
    - Medicare Supplement Insurance;

- coverage supplemental to TRICARE;

- similar supplemental coverage provided to coverage under a Group Health Plan;

- Health flexible spending arrangement, if the following are satisfied
:

  - the maximum benefit from employee and employer contributions for the year does not exceed two times the employee's annual salary reduction;

  - the employee has other group health coverage available that is not limited to Excepted Benefits.

Experimental or Investigational Measures mean any Treatment or Service, regardless of any claimed therapeutic value not generally accepted by specialists in that particular field of medicine or dentistry, as determined by Us.

Functioning Natural Tooth means a Natural Tooth which is performing its normal role in the chewing process in the covered person's upper or lower arch and which is opposed in the person's other arch by another Natural Tooth or prosthetic (i.e. artificial) replacement.

Health Insurance Coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health Insurance Coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

Hospital means an institution that is:

- operated according to the laws pertaining to hospitals; and

- primarily and continuously engaged in providing inpatient care and treatment through medical, diagnostic, and major surgical facilities, either on its premises or in facilities available to the hospital on a prearranged basis, under the supervision of a staff of doctors and with a 24-hour nursing service; and

- licensed as a hospital by the proper authority of the state in which it is located (if licensing is required by that state);

but not including any institution, or part thereof, that is used primarily as a clinic, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

Immediate Family means an Employee's or Dependent's husband or wife, natural or adoptive parent, child or sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or spouse of grandparent or grandchild.

Member (Employer) means any corporation, establishment, or institution that has fulfilled participation requirements of the Trust and which:

- is operated under the auspices of the Roman Catholic Church, in good standing thereof, and is currently listed, or approved for listing in The Official Catholic Directory, published by P.J. Kenedy & Sons; and

- is exempt from taxation under section 501(c) (3) of the Internal Revenue Code of 1986, as amended; and

- is organized as a not-for-profit corporation, if the organization is a corporation.

Natural Tooth means any tooth or part of a tooth that is organic and formed by the natural development of the body (i.e. not manufactured).

Necessary Dental Care means any treatment, service, or materials prescribed by a Dentist and considered by Us to be:

- necessary and appropriate; and

- not Experimental or Investigational Measures and not in conflict with accepted dental standards.

Period of Dental Treatment means all sessions of dental care that result from the same initial diagnosis and any related complications.

Physical Handicap means a Dependent child's substantial physical or mental impairment which:

- results from injury, accident, congenital defect, or sickness; and

- is diagnosed by a Physician as a permanent or long term dysfunction or malformation of the body.

Physician means a licensed Doctor of Medicine or Osteopathy.

Plan Administrator means, Christian Brothers Services, the entity retained to perform certain administrative services for the Plan, and who is appointed by the Trustees.

Plan Sponsor means the Trustees of the Christian Brothers Employee Benefit Trust, as elected.

Prevailing Charge means the amount, as determined by Us, that most Dentists or other dental care providers charge for the same or a similar Treatment or Service in the cost area (or a comparable cost area) where the Treatment or Service is provided.

Required Contribution/Contributions means the amount of monies required to make coverage effective. The amount is decided by Us, from time to time.

Spouse means a person of the opposite sex who is the legally married husband or wife of the Employee.

Total Disability (Disability) means your inability, because of sickness or injury, to work at any occupation that reasonably fits your background and training.

Treatment or Service when used in this Plan will be considered to mean 'confinement, treatment, service, substance, material, or device'.

Trust means the funding medium for accumulation of assets and payment of benefits and known as, The Christian Brothers Employee Benefit Trust.

Trustee(s) means the entity elected by the Members (Employers) which has the responsibility for the administration of the Trust and Plan.

We, Us, and Our means The Trustee or Plan Administrator for specific duties which have been delegated to the Administrator by the Trustee.

XVI. PLAN INFORMATION

Plan Name:

Christian Brothers Employee Benefit Trust

Plan Sponsor:

Trustees of Christian Brothers Employee Benefit Trust
c/o Christian Brothers Services
1205 Windham Parkway
Romeoville, IL 60446-1679

Plan Year:

January 1 thru December 31

Plan Administrator:

Christian Brothers Services (appointed by the Trustees)
1205 Windham Parkway
Romeoville, IL 60446-1679

Telephone No. 800-807-0100

EIN No. 36-3884439

Plan Costs:

Dental benefits are paid by the Employee and Member (Employer) as determined by the Member (Employer) at each location.

Agent for Service or Legal Process:

Managing Director, Employee Benefit Services, the Christian Brothers Employee Benefit Trust
1205 Windham Parkway
Romeoville, IL 60446-1679

Legal process may be served on the Plan Administrator or a Trustee

Plan Benefits Provided by:

Dental benefits are provided through the Christian Brothers Employee Benefit Trust.

Plan Eligibility and Benefits:

See the Table of Contents and the Summary of Benefits section of the booklet to locate description of dental benefits and eligibility requirements.

How to File a Claim:

See the table of contents in this section of the booklet to locate "Claim Procedures".

Plan Trustees:

The Plan Administrator will provide the names of the current Trustees upon request.