The Roman Catholic Archdiocese of Atlanta Group Health Care Plan

Plan Document

Group No.: 10974

Originally Effective: January 1, 2005

Amended and Restated Effective: January 1, 2020

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GROUP HEALTH CARE PLAN
ESTABLISHMENT OF THE GROUP HEALTH CARE PLAN

The Roman Catholic Archdiocese of Atlanta previously established The Roman Catholic Archdiocese of Atlanta Group Health Care Plan (hereinafter referred to as the "Health Care Plan"), as set forth herein for the exclusive benefit of its Employees and their eligible Dependents. This Health Care Plan Document combines two separate plans, the Group Medical Plan, and the Group Dental and Vision Plan. The following sections apply to both the Group Medical, and the Group Dental and Vision Plans. The Health Care Plan was originally adopted by the Employer effective as of January 1, 2005. Effective January 29, 2019, the Archdiocese transferred sponsorship of the Plan to RCAA Administrative Services, Inc. (the "Plan Sponsor"), and the Health Care Plan was amended and restated to reflect the change in Plan Sponsor, effective as of February 1, 2019.

The Health Care Plan is hereby amended and restated, effective as of January 1, 2020.

Grandfathered Plan Status
The Roman Catholic Archdiocese of Atlanta and the Plan Sponsor believe this Health Care Plan, and the underlying Medical Plan, is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means your Group Health Care Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime dollar limits on Essential Health Benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status, can be directed to the Plan Administrator at, 2401 Lake Park Drive S.E, Smyrna, GA 30080-8862 or at (404) 920-7486.

Purpose of the Plan
This Group Health Care Plan is written, adopted and operative for the sole and exclusive purpose of providing to the eligible Employees and their eligible Dependents employee welfare benefits as described herein. The Health Care Plan agrees to provide the benefits set forth in The Roman Catholic Archdiocese of Atlanta Group Medical Plan and The Roman Catholic Archdiocese of Atlanta Group Dental and Vision Care Plan to all Covered Persons in accordance with the provisions and conditions of the Health Care Plan. The Health Care Plan is subject to all conditions and provisions set forth in this document and subsequent amendments, which are made a part of this Health Care Plan. The Health Care Plan is a non-electing church plan in accordance with section 4(b)(2) of the Employee Retirement Income Security Act (ERISA). The Group Medical Plan and the Group Dental and Vision Plan are separate plans. The information provided in this section is for the convenience of the participants in these plans.

Adoption of this Group Health Care Plan Document
The Health Care Plan Sponsor, as the settlor of the Health Care Plan, hereby adopts this amended and restated Health Care Plan Document as the written description of the Health Care Plan. This Health Care Plan Document amends and replaces any prior statement of the health care coverage contained in the Health Care Plan or any predecessor to the Health Care Plan.

RCAA Administrative Services, Inc. has caused this RESTATED Health Care Plan to take effect as of 12:01 a.m., local time on January 1, 2020 at Smyrna, Georgia.

ELIGIBILITY AND ENROLLMENT

Employee Eligibility

Priests, Religious and Seminarians:
Priests, Religious and Seminarians who provide services to the Employer will be eligible to enroll for coverage under this Health Care Plan as of the first day of service upon approval of the Archbishop.

Lay Employees
A full time Employee (including Deacons) who works a minimum of 1500 Hours of Service annually will be eligible to enroll for coverage under this Health Care Plan once he/she completes a waiting period of 60 days of full-time employment, from the date such full-time employment begins. The Employee's eligibility date is the next day following completion of the waiting period.

Other Employees such as part-time, temporary, or Seasonal Employees will not be eligible to enroll for coverage under this Health Care Plan.

Part-time Employees working a minimum of 20 Hours of Service per week (but no less than 1000 Hours of Service per year) immediately preceding the date that they become a full-time Employee may be given credit towards satisfaction of the waiting period.

Timely Enrollment
All Priests are automatically enrolled in the Premier Medical Plan on their first day of service, upon approval by the Archbishop, unless they have coverage through another Diocese or order.

Religious and Seminarians are required to complete, sign and return their enrollment form to the Employee Benefits Department within 31 days of their eligibility date.

All eligible Lay Employees must participate in the Health Care Plan and are required to complete all election and enrollment forms and submit them to the Employer within 31 days of their eligibility date. If the eligible Lay Employee fails to submit a completed enrollment form within 31 days of their eligibility date, the Employer will automatically enroll the Employee in the Medical Value Plan and Group Dental and Vision Plan, with Employee Only Coverage.

As part of the enrollment requirements, you will be required to provide your social security number, as well as the social security numbers of your Dependents. The Employer may request this information at any time for continued eligibility under the Health Care Plan. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Health Care Plan.

If you decline enrollment for your Dependents, you must provide a written statement to the Employer indicating that the reason your Dependents are declining enrollment is due to other health coverage. If your Dependent loses such other health coverage, it may constitute a Special Enrollment Event (described below) that gives your Dependents a right to enroll in the Health Care Plan mid-year due to such loss of coverage. However, if your Dependent failed to submit such written statement when initially eligible, your Dependent will lose your right to this special mid-year enrollment opportunity.

Re-hire Provision
If an Employee who was previously covered by this Health Care Plan is re-hired and eligible for benefits within 6 months after termination of employment, coverage will become effective on the date of re-employment and the waiting period will be waived.

If an Employee who was previously covered by this Health Care Plan is re-hired more than 6 months after termination of employment, the Employee will be considered a new Employee and will be subject to all provisions of this Health Care Plan.

Dependent Eligibility
Your Dependents are eligible for participation in this Health Care Plan provided he/she is:

(1) Your Spouse.

(2) Your Child until the end of the month in which he/she attains age 26.

(3) Your Child age 26 or older, who is unable to be self supporting by reason of mental or physical handicap and is incapacitated, provided the child suffered such incapacity prior to the end of the month in which he/she attained age 26. Your Child must be unmarried, primarily dependent upon you for support, and have the same principal residence as the Employee. The Health Care Plan Sponsor may require subsequent proof of your Child's disability and dependency, including a Physician's statement certifying your Child's physical or mental incapacity.

(4) A child for whom you are required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Employer at no cost.

The below terms have the following meanings:

"Spouse" means a person of the opposite sex recognized as the Covered Employee's husband or wife under the laws of the state where you live. Specifically excluded from this definition is a Spouse by reason of common law marriage or a Spouse of the same gender, whether or not permitted in your State. The Employer may require documentation proving a legal marital relationship.

"Child" means your natural born son, daughter, stepson, stepdaughter, legally adopted child (or a child placed with you in anticipation of adoption), or a child for whom you are the Legal Guardian. Coverage for a child for whom you are the Legal Guardian will remain in effect until such child no longer meets the age requirements of an eligible Dependent under the terms of the Health Care Plan, regardless of whether or not such child has attained age 18 (or any other applicable age of emancipation of minors). The term "Child" does not include a child of any "same-sex" or "opposite-sex" domestic partner, or a child of any "same-sex" Spouse.

"Child placed with you in anticipation of adoption" means a child that you intend to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

"Legal Guardian" means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual that is placed with such person by judgment, decree or other order of any court of competent jurisdiction.

To establish an individual's status as an eligible Dependent it is necessary to provide the documentation of the relationship to the Employer. Except as regarding Medicaid or a state Children's Health Insurance Program (CHIP), all documents must be received within 31 days of whichever of the following occurs first: an Employee's eligibility date if the Employee has any eligible Dependents at that time, or the date the Employee acquires an eligible Dependent. For example, to add a natural born son or daughter to the Health Care Plan, acceptable proof would be a copy of the birth certificate. For more information on the acceptable documents, contact the Employer.

The Plan Administrator, in its sole discretion, shall have the right to require documentation necessary to establish an individual's status as an eligible Dependent.

When you and your Spouse are both Covered Employees
When both you and your Spouse are Covered Employees, each of you must be covered as an Employee. You may not be covered under this Health Care Plan as both an Employee and a Dependent. Eligible Dependent children of two Covered Employees may not be enrolled as Dependents of both Employees, whether the Employees are married or unmarried.

Court Ordered Coverage for a Child
Federal law requires the Health Care Plan, under certain circumstances, to provide coverage for your children. The details of these requirements are summarized below.

The Employer shall enroll for immediate coverage under this Health Care Plan any Child of a Covered Employee, who is the subject of a "qualified medical child support order" ("QMCSO"). Coverage under the Health Care Plan will be effective as of the later of the date specified in the order or the date the Employer determines that the order is a QMCSO. Any required contribution for coverage pursuant to this section will be deducted from your pay in accordance with the Employer's payroll schedule and policies.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your child and includes certain information concerning such coverage. The Employer will determine whether any child support order it receives constitutes a QMCSO. Except for QMCSO's, no child is eligible for Health Care Plan coverage, even if you are required to provide coverage for that child under the terms of a separation agreement or court order, unless the child is an eligible Child under this Health Care Plan. Procedures for determining a QMCSO may be obtained, free of charge, by contacting the Employer.

Annual Enrollment Period
You may enroll your Dependents for coverage during the Health Care Plan's annual enrollment period, designated by the Health Care Plan Sponsor and communicated to you prior to such enrollment period. During this time you will be permitted to make changes to any existing benefit elections. Benefit elections made during the annual enrollment period will be effective as of January 1st and will remain in effect until the next annual enrollment period unless you or your Dependent experiences a Special Enrollment Event. A Covered Employee who fails to make an election during annual enrollment will automatically retain their present coverage.

Late Enrollment
If you did not enroll your Dependents during the original 31-day eligibility period you may do so by making written application to the Employer during the annual enrollment period (refer to annual enrollment period section above). In these circumstances, your eligible Dependents will be considered Late Enrollees.

Special Enrollment Event
A special enrollment event occurs when your Dependents suffer a loss of other health care coverage, when they become eligible for a state premium assistance subsidy or you acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption. In these circumstances, your eligible Dependents will be considered Special Enrollees and will be eligible for coverage under the Health Care Plan, subject to your timely notification of the Employer of the special enrollment date (generally, 31 days, except as specifically provided below).

Each special enrollment event is more fully described below:

(1) **Loss of Other Coverage (other than under Medicaid or SCHIP).** If you declined enrollment for your Dependents (including your Spouse) because your Dependents had other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution, a medical care program of the Indian Health Service or of a tribal organization), you may enroll your Dependents for coverage under this Health Care Plan if the other health coverage is lost as a result of one of the following; provided, however, you submitted a written statement to the Employer when your Dependents were initially eligible stating that other health coverage was the reason for declining enrollment under this Health Care Plan:

   (a) The other health coverage was under COBRA and the maximum continuation period available under COBRA has been exhausted;

   (b) Loss of eligibility under the other health coverage for reasons other than non-payment of the required contribution or premium, making a fraudulent claim or intentional misrepresentation of a material fact in connection with the other plan; or

(c) Employer contributions cease for the other health coverage.

If your Dependents are already enrolled in a benefit option available under the Health Care Plan and your Dependent lost his or her other health coverage, that Dependent will be enrolled in the same benefit option as your other Dependents under the Health Care Plan due to the special enrollment event of your Dependent.

You must submit the appropriate election and enrollment forms to the Employer within 31 days after the date the other health coverage was lost. Coverage under the Health Care Plan will become effective on the day following loss of coverage. Failure to enroll in the Health Care Plan within this 31-day period will result in no coverage under the Health Care Plan.

(2) **Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy.** If your Dependents did not enroll in the Health Care Plan when initially eligible because your Dependents were covered under Medicaid or a State sponsored Children's Health Insurance Program (SCHIP) and coverage terminates because your Dependents are no longer eligible for Medicaid or SCHIP or your Dependents become eligible for a State premium assistance subsidy under Medicaid or SCHIP, you may enroll for coverage under this Health Care Plan for your Dependents after Medicaid or SCHIP coverage terminates or after your Dependents' eligibility for a State assistance subsidy under Medicaid or SCHIP is determined.

You must submit the appropriate election and enrollment forms to the Employer within 60 days after coverage under Medicaid or SCHIP terminates or within 60 days after eligibility for a State premium assistance subsidy under Medicaid or SCHIP is determined. Coverage under the Health Care Plan will become effective on the day following loss of coverage. Failure to enroll in the Health Care Plan within this 31-day period will result in no coverage under the Health Care Plan.

(3) **Acquisition of a New Dependent.** If you acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your Dependents for coverage under this Health Care Plan. Your Dependents will be enrolled in the same benefit option as you are enrolled currently. You must submit the appropriate election and enrollment forms to the Employer within 31 days after the date you acquire such Dependent.

(a) Coverage becomes effective for a Dependent Child who is born after the date your coverage becomes effective as of such child's date of birth provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 31 days after the child's birth. Failure to enroll in the Health Care Plan within this 31-day period will result in no coverage under the Health Care Plan.

(b) Coverage for a newly acquired Dependent due to marriage will be effective on the date of marriage provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 31 days after your date of marriage. Failure to enroll in the Health Care Plan within the 31-day period described above will result in no coverage under the Health Care Plan.

(c) Coverage for a newly acquired Dependent due to adoption (or placement with you in anticipation of adoption) will be effective as of the date of adoption (or placement in anticipation of adoption) provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 31 days after adoption or placement in anticipation of adoption, as applicable. Failure to enroll in the Health Care Plan within the 31-day period described above will result in no coverage under the Health Care Plan.

TERMINATION OF COVERAGE

Termination of Employee Coverage
Coverage under the Health Care Plan will terminate on the earliest of the following dates:

(1) The date the Health Care Plan terminates, in whole or in part.

(2) If you fail to make any contribution when it is due, coverage will be reduced to Employee only (single) coverage.

(3) The date you enter military service on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year.

(4) The date you terminate employment, retire or cease to be included in an eligible class of Employees.

(5) The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud.

(6) The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact.

Termination of Dependent Coverage
Coverage under the Health Care Plan will terminate on the earliest of the following dates:

(1) The date the Health Care Plan terminates, in whole or in part.

(2) The date the Health Care Plan discontinues coverage for Dependents.

(3) The date your Dependent becomes covered as an Employee under the Health Care Plan.

(4) The date coverage terminates for the Employee.

(5) If you and/or your Dependents fail to make any contribution when it is due, Dependent coverage will terminate and coverage for the Employee will be reduced to Employee only (single) coverage in the Medical Value Plan and the Group Dental and Vision Plan.

(6) The date the Dependent enters military service on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year.

(7) The date a Dependent Spouse ceases to be a Dependent as defined by the Health Care Plan.

(8) The end of the month in which a Dependent Child attains age 26 unless disabled as defined under Dependent eligibility.

(9) The date your Dependent (or any person seeking coverage on behalf of your Dependent) performs an act, practice or omission that constitutes fraud.

(10) The date your Dependent (or any person seeking coverage on behalf of your Dependent) makes an intentional misrepresentation of a material fact.

Retroactive Termination of Coverage
Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Health Care Plan will not retroactively terminate coverage under the Health Care Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Health Care Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Health Care Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected

before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required Employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

Continuation of Coverage under the Family and Medical Leave Act (FMLA)
An eligible Employee that qualifies for FMLA is entitled to a maximum of 12 weeks of unpaid leave in any 12 month period for reasons that qualify under FMLA. The Employee must have worked for the Employer for at least 12 months, and have worked at least 1,250 hours during the 12 months preceding the start of the leave.

The National Defense Authorization Act (NDAA) expands FMLA to include leaves for military families. A Spouse, son, daughter, parent, or next of "kin" will be allowed up to 26 weeks during a 12 month period to care for a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious Injury or Illness.

An Employee may choose not to retain health coverage during the FMLA leave. However, when an Employee returns from leave, the Employee is entitled to have coverage reinstated on the same basis as it would have been if the leave had not been taken. Coverage will be reinstated without any additional qualification requirements imposed by the Health Care Plan. (The Health Care Plan's provisions with respect to Deductibles and Coinsurance amounts will apply on the same basis as they did prior to the FMLA leave.)

The Employer may offer FMLA payment options as follows: (1) in advance; (2) as the FMLA leave goes along; or (3) upon return to active work. However, item number (1), payments in advance, may not be the only option offered.

Continuation of Coverage under State Family and Medical Leave Laws
To the extent this Health Care Plan is required to comply with a State family and medical leave law that is more generous than the FMLA, continuation of coverage under this Health Care Plan will be provided in accordance with such State family and medical leave law, as well as under FMLA.

Continuation of Coverage under USERRA
You may elect to continue Health Care Plan coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) if you are absent from work due to military service in the Uniformed Services (as defined under USERRA). You may elect to continue coverage for yourself and any of your Dependents that were covered under the Health Care Plan at the time of your leave. Your eligible Dependents do not have an independent right to elect coverage under USERRA; therefore unless you elect to continue coverage on their behalf, your eligible Dependents will not be permitted to continue coverage under USERRA separately.

To elect coverage under USERRA, you must submit your election to continue coverage under USERRA, on a form prescribed by the Employer to the Employer within 60 days after the date of your leave. Coverage under the Health Care Plan will become effective as of the date of your leave and will continue for the lesser of (a) 24 months (beginning on the date your absence begins); or (b) the period of time beginning on the date your absence begins and ending on the day after the date you return to employment with the Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA.

If your leave is 31 days or more, you will be required to pay up to 102% of the full contribution under the Health Care Plan. If your leave is 30 days or less, you will not be required to pay more than the amount (if any) you would have paid had you remained an active Employee of the Employer. Your Employer will notify you of the procedures for making payments under this Health Care Plan.

Continuation coverage provided under USERRA counts towards the maximum coverage period under the Continuation Coverage provision of the Health Care Plan (if applicable).

An Employee returning from USERRA-covered military leave who participated in the Health Care Plan immediately before going on USERRA leave has the right to resume coverage under the Health Care Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period will apply to an Employee returning from USERRA leave (within the

applicable time period) unless the waiting period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

BENEFITS EXTENSION PROGRAM

If a Covered Person's coverage ceases due to termination of employment, reduction in hours, death of the Employee, Spouse's divorce from the Employee, or the Dependent Child ceases to meet the Dependent requirements; and the Covered Person has been covered under the Health Care Plan for at least 6 consecutive months and is not eligible for Medicare or any other group coverage, benefits may continue for a maximum period not to exceed 6 months (12 months for Priests who are incardinated with the Archdiocese) with payment of the appropriate contribution. This election must be made and the contribution paid within 31 days of termination of coverage. If the premiums are not paid when due, coverage lapses retroactively to the last day for which a premium payment was received, and the affected member will not be eligible for reenrollment.

If health coverage is provided to a qualified beneficiary after a qualifying event without regard to Extension of Benefits continuation coverage (e.g. as a result of the Uniformed Services Employment and Reemployment Rights Act of 1994), Extension of Benefits continuation coverage will run concurrently with the other health coverage. In other words, the maximum period of Extension of Benefits continuation coverage will continue to be measured from the date of the qualifying event, regardless of whether other alternative coverage is provided.

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

Priest, Religious and Seminarian Coverage

In the event that Priests who are incardinated with the Archdiocese are unable to perform full and all duties for the Archdiocese, they will no longer be eligible for coverage under the Health Care Plan, and will instead be covered under either The Roman Catholic Archdiocese of Atlanta High Deductible Health Plan or The Roman Catholic Archdiocese of Atlanta Senior Priest Medicare Supplemental Plan, as applicable.

In the event that Priests who are not incardinated with the Archdiocese, Religious, or Seminarians are unable to perform full and all duties for the Archdiocese, and such Priest, Religious, or Seminarian has been covered under the Health Care Plan for at least 6 consecutive months and is not eligible for Medicare or any other group coverage, benefits may continue for a maximum period not to exceed 6 months with payment of the appropriate contribution. This election must be made and the contribution paid within 31 days of termination of coverage. If the premiums are not paid when due, coverage lapses retroactively to the last day for which a premium payment was received, and the affected member will not be eligible for reenrollment.

Continuation of Participation for Employees Receiving Disability Benefits

Employees participating in the Health Care Plan who become disabled and who are eligible for benefits under the Long Term Disability Income Plan may continue participation during all or a portion of the period of their disability. During the period of continued participation, the Employee's eligible Dependents may also continue participation as long as Dependent contributions are paid.

Disabled participants may be entitled to receive Medicare benefits. In this event, the Health Care Plan will remain primary.

The maximum period that participation may continue depends on the length of continuous service of the Employee at the onset of the disability:

Continuous Full-Time Service	Maximum Continuation of Participation
Less than 1 year	6 months
1 or more years	12 months

Except as otherwise provided in this Extension of Benefits section, participation will end immediately if one of the following occurs:

(1) The participant becomes ineligible to receive disability income plan payments;

(2) Coverage terminates as a result of termination of the Health Care Plan or modification of the Health Care Plan;

(3) Applicable contributions are not paid in a timely fashion (if any).

Generally, this period of continuation coverage will run concurrently and will be applied toward satisfaction of any of the Extension of Benefits provisions. However, upon the death of a Disabled participant, the enrolled eligible Dependents of that participant who are not eligible for Medicare or any other group health coverage can continue coverage under the Extension of Benefits provision for a maximum period not to exceed 6 months after the death of the Disabled participant.

COORDINATION OF BENEFITS

There is no Coordination of Benefits for prescription drug charges.

If a Covered Person is covered under more than one Health Care Plan as defined below, including this Health Care Plan, benefits will be coordinated. The benefits payable under this Health Care Plan for any Claim Determination Period, will be either its regular benefits or reduced benefits which, when added to the benefits of the other Plan, may equal 100% of the Allowable Expenses defined below.

Definitions

Allowable Expenses: Any Medically Necessary, Usual and Customary item of expense Incurred by a Covered Person which is covered at least in part under this Health Care Plan.

Claim Determination Period: A Calendar or Plan Year or that portion of a Calendar or Plan Year during which the Covered Person for whom a Claim is made has been covered under this Health Care Plan.

Plan: For purposes of this Coordination of Benefits section and the Reimbursement Rights section, Plan shall mean any plan or policy under which benefits or services are provided by:

(1) Group, blanket or franchise insurance coverage;

(2) Any group Hospital service prepayment, group medical or dental service prepayment, group practice or other group prepayment coverage;

(3) Group coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefits plans;

(4) Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary for medical only;

(5) Coverage provided through a school or other educational institution;

(6) Coverage under any Health Maintenance Organization (HMO);

(7) Coverage provided by no-fault auto insurance, by whatever name it is called, when not prohibited by law; or

(8) Coverage provided by Workers' Compensation.

When medical payments are available under vehicle insurance, this Health Care Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Health Care Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal Injury protection) coverage with the auto carrier.

Order of Benefit Determination

When a Covered Person is covered by this Health Care Plan and another Plan, the Plans will coordinate benefits when a Claim is made.

When a Claim is made, the Plan that pays first (or the primary Plan) will pay as if there were no other Plan involved. A Plan that does not include a coordination of benefits provision may not take the benefits of another Plan into account when it determines benefits.

The secondary Plan may take the benefits of another Plan into account only when it is secondary to that Plan. The secondary Plan will adjust its benefits so that the total benefits paid by both Plans will not exceed 100% of the Allowable Expenses. Neither Plan pays more than it would without the Coordination of Benefits provision.

(1) The benefits of the Plan which covers the individual as an Employee (that is, other than as a dependent) are determined before those of the Plan which covered the individual as a dependent.

(2) The rules for the order of benefits for a dependent child when parents are not separated or divorced are as follows:

(a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year where the word “birthday” refers only to month and day in a calendar year, not the year in which the person was born.

(b) 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.

(c) If the other Plan does not have the rules described above relating to the parents’ birthday, but instead has a rule based upon the gender of the parent, and the Plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

(3) If the Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the Plan of the parent with custody of the child;

(b) Then, the Plan of the Spouse of the parent with the custody of the child;

(c) Then, the Plan of the parent not having custody of the child.

(d) 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. The Plan of the other parent shall be the secondary Plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(e) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above.

(4) 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 those 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 the Plans do not agree on the order of benefits, this rule is ignored.

(5) If none of the above rules determines the order of benefits, the benefits of the Plan which covered an Employee longer are determined before those of the Plan which covered that person for the shorter term. To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the person was eligible under the second Plan within twenty-four hours after the first ended. The start of a new Plan does not include a change in the amount of scope of a Plan’s benefits, a change in the entity which pays, provides or administers the Plan’s benefits, or a change from one type of Plan to another (such as, from a single employer plan to that of a multiple employer plan).

When there is a conflict in the Plans' Coordination of Benefit rules, this Plan will never pay more than 50% of allowable charges when paying as the secondary Plan.

This Plan will not pay first if the Covered Person would have been eligible under another primary Plan but for the failure of the Covered Person to meet the technical requirements of the other Plan (such as obtaining pre-authorization). In that instance, this Plan shall pay as if it were the secondary Plan, but in no event shall this Health Care Plan pay more than 50% of the allowable charges.

Coordination of Benefits may operate to reduce the total amount of benefits otherwise payable during any claim determination period with respect to a Covered Person under this Health Care Plan. When the benefits of this Health Care Plan are reduced, each benefit is reduced proportionately. The reduced amount is then charged against any applicable benefit limit of this Health Care Plan.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Allowable Expense and a benefit paid.

Recovery

If the amount of the payment made by this Health Care Plan is more than it should have been due to lack of information or error, or should have been paid by another Plan, the Claims Administrator, on behalf of the Health Care Plan, has the right to recover the amount paid from one or more of the following:

(1) The person this Health Care Plan has paid;

(2) The Covered Person;

(3) Providers of care;

(4) Insurance companies;

(5) Other organizations; or

(6) Another Plan.

Payment to Other Carriers

Whenever payments, which should have been made under this Health Care Plan in accordance with the above provisions, have been made, this Health Care Plan will have the right to pay any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be benefits paid under this Health Care Plan and, to the extent of these payments, this Health Care Plan will be fully discharged from liability.

Effect of Medicare

In accordance with Federal Medicare regulations, the following is a brief explanation of the Medicare guidelines, not to be considered all inclusive.

(1) Working Aged Benefits

Employers with 20 or more Employees: This Health Care Plan will be primary when an active Employee or Spouse is age sixty-five (65) and over.

(2) Disabled Employees/Spouses

Employers with 100 or more Employees: This Health Care Plan will be primary when an active Employee or Dependent is disabled and covered by Medicare.

(3) Disability Due to End Stage Renal Disease (ESRD)

For Employees or Dependents under age sixty-five (65), if Medicare eligibility is due solely to End Stage Renal Disease (ESRD), the Health Care Plan will be primary only during the first thirty (30) months of Medicare coverage. Thereafter, the Health Care Plan will be secondary with respect to Medicare coverage.

If an Employee or Dependent is under age sixty-five (65) when Medicare eligibility is due solely to ESRD, and the individual attains age sixty-five (65), the Health Care Plan will be primary for a full thirty (30) months (or 33 months, depending upon whether a transplant or self-dialysis is involved) from the date of ESRD eligibility. Thereafter, Medicare will be primary and the Plan will be secondary.

If an Employee or Dependent is age sixty-five (65) and over, working and develops or is undergoing treatment for ESRD, the Health Care Plan will be primary for a full thirty (30) months (or 33 months from the date of ESRD eligibility). Thereafter, Medicare will be primary and the Health Care Plan will be secondary.

(4) All Individuals Eligible for Medicare

Covered Persons should be certain to enroll in Medicare Part A & B coverage in a timely manner to assure maximum coverage. Contact the Social Security Administration office to enroll for Medicare. If this Health Care Plan is secondary, benefits under this Health Care Plan will be coordinated with the dollar amount that Medicare will pay, subject to the rules and regulations specified by federal law.

REIMBURSEMENT RIGHTS

Benefits are payable only upon the Covered Person's acceptance of the terms of the Health Care Plan. As a condition to receiving benefits under this Health Care Plan, a Covered Person agrees to provisions of the following Reimbursement Rights.

(1) Responsible Party: For purposes of this Reimbursement Rights section, Responsible Party means any party actually, possibly or potentially responsible for making any payment to a Covered Person due to an Injury, Illness, or condition. This also includes any other Plan (as defined under Coordination of Benefits), person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, Workers' Compensation, other insurance policies for funds any insurance coverage, or the liability insurance for such party.

(2) Constructive Trust: By accepting benefits from this Health Care Plan, the Covered Persons agree to serve as a constructive trustee, and to hold in constructive trust such money or property resulting from any payments or settlement proceeds from any Responsible Party. Further, the Covered Persons agree that they will not dissipate any such money or property without prior written consent of this Health Care Plan, regardless of how such money or property is classified or characterized, from any Responsible Party. Failure to hold such funds in trust will be deemed a breach to the Health Care Plan.

(3) Reimbursement: In addition, if this Health Care Plan has already paid benefits to the Covered Person (or other providers on their behalf) for any Injury or Illness where a Responsible Party has a legal obligation to compensate the Covered Person for his or her Injury or Illness, this Health Care Plan has a right of reimbursement for such payments.

(4) Cooperation : The Covered Person agrees to refrain from releasing any Responsible Party or funds that may be liable for or obligated to the Covered Person for the Injury, Illness, or condition without obtaining this Health Care Plan's written approval. By participating in this Health Care Plan, the Covered Person automatically agrees to (a) promptly execute any documents and instruments, including a reimbursement agreement, and take any action that this Health Care Plan considers necessary to protect its rights; (b) not take any actions that could jeopardize or prejudice this Health Care Plan's position or rights (including refraining from making any settlement or recovery that attempts to reduce or recover or exclude the full cost of all benefits provided by this Health Care Plan); and (c) notify this Health Care Plan within thirty (30) days following the date any notice is given to any party of the Covered Person's intention to pursue or investigate a Claim due to Injury, Illness, condition, or other loss.

(5) Recovery from Covered Person: If the Covered Persons fail to reimburse this Health Care Plan for any benefits paid or to be paid, as a result of said Illness, Injury or condition, out of any recovery or reimbursement received, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with this Health Care Plan's attempt to recover such money from the Covered Person.

(6) Lien Rights: This Health Care Plan will automatically have a lien to the extent of benefits paid by this Health Care Plan for the treatment of the Illness, Injury, or condition, and other losses for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any Responsible Party or insurance coverage related to treatment for any Illness, Injury, or condition for which this Health Care Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by this Health Care Plan including, but not limited to, the Covered Person; any Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by this Health Care Plan.

(7) Applicability to All Settlements and Judgments: This Reimbursement Rights section shall apply and this Health Care Plan is entitled to recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the benefits this Health Care Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than expenses paid by this Health Care Plan.

(8) Rights under State Law: By accepting benefits under this Health Care Plan, each Covered Person acknowledges that this Health Care Plan may enforce these provisions under Georgia statutes and other state laws relating to contract theory, constructive trust, constructive lien, or other equitable theory under state common law.

(9) Interpretation: The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of this Health Care Plan document. The Plan Administrator may amend this Health Care Plan in its sole discretion at any time without notice. This right of reimbursement shall bind the Covered Person's guardian(s), estate, executor, personal representative, and heir(s).

RIGHTS OF RECOVERY

In the event of any overpayment of benefits by this Health Care Plan, the Health Care Plan will have the right to recover the overpayment. If a Covered Person is paid a benefit greater than allowed in accordance with the provisions of this Health Care Plan, the Covered Person will be required to refund the overpayment. If payment is made on behalf of a Covered Person to a Hospital, Physician, or other provider of health care, and the payment is found to be an overpayment, the Health Care Plan will request a refund of the overpayment from the provider. If the refund is not received from the provider, or from the Covered Person, the amount of the overpayment will be deducted from future benefits, if available. If future benefits are not available, the Covered Person will be required to refund the overpayment.

Excess Insurance
If at the time of Injury, Illness, disease or disability, there is available or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Health Care Plan shall apply only as an excess over such other sources of coverage, except as provided for under the Health Care Plan's "Coordination of Benefits" section. The Health Care Plan's benefits shall be excess to:

(1) The responsible party, its insurer or any other source on behalf of that party;

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(3) Any policy of insurance from any insurance company or guarantor of a third party;

(4) Workers' Compensation or other liability insurance company; or

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Separation of Funds
Benefits paid by the Health Care Plan, funds recovered by the Covered Person and funds held in trust over which the Health Care Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person or filing of bankruptcy by the Covered Person, will not affect the Health Care Plan's equitable lien, the funds over which the Health Care Plan has a lien or the Health Care Plan's right to subrogation and reimbursement.

Wrongful Death
In the event that the Covered Person dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any coverage, the Health Care Plan's subrogation and reimbursement rights shall still apply.

Obligations
(1) It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Health Care Plan:

   (a) To cooperate with the Health Care Plan or any representatives of the Health Care Plan, in protecting its rights, including discovery, attending depositions and/or cooperating in trial to preserve the Health Care Plan's rights;

   (b) To provide the Health Care Plan with pertinent information regarding the Illness, disease, disability or Injury, including Accident reports, settlement information and any other requested additional information;

   (c) To take such action and execute such documents as the Health Care Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

   (d) To do nothing to prejudice the Health Care Plan's rights of subrogation and reimbursement;

(e) To promptly reimburse the Health Care Plan when a recovery through settlement, judgment, award or other payment is received; and

(f) To not settle or release, without the prior consent of the Health Care Plan, any claim to the extent that the Health Care Plan beneficiary may have against any responsible party or coverage.

(2) If the Covered Person and/or his or her attorney fails to reimburse the Health Care Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Health Care Plan's attempt to recover such money from the Covered Person.

(3) The Health Care Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Persons' cooperation or adherence to these terms.

Offset
Failure by the Covered Person and/or his or her attorney to comply with any of these requirements may, at the Health Care Plan's discretion, result in a forfeiture of payment by the Health Care Plan of medical benefits and any funds or payments due under this Health Care Plan may be withheld until the Covered Person satisfies his or her obligation.

Minor Status
(1) In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Health Care Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

(2) If the minor's parents or court-appointed guardian fail to take such action, the Health Care Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court- appointed guardian.

Language Interpretation
The Health Care Plan Sponsor retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Health Care Plan's reimbursement rights. All actions or determinations by the Health Care Plan Sponsor or a person designated as responsible for a particular aspect of the control, management or administration of this Health Care Plan on all matters within the scope of their authority under this Health Care Plan shall be final, conclusive and binding on all persons, and shall be given full effect under applicable law, unless such interpretation of determination is determined by a court of competent jurisdiction to be an abuse of discretion and arbitrary or capricious. The Health Care Plan Sponsor may amend the Health Care Plan at any time without notice.

Severability
In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Health Care Plan. The section shall be fully severable. The Health Care Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Health Care Plan.

Notwithstanding anything contained herein to the contrary, the Health Care Plan's right to subrogation and reimbursement may be subject to applicable State subrogation laws.

Right to Receive and Release Necessary Information
For the purposes of implementing the terms of this Health Care Plan, the Claims Administrator retains the right to request any medical or dental information from any insurance company or provider of service it deems necessary to properly process a claim. The Claims Administrator may, without consent of the Covered Person, release or obtain any information it deems necessary. Any person claiming benefits under this Health Care Plan shall furnish to the Claims Administrator such information as may be necessary to implement this provision.

HEALTH CARE PLAN ADMINISTRATION

Delegation of Responsibility
The Health Care Plan Sponsor has full discretionary authority for the control and management of the operation and administration of the Health Care Plan. The Health Care Plan Sponsor may delegate any duties and other responsibilities to any individual or entity. Any person to whom any responsibility is delegated may serve in more than one capacity with respect to the Health Care Plan and may be a participant in the Health Care Plan.

Authority to Make Decisions
The Health Care Plan is administered by the Employer. The Employer has retained the services of the Claims Administrator to provide certain claims processing and other ministerial services. The Claims Administrator adjudicates claims in accordance with provisions of the Health Care Plan and Employer's claim guidelines.

The Employer will administer this Health Care Plan in accordance with its terms and establish its policies, interpretations, practices and procedures. It is the express intent of this Health Care Plan that the Employer will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Health Care Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to you and/or your Dependent's rights and to decide questions of Health Care Plan interpretation and those of fact and law relating to the Health Care Plan. The decisions of the Employer as to the facts related to any claim for benefits and the meaning and intent of any provision of the Health Care Plan or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Health Care Plan will be paid only if the Employer decides, in its discretion, that you and/or your Dependent (as applicable) are entitled to them.

The duties of the Employer include the following:

(1) To administer the Health Care Plan in accordance with its terms;

(2) To determine all questions of eligibility, status and coverage under the Health Care Plan;

(3) To interpret the Health Care Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;

(4) To make factual findings;

(5) To decide disputes which may arise relative to a Covered Person's rights;

(6) To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials; or alternatively, to appoint a qualified administrator to carry out these functions on the Employer's behalf.

(7) To keep and maintain the Health Care Plan documents and all other records pertaining to the Health Care Plan;

(8) To appoint and supervise a Contract Administrator to pay claims;

(9) To perform all necessary reporting as required by Federal or State law;

(10) To establish and communicate procedures to determine whether a child support order or decree is a QMCSO;

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

(12) To perform each and every function necessary for or related to the Health Care Plan's administration.

Amendment or Termination of Health Care Plan
The Health Care Plan Sponsor may amend or terminate this Health Care Plan at any time without prior notice.

It is the intent of the Health Care Plan Sponsor to comply with all applicable laws.

MISCELLANEOUS INFORMATION

Affiliated Companies
Any of the Health Care Plan Sponsor's affiliates, subsidiaries, or divisions may be deleted or added to the Health Care Plan upon written notice on or before the date such deletion or addition is effective.

Assignment of Benefits
No benefit under the Health Care Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so shall be void. No benefit under the Health Care Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Health Care Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Health Care Plan for an alternate recipient, in the manner described in the Health Care Plan's QMCSO procedures.

Clerical Error
Clerical errors made on the records of the Health Care Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Health Care Plan regardless of whether any contributions with respect to you and/or your Dependents have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity with Applicable Laws
This Health Care Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Health Care Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Employer to pay claims that are otherwise limited or excluded under this Health Care Plan, such payments will be considered as being in accordance with the terms of Health Care Plan. It is intended that the Health Care Plan will conform to the requirements of any applicable federal or state law. This Health Care Plan is a non- electing church Health Care Plan as such term is defined in ERISA Section 4(b)(2).

Contributions
Dependent participation in this Health Care Plan is entirely voluntary. The Employer reserves the right to modify the amount of any contributions.

Cost and Funding of the Health Care Plan
The Health Care Plan Sponsor is responsible for funding the Health Care Plan and will do so as required by law. The Health Care Plan is funded by the Roman Catholic Archdiocese of Atlanta Group Health Care Plan Trust (the “Trust”), established for purposes of funding the plan and paying plan expenses. Contributions to the Health Care Plan are deposited in the Trust and the Health Care Plan Sponsor may, from time to time, make contributions to the Trust in amounts determined by the Health Care Plan Sponsor. The Health Care Plan Sponsor may also, in its discretion, pay for expenses or benefits from the Employer’s general assets. The amount of contribution (if any) for your coverage or coverage for your Dependents will be determined from time to time by the Health Care Plan Sponsor, in its sole discretion.

Employer
RCAA Administrative Services, Inc., or any successor thereto, and its participating Affiliated Companies.

Interpretation of this Document
The use of masculine pronouns in this Health Care Plan shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Health Care Plan are used for convenience of reference only. You and your Dependents are advised not to rely on any provision because of the heading.

The use of the words, “you” and “your” throughout this Health Care Plan applies to eligible or Covered Employees and, where appropriate in context, their covered Dependents.

No Contract of Employment
This Health Care Plan and any amendments constitute the terms and provisions of coverage under this Health Care Plan. The Health Care Plan shall not be deemed to constitute a contract of any type between the Employer and any person or to be consideration for or an inducement or condition of, the employment of any Employee. Nothing in this Health Care Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

Release of Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Employer may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or person covered for benefits under this Health Care Plan. In so acting, the Employer shall be free from any liability that may arise with regard to such action; however, the Employer at all times will comply with the applicable privacy standards. Any Covered Person claiming benefits under this Health Care Plan shall furnish to the Employer such information as may be necessary to implement this provision.

Unclaimed Property
If the Employer is unable to make payment to any Covered Person or other person to whom a payment is due under the Health Care Plan because the Employer cannot ascertain the identity or whereabouts of such Covered Person or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Covered Person or other person shall be forfeited after a reasonable time of no more than two (2) years, as determined in the sole discretion of the Employer, after the date any such payment first became due.

Any benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the second Health Care Plan Year following the Health Care Plan Year in which the payments are issued shall be forfeited. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with the Health Care Plan and applicable rules and regulations.

Workers’ Compensation
This Health Care Plan excludes coverage for any Injury or Illness that is eligible for coverage under any Workers’ Compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Health Care Plan and it is later determined that you received or are eligible to receive Workers’ Compensation coverage for the same Injury or Illness, the Health Care Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement you receive from Workers’ Compensation. The Health Care Plan will exercise its right to recover against you. The Health Care Plan reserves its right to exercise its rights under this section and the section entitled “Recovery of Payment” even though:

(1) The Workers’ Compensation benefits are in dispute or are made by means of settlement or compromise;

(2) No final determination is made that the Injury or Illness was sustained in the course of or resulted from your employment;

(3) The amount of Workers’ Compensation benefits due specifically to health care expense is not agreed upon or defined by you or the Workers’ Compensation carrier; or

(4) The health care expense is specifically excluded from the Workers’ Compensation settlement or compromise.

You are required to notify the Employer immediately when you file a claim for coverage under Workers’ Compensation if a claim for the same Injury or Illness is or has been filed with this Health Care Plan. Failure to do so or to reimburse the Health Care Plan for any expenses it has paid for which coverage is available through Workers’ Compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Health Care Plan for recovery and disciplinary action.

Minimum Essential Coverage

Refer to the Employer's Summary of Benefits and Coverage (SBC) for determination as to whether the Group Medical Plan of the Health Care Plan provides "minimum essential coverage" within the meaning of Code Section 5000A(f) and any accompanying regulations or guidance and whether it provides "minimum value" within the meaning of Code Section 36B(c)(2)(C)(ii) and any accompanying regulations or guidance (e.g. the Group Medical Plan of the Health Care Plan provides at least 60% actuarial value).

HIPAA PRIVACY PRACTICES

The following is a description of certain rules that apply to the Health Care Plan Sponsor regarding uses and disclosures of your health information.

Disclosure of Summary Health Information to the Health Care Plan Sponsor

In accordance with HIPAA's standards for privacy of individually identifiable health information (the "privacy standards"), the Health Care Plan may disclose summary health information to the Health Care Plan Sponsor, if the Health Care Plan Sponsor requests the summary health information for the purpose of:

(1) Obtaining premium bids from Health Care Plans for providing health insurance coverage under this Health Care Plan; or

(2) Modifying, amending or terminating the Health Care Plan.

"Summary health information" is information, which may include individually identifiable health information, that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Health Care Plan, but that excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by 5-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Health Care Plan Sponsor for Health Care Plan Administration Purposes

Except as described under "Disclosure of Summary Health Information to the Health Care Plan Sponsor" above or under "Disclosure of Certain Enrollment Information to the Health Care Plan Sponsor" below or under the terms of an applicable individual authorization, the Health Care Plan may disclose PHI to the Health Care Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer or HMO with respect to the Health Care Plan to the Health Care Plan Sponsor only if the Health Care Plan Sponsor requires the PHI to administer the Health Care Plan. The Health Care Plan Sponsor by formally adopting this Health Care Plan document certifies that it agrees to:

(1) Not use or further disclose PHI other than as permitted or required by the Health Care Plan or as required by law;

(2) Ensure that any agents , to whom the Health Care Plan Sponsor provides PHI received from the Health Care Plan agree to the same restrictions and conditions that apply to the Health Care Plan Sponsor with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit Health Care Plan of the Health Care Plan Sponsor;

(4) Report to the Health Care Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Health Care Plan Sponsor becomes aware;

(5) Make available PHI in accordance with section 164.524 of the privacy standards;

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;

(7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Health Care Plan available to the U.S. Department of Health and Human Services ("HHS"), for purposes of determining compliance by the Health Care Plan with part 164, subpart E, of the privacy standards;

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

(10) Ensure that adequate separation between the Health Care Plan and the Health Care Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards, is established as follows:

(a) The Health Care Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Health Care Plan Sponsor who have been designated to carry out Health Care Plan administration functions, access to PHI. The Health Care Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to Health Care Plan administration functions that the Health Care Plan Sponsor performs for the Health Care Plan.

(b) In the event any of the individuals described in (a) above do not comply with the provisions of the Health Care Plan documents relating to use and disclosure of PHI, the Employer shall impose reasonable sanctions as necessary, in its discretion. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

"Health Care Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Health Care Plan or solicit bids from prospective issuers. "Health Care Plan administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out Health Care Plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit Health Care Plans.

The Health Care Plan shall disclose PHI to the Health Care Plan Sponsor only upon receipt of a certification by the Health Care Plan Sponsor that:

(1) The Health Care Plan documents have been amended to incorporate the above provisions; and

(2) The Health Care Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Health Care Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the privacy standards, the Health Care Plan may disclose to the Health Care Plan Sponsor information on whether an individual is participating in the Health Care Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the Health Care Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Genetic Information
Except as otherwise provided below, the Health Care Plan Sponsor hereby authorizes and directs the Health Care Plan, through the Employer or the Contract Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Health Care Plan. Such disclosures shall be made in accordance with the privacy standards.

The Health Care Plan will not use or disclose genetic information, including information about genetic testing and family medical history, for underwriting purposes. The Health Care Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include genetic information.

"Underwriting purposes" is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Health Care Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Health Care Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); and (3) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, "underwriting purposes" does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Health Care Plan Sponsor for Health Care Plan Administration Functions

In accordance with HIPAA's standards for security (the "security standards"), to enable the Health Care Plan Sponsor to receive and use Electronic PHI for Health Care Plan administration functions (as defined in 45 CFR § 164.504(a)), the Health Care Plan Sponsor agrees to:

(1) Implement and maintain administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Health Care Plan.

(2) Ensure that adequate separation between the Health Care Plan and the Health Care Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.

(3) Ensure that any agent, including any business associate or subcontractor, to whom the Health Care Plan Sponsor provides Electronic PHI created, received, maintained or transmitted on behalf of the Health Care Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI.

(4) Report to the Health Care Plan any Security Incident of which it becomes aware.

(5) The Health Care Plan Sponsor will promptly report to the Health Care Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Health Care Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

Any terms not otherwise defined in this section shall have the meanings set forth in the security standards.

GENERAL HEALTH CARE PLAN INFORMATION

Name of Plan(s):	The Roman Catholic Archdiocese of Atlanta Group Health Care Plan The Roman Catholic Archdiocese of Atlanta Group Medical Plan The Roman Catholic Archdiocese of Atlanta Group Dental and Vision Plan
Health Care Plan Administrator: **Health Care Plan Sponsor:**	RCAA Administrative Services, Inc. 2401 Lake Park Drive S.E Smyrna, GA 30080-8862 (404) 920-7485
Plan Administrator/Sponsor EIN:	83-3544215
Plan Trust	The Roman Catholic Archdiocese of Atlanta Group Health Care Plan Trust
Plan Trust EIN	83-6418299
Plan Year:	January 1 - December 31
Meritain Health, Inc. Group Number:	10974 – Group Health Care Plan 10974-M – Group Medical Plan
Claims Administrator:	Meritain Health, Inc. P.O. Box 27267 Minneapolis, MN 55427-0267 (800) 925-2272
Medical Management Program Administrator:	Meritain Health Medical Management 7400 West Campus Road, F-510 New Albany, OH 43054-8725 (800) 242-1199
Prescription Drug Card Program Administrator:	OptumRx P.O. Box 9472 Minneapolis, MN 55440-9472 (855) 896-9779 www.optumrx.com

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The Roman Catholic Archdiocese of Atlanta
Group Medical Plan

Plan Document

Group No.: 10974 - M

Originally Effective: January 1, 2005

Amended and Restated Effective: January 1, 2020

GROUP MEDICAL PLAN
GENERAL OVERVIEW OF THE MEDICAL PLAN

The Medical Plan Sponsor has entered into an agreement with Aetna Choice® POS II (the "Network"). This Network offers you health care services at discounted rates. Using a Network provider will normally result in a lower cost to the Medical Plan as well as a lower cost to you. There is no requirement for anyone to seek care from a provider who participates in the Network. The choice of provider is entirely up to you.

Non-Participating Provider Exceptions
Covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level when a:

(1) Covered Person has a Medical Emergency requiring immediate care, including emergency transportation via ambulance.

(2) Participating Provider submits specimens and x-rays to a Non-Participating Provider.

(3) Non-Participating Provider provides services at a Network facility.

(4) Referral is made by a Participating Provider to receive services from a Non-Participating Provider, subject to Usual and Customary Charges.

(5) Covered Person receives medical supplies for which there is no Network Provider available.

(6) Covered Person receives services from a Network surgeon who uses a non-Network facility.

(7) Covered Person receives professional services which are not available within 30 miles of the Network area.

(8) Covered Person resides more than 30 miles outside Network area.

Not all providers based in Network Hospitals or medical facilities are Participating Providers. It is important when you enter a Hospital or medical facility that you request that ALL Physician services be performed by Participating Providers. By doing this, you will always receive the greater Participating Provider level of benefits.

Costs
You must pay for a certain portion of the cost of Covered Expenses under the Medical Plan, including (as applicable) any Copay, Deductible and Coinsurance percentage that is not paid by the Medical Plan, up to the Out-of-Pocket Maximum set by the Medical Plan.

Coinsurance
Coinsurance is the percentage of eligible expenses the Medical Plan and the Covered Person are required to pay. The amount of Coinsurance a Covered Person is required to pay is the difference from what the Medical Plan pays as shown in the **Medical Schedule of Benefits**.

There may be differences in the Coinsurance percentage payable by the Medical Plan depending upon whether you are using a Participating Provider or a Non-Participating Provider. These payment levels are also shown in the **Medical Schedule of Benefits**.

Copay
A Copay is the portion of the medical expense that is your responsibility, as shown in the **Medical Schedule of Benefits**. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible, Coinsurance or Out-of-Pocket Maximum.

Deductible

NOTE: This section only applies to medical benefits under the Group Medical Plan. Please refer to the Dental and Vision Plan included in the Group Health Plan for the Deductible, if any, applicable to those benefits.

A Deductible is the total amount of eligible expenses as shown in the **Medical Schedule of Benefits**, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Medical Plan. The family Deductible maximum, as shown in the **Medical Schedule of Benefits**, is the number of deductibles which must be Incurred by the covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one individual Deductible amount to a family Deductible.

If the Deductible is satisfied in whole or in part by eligible expenses Incurred during October, November or December, those expenses will apply to the Deductible applicable in the next Calendar Year.

If 2 or more covered family members suffer Injuries from the same Accident, only one Deductible will be applied to all charges Incurred for the treatment of those Injuries during the Calendar Year.

Out-of-Pocket Maximum

An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Medical Plan increases to 100%.

The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Medical Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Calendar Year.

The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum, if applicable, is the maximum amount that must be satisfied by covered family members during a Calendar Year. The entire family Out-of-Pocket Maximum must be satisfied; however when an individual in a family meets the Out-of-Pocket amount for single coverage, the amount applies towards the family Out-of-Pocket Maximum. The Medical Plan will pay 100% of Covered Expenses for any Covered Person in the family during the remainder of that Calendar Year.

Your Out-of-Pocket Maximum may be higher for Non-Participating Providers than for Participating Providers. Please note, however, that not all Covered Expenses are eligible to accumulate toward your Out-of-Pocket Maximum. The types of expenses, which are not eligible to accumulate toward your Out-of-Pocket Maximum, ("non-accumulating expenses") include:

(1) Copays, including Prescription Drug Copays.

(2) Deductibles.

(3) Dental and vision benefits, other than those dental and vision expenses paid under the major medical component of the Medical Plan.

(4) Precertification penalties.

(5) Any charges as defined in the General Exclusions and Limitations section.

Reimbursement for these non-accumulating expenses will continue at the percentage payable shown in the **Medical Schedule of Benefits**, subject to the Medical Plan maximums.

The Medical Plan will not reimburse any expense that is not a Covered Expense. In addition, you must pay any expenses that are in excess of the Usual and Customary Charges for Non-Participating Providers and any penalties for failure to comply with requirements of the Medical Management and Precertification Program section of the Medical Plan (if applicable) or any other penalty that is otherwise stated in this Medical Plan. This could result in you having to pay a significant portion of your claim. None of these amounts will accumulate toward your Out-of-Pocket Maximum.

Once you have paid the Out-of-Pocket Maximum for eligible expenses Incurred during a Calendar Year, the Medical Plan will reimburse additional eligible expenses Incurred during that year at 100%.

If you have any questions about whether an expense is a Covered Expense or whether it is eligible for accumulation toward your Out-of-Pocket Maximum, please contact your Employer for assistance.

Integration of Deductibles and Out-of-Pocket Maximums
The Deductible amounts are combined for Network and out of Network Providers, however the Out-of-Pocket Limit amounts for Network and out of Network Providers are separate amounts and do not integrate. In other words, you will be required to satisfy the Out-of-Pocket Maximum amount for Participating Providers and Non-Participating Providers separately.

Medical Expense Audit Bonus
The Medical Plan offers an incentive to all Covered Persons to encourage examination and self auditing of eligible medical bills to ensure the amounts billed by any provider accurately reflect the services and supplies received by the Covered Person. The Covered Person is asked to review all medical charges and verify that each itemized service has been received and the bill does not represent either an overcharge or a charge for services never received. This self auditing procedure is strictly voluntary; however, it is to the advantage of the Medical Plan as well as the Covered Person to avoid unnecessary payment of healthcare costs.

In the event a self audit results in elimination or reduction of benefits paid, 25% of the amount saved will be reimbursed directly to the Employee (subject to a $10 minimum payment and a $500 maximum payment per Calendar Year), provided the savings are accurately documented, and satisfactory evidence is submitted to the Claims Administrator (e.g., a copy of the incorrect bill and a copy of the corrected billing).

This self audit credit is in addition to the payment of all other applicable Medical Plan benefits for legitimate medical expenses.

This credit will not be payable for expenses in excess of the Usual and Customary Charges or expenses that are not covered under the Medical Plan, regardless of whether benefits paid are reduced.

MEDICAL MANAGEMENT AND PRECERTIFICATION PROGRAM

You, your eligible Dependents or a representative acting on your behalf must call the Medical Management and Precertification Program Administrator to receive certification of inpatient admissions, as well as other non-Medical Emergency services listed below. This call must be made at least 24 hours in advance of inpatient admissions or receipt of the non-Medical Emergency services identified below; or within 72 hours, or if later, by the next business day after a Medical Emergency inpatient admission. Failure to obtain precertification or notify the Medical Management and Precertification Program Administrator within the time frame indicated above may result in eligible expenses being reduced or denied. Please refer to the penalty section below.

Meritain Health Medical Management/Precertification: 866-405-2021
Meritain Health Nurse line: 888-229-9301

Medical Management/Precertification is a program designed to help ensure that you receive necessary and appropriate healthcare while avoiding unnecessary expenses. The program consists of:

(1) Precertification of Medical Necessity. The following items and/or services must be precertified before any medical services are provided:

   (a) Chemotherapy - all settings including services rendered in a Physician's office;

   (b) Inpatient admissions, including inpatient admissions to a Skilled Nursing Facility, Extended Care Facility, Rehabilitation Facility, and inpatient admissions due to a Mental Disorder;

   (c) Radiation therapy - all settings including services rendered in a Physician's office; or

   (d) Transplants.

(2) Concurrent Review for continued length of stay and assistance with discharge planning activities.

Medical Management/Precertification Does Not Guarantee Payment
All benefits/payments are subject to the patient's eligibility for benefits under the Plan. For benefit payment, services rendered must be considered an eligible expense under the Plan and are subject to all other provisions of the Plan.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other healthcare provider.

How the Program Works

Precertification
Before you or your eligible Dependents are admitted to a medical facility or receive items or services that require precertification on a non-Medical Emergency basis (that is, a Medical Emergency is not involved), the Medical Management and Precertification Program Administrator will, based on clinical information from the provider or facility, certify the care according to the Medical Management and Precertification Program Administrator's policies and procedures.

The Medical Management and Precertification Program is set in motion by a telephone call from you, the patient or a representative acting on your behalf or on behalf of the patient.

To allow for adequate processing of the request, contact the Medical Management and Precertification Program Administrator at least 24 hours before receiving any item or service that requires precertification or an inpatient admission for a Non-Medical Emergency with the following information:

(1) Name, identification number and date of birth of the patient;

(2) The relationship of the patient to the Covered Employee;

(3) Name, identification number, address and telephone number of the Covered Employee;

(4) Name of Employer and group number;

(5) Name, address, Tax ID # and telephone number of the admitting Physician;

(6) Name, address, Tax ID # and telephone number of the medical facility with the proposed date of admission and proposed length of stay;

(7) Proposed treatment plan; and

(8) Diagnosis and/or admitting diagnosis.

If there is an inpatient admission with respect to a Medical Emergency, you, the patient or a representative acting on your behalf or on behalf of the patient, including, but not limited to, the Hospital or admitting Physician, must contact the Medical Management and Precertification Program Administrator within 72 hours after the start of the confinement or on the next business day, whichever is later.

Hospital stays in connection with childbirth for either the mother or newborn may not be less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother.

You, the patient and the providers are NOT REQUIRED to obtain precertification for a maternity delivery admission, unless the stay extends past the applicable 48- or 96-hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified with the Medical Management and Precertification Program Administrator or a penalty will be applied.

The Medical Management and Precertification Program Administrator, in coordination with the facility and/or provider, will make a determination on the number of days certified based on the Medical Management and Precertification Program Administrator's policies, procedures and guidelines. If the confinement will last longer than the number of days certified, a representative of the Physician or the facility must call the Medical Management and Precertification Program Administrator before those extra days begin and obtain certification for the additional time. If the additional days are not requested and certified, room and board expenses will not be payable for any days beyond those certified.

If the patient does not obtain precertification for their inpatient admission at least 24 hours in advance of the admission or notify the Medical Management and Precertification Program Administrator within 72 hours after a Medical Emergency admission or if precertification is obtained or notification received outside the time frames specified, eligible expenses may be reduced or denied. Please refer to the penalty section below.

Penalty

If you fail to obtain precertification or fail to notify the Medical Management and Precertification Program Administrator within the time periods described above, benefits under the Medical Plan will be reduced by $500 per occurrence and this penalty amount will not accumulate toward any Out-of-Pocket Maximum limit. Please note that this penalty will not apply if the patient's hospital stay is less than 24 hours.

Discharge Planning

Discharge planning needs are part of the Medical Management and Precertification Program. The Medical Management and Precertification Program Administrator will assist and coordinate the initial implementation of any services the patient will need post hospitalization with the attending Physician and the facility. If the

attending Physician feels that it is Medically Necessary for a patient to stay in the medical care facility for a greater length of time than has been precertified, the attending Physician or the medical facility must request the additional service or days.

Concurrent Inpatient Review
Once the inpatient setting has been precertified, the on-going review of the course of treatment becomes the focus of the program. Working directly with your Physician, the Medical Management and Precertification Program Administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

To File a Complaint or Request an Appeal to a Non-Certification
Verbal appeal requests and information regarding the appeal process should be directed to the Medical Management and Precertification Program Administrator as identified on the General Plan Information page of this Medical Plan.

Case Management
When a catastrophic condition, such as a spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the patient's condition is diagnosed, the patient might need extensive services or might be able to be moved into another type of care setting, even to the patient's home.

Case management is a program whereby a Case Manager contacts the patient to obtain consent for case management services. The Case Manager monitors the patient and explores, discusses and recommends coordinated and/or alternate types of appropriate medical care. The Case Manager consults with the patient, family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient.

This plan of care may include some or all of the following:

(1) Personal support to the patient;

(2) Contacting the family to offer assistance and support;

(3) Monitoring Hospital or skilled nursing care or home health care;

(4) Determining alternate care options; and

(5) Assisting in obtaining any necessary equipment and services.

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

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

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

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

Medical Management will not interfere with your course of treatment or the Physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this Program.

The Medical Management and Precertification Program Administrator contact information for this Medical Plan is identified on the Employee insurance card and also on the General Medical Plan Information page

of this Group Health Plan.

Meritain Health 24x7 Nurse Line
The Medical Plan provides coverage for telephonic medical advice provided by specially trained registered nurses for non-emergent care. Common examples of when to use the Meritain Health 24x7 nurse line for non- emergent medical care include but are not limited to the following: medical advice after office hours; care while on vacation; and research and advice on a particular health conditions, lifestyle choices or self-care strategies.

The Meritain Health 24x7 nurse line also provides all Covered Persons with access to the voice-activated Health Information Library with more than 1,500 regularly updated pre-recorded information topics such as:

(1) Choosing a Physician

(2) Chronic conditions

(3) Disease management and prevention

(4) Medications

(5) Mental and emotional health

(6) Nutrition and fitness

(7) Pediatric health

(8) Senior care

(9) Smoking cessation

(10) Sports Injuries

To utilize the confidential Meritain Health 24x7 nurse line service, please call (866) 726-6529.

MEDICAL SCHEDULE OF BENEFITS: VALUE MEDICAL PLAN

IMPORTANT: Meritain Health Medical Management must pre-certify all acute inpatient stays (including acute inpatient rehabilitation and subacute care provided in a facility that has nursing staff on-site 24 hours a day, 7 days a week, and a Physician on call 24 hours a day, 7 days a week), transplants, and all Chemotherapy and Radiation Therapy treatment. See **Medical Management and Precertification Program** of the Medical Plan for details on precertification. If these procedures are not followed, eligible expenses will be reduced by $500 per occurrence, per individual.

The Institute of Excellence (IOE) is a facility that is contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE. Your Participating Provider should confirm if there is an Institute of Excellence (IOE) for your condition.

	AETNA POS PROVIDERS	**NON POS PROVIDERS** (Subject to Usual & Customary Charges)
OVERALL LIFETIME MAXIMUM BENEFIT	Unlimited	
OVERALL CALENDAR YEAR MAXIMUM	Unlimited	
CALENDAR YEAR DEDUCTIBLE Individual Family	$450 $1,350	
CALENDAR YEAR OUT OF POCKET LIMIT (does not include Deductibles) Individual Family	$2,250 $4,500	$3,900 $7,800
Expenses for obtaining medical records will be paid in full to a maximum benefit of $100 per provider.		

	AETNA POS PROVIDERS		**NON POS PROVIDERS** (Subject to Usual & Customary Charges)	
MEDICAL BENEFITS	**Plan Pays**	**Covered Person Pays**	**Plan Pays**	**Covered Person Pays**
Allergy Services	100% after Copay	$25 Copay; Deductible waived (Part of Physician Office Visit benefit)	60%	40% after Deductible
Ambulance Services	80%	20% after Deductible	80%	20% after Deductible; subject to POS Out-of-Pocket Limits
Chiropractic Care Calendar Year Maximum Benefit	100% 20 visits	$25 Copay; Deductible waived	60% 20 visits	40% after Deductible
Durable Medical Equipment	80%	20% after Deductible	80%	20% after Deductible; subject to POS Out-of-Pocket Limits
Emergency Room Services	80%	20% after Deductible	80%	20% after Deductible
Extended Care Facility/ Rehabilitation Facility	80%	20% after Deductible	80%	20% after Deductible; subject to POS Out-of-Pocket Limits

	AETNA POS PROVIDERS		NON POS PROVIDERS (Subject to Usual & Customary Charges)	
MEDICAL BENEFITS	**Plan Pays**	**Covered Person Pays**	**Plan Pays**	**Covered Person Pays**
Hearing Aids Maximum Benefit every 48 months	100% $2,000 per ear	$0 up to plan limit; 100% over limit	100% $2,000 per ear	$0 up to plan limit; 100% over limit; not subject to usual & customary charges
Home Health Care Calendar Year Maximum Benefit	80% 120 visits	20% after Deductible	60% 120 visits	40% after Deductible
Hospice Care	80%	20% after Deductible	80%	20% after Deductible; subject to POS Out-of-Pocket Limits
Hospital Expenses (facility charges) Inpatient Room & Board Allowance Intensive Care Unit Miscellaneous Services & Supplies Outpatient 	80% Semi-private room rate (private room when Medically Necessary) Negotiated Fee 80% 80%	20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible	60% Semi-private room rate (private room when Medically Necessary) Negotiated Fee 60% 60%	40% after Deductible 40% after Deductible 40% after Deductible 40% after Deductible
Maternity	80%	20% after Deductible	60%	40% after Deductible
Mental Disorders Inpatient Outpatient Office Visits All Other Outpatient Care	80% 100% 80%	20% after Deductible $25 Copay; Deductible waived 20% after Deductible	60% 60% 60%	40% after Deductible 40% after Deductible 40% after Deductible
Outpatient Diagnostic Testing, X-ray and Laboratory Services	80%	20% after Deductible	60%	40% after Deductible
Outpatient Lab Card Services	100%	N/A	N/A	N/A

The use of Quest Diagnostics or LabCorp is strictly voluntary. If utilizing these labs for services offered under the Lab Card program, the Medical Plan will pay 100% of the eligible charges a Covered Person incurs for outpatient laboratory services and will waive any of this Medical Plan's Copays, Deductibles and/or Coinsurance requirements. If a Covered Person and/or a Physician elect to use another lab – including the lab in the Physician's office, normal Medical Plan benefits will apply. See the Diagnostic Testing, X-ray and Laboratory Services benefit under **Eligible Medical Expenses** for further details of this program.

	AETNA POS PROVIDERS		NON POS PROVIDERS (Subject to Usual & Customary Charges)	
MEDICAL BENEFITS	**Plan Pays**	**Covered Person Pays**	**Plan Pays**	**Covered Person Pays**
Outpatient Therapies (i.e. physical, speech, occupational)	80%	20% after Deductible	80%	20% after Deductible; subject to POS Out-of-Pocket Limits
Physician Office Visits X-ray and Lab Services Performed in a Physician's Office	100% 100%	$25 Copay; Deductible waived $0	60% 60%	40% after Deductible 40% after Deductible
Routine Cancer Screening (see **Eligible Medical Expenses** for additional limits)	100%	N/A	No Coverage	N/A
Routine Care (age 19 and over) X-ray and Lab Services Performed in a Physician's Office	100% 100%	$25 Copay; Deductible waived $0	No Coverage	N/A
Routine Eye Exam	100%	$25 Copay; Deductible waived	No Coverage	N/A
Routine Mammograms	100%	N/A	No Coverage	N/A
Routine Newborn Care (whether or not the newborn is enrolled as a dependent)	Paid under the mother's maternity benefit	Paid under the mother's maternity benefit	Paid under the mother's maternity benefit	Paid under the mother's maternity benefit
Smoking Cessation Calendar Year Maximum Benefit	100% after Copay 1 program	$25 Copay; Deductible waived	No Coverage	N/A
Substance Use Disorders	Not Covered	Not Covered	Not Covered	Not Covered
Transplants Performed at an Aetna Institute of Excellence (IOE) Facility	80%	20% after Deductible	N/A	N/A
The Institute of Excellence (IOE) is a facility that contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE. Your Participating Provider should confirm if there is an Institute of Excellence (IOE) for your condition.				
Transplants Performed at any Other Facility (non-IOE facility - including a Participating Aetna Facility not specified as an IOE facility)	N/A	N/A	60%	40% after Deductible
Urgent Care Facility	100%	$25 Copay; Deductible waived	60%	40% after Deductible
Well Child Care (up to age 19)	100%	$25 Copay; Deductible waived	No Coverage	N/A

	AETNA POS PROVIDERS		NON POS PROVIDERS (Subject to Usual & Customary Charges)	
MEDICAL BENEFITS	**Plan Pays**	**Covered Person Pays**	**Plan Pays**	**Covered Person Pays**
Wig Due to Chemotherapy Lifetime Maximum Benefit	80% 1 wig	20% after Deductible	60% 1 wig	40% after Deductible
All Other Eligible Expenses	80%	20% after Deductible	60%	40% after Deductible

MEDICAL SCHEDULE OF BENEFITS: PREMIER MEDICAL PLAN

IMPORTANT: Meritain Health Medical Management must pre-certify all acute inpatient stays (including acute inpatient rehabilitation and subacute care provided in a facility that has nursing staff on-site 24 hours a day, 7 days a week, and a Physician on call 24 hours a day, 7 days a week), transplants, and all Chemotherapy and Radiation Therapy treatment. See **Medical Management and Precertification Program** of the Medical Plan for details on precertification. If these procedures are not followed, eligible expenses will be reduced by $500 per occurrence, per individual.

The Institute of Excellence (IOE) is a facility that is contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE. Your Participating Provider should confirm if there is an Institute of Excellence (IOE) for your condition.

	AETNA POS PROVIDERS	**NON POS PROVIDERS** (Subject to Usual & Customary Charges)
OVERALL LIFETIME MAXIMUM BENEFIT	Unlimited	
OVERALL CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE Individual Family	 $400 $1,200	
CALENDAR YEAR OUT-OF-POCKET LIMIT (does not include Deductibles) Individual Family	 $1,750 $3,500	 $2,900 $5,800
Expenses for obtaining medical records will be paid in full to a maximum benefit of $100 per provider.		

	AETNA POS PROVIDERS		**NON POS PROVIDERS** (Subject to Usual & Customary Charges)	
MEDICAL BENEFITS	**Plan Pays**	**Covered Person Pays**	**Plan Pays**	**Covered Person Pays**
Allergy Services	100% after Copay	$20 Copay; Deductible waived (Part of Physician Office Visit benefit)	70%	30% after Deductible
Ambulance Services	90%	10% after Deductible	90%	10% after Deductible; subject to POS Out-of-Pocket Limits
Chiropractic Care Calendar Year Maximum Benefit	100% 20 visits	$20 Copay; Deductible waived	70% 20 visits	30% after Deductible
Durable Medical Equipment	90%	10% after Deductible	90%	10% after Deductible; subject to POS Out-of-Pocket Limits
Emergency Room	90%	10% after Deductible	90%	10% after Deductible
Extended Care Facility/ Rehabilitation Facility	90%	10% after Deductible	90%	10% after Deductible; subject to POS Out-of-Pocket Limits

	AETNA POS PROVIDERS		NON POS PROVIDERS (Subject to Usual & Customary Charges)	
MEDICAL BENEFITS	**Plan Pays**	**Covered Person Pays**	**Plan Pays**	**Covered Person Pays**
Hearing Aids Maximum Benefit every 48 months	100% $2,000 per ear	$0 up to plan limit; 100% over limit	100% $2,000 per ear	$0 up to plan limit; 100% over limit; not subject to usual & customary charges
Home Health Care Calendar Year Maximum Benefit	90% 120 visits	10% after Deductible	70% 120 visits	30% after Deductible
Hospice Care	90%	10% after Deductible	90%	10% after Deductible; subject to POS Out-of-Pocket Limits
Hospital Expenses (facility charges) Inpatient	90%	10% after Deductible	70%	30% after Deductible
Room & Board Allowance	Semi-private room rate (private room when Medically Necessary)		Semi-private room rate (private room when Medically Necessary)	
Intensive Care Unit	Negotiated Fee	10% after Deductible	Negotiated Fee	30% after Deductible
Miscellaneous Services & Supplies	90%	10% after Deductible	70%	30% after Deductible
Outpatient	90%	10% after Deductible	70%	30% after Deductible
Maternity	90%	10% after Deductible	70%	30% after Deductible
Mental Disorders Inpatient	90%	10% after Deductible	70%	30% after Deductible
Outpatient Office Visits	100%	$20 Copay; Deductible waived	70%	30% after Deductible
All Other Outpatient Care	90%	10% after Deductible	70%	30% after Deductible
Outpatient Diagnostic Testing, X-ray and Laboratory Services	90%	10% after Deductible	70%	30% after Deductible
Outpatient Lab Card Services	100%	N/A	N/A	N/A

The use of Quest Diagnostics or LabCorp is strictly voluntary. If utilizing these labs for services offered under the Lab Card program, the Medical Plan will pay 100% of the eligible charges a Covered Person incurs for outpatient laboratory services and will waive any of this Medical Plan's Copays, Deductibles and/or Coinsurance requirements. If a Covered Person and/or a Physician elect to use another lab – including the lab in the Physician's office, normal Medical Plan benefits will apply. See the Diagnostic Testing, X-ray and Laboratory Services benefit under **Eligible Medical Expenses** for further details of this program.

	AETNA POS PROVIDERS		NON POS PROVIDERS (Subject to Usual & Customary Charges)	
MEDICAL BENEFITS	**Plan Pays**	**Covered Person Pays**	**Plan Pays**	**Covered Person Pays**
Outpatient Therapies (i.e. physical, speech, occupational)	90%	10% after Deductible	90%	10% after Deductible; subject to POS Out-of-Pocket Limits
Physician Office Visits X-ray and Lab Services Performed in a Physician's Office	100% 100%	$20 Copay; Deductible waived $0	70% 70%	30% after Deductible 30% after Deductible
Routine Cancer Screening (see **Eligible Medical Expenses** for additional limits)	100%	N/A	No Coverage	N/A
Routine Care (age 19 and over) X-ray and Lab Services Performed in a Physician's Office	100% 100%	$20 Copay; Deductible waived $0	No Coverage	N/A
Routine Eye Exam	100%	$20 Copay; Deductible waived	No Coverage	N/A
Routine Mammograms	100%	N/A	No Coverage	N/A
Routine Newborn Care (whether or not the newborn is enrolled as a dependent)	Paid under the mother's maternity benefit	Paid under the mother's maternity benefit	Paid under the mother's maternity benefit	Paid under the mother's maternity benefit
Smoking Cessation Calendar Year Maximum Benefit	100% after Copay 1 program	$20 Copay; Deductible waived	No Coverage	N/A
Substance Use Disorders	Not Covered	Not Covered	Not Covered	Not Covered
Transplants Performed at an Aetna Institute of Excellence (IOE) Facility	90%	10% after Deductible	N/A	N/A
The Institute of Excellence (IOE) is a facility that contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE. Your Participating Provider should confirm if there is an Institute of Excellence (IOE) for your condition.				
Transplants Performed at any Other Facility (non-IOE facility - including a Participating Aetna Facility not specified as an IOE facility)	N/A	N/A	70%	30% after Deductible
Urgent Care Facility	100%	$20 Copay; Deductible waived	70%	30% after Deductible
Well Child Care (up to age 19)	100%	$20 Copay; Deductible waived	No Coverage	N/A

	AETNA POS PROVIDERS		NON POS PROVIDERS (Subject to Usual & Customary Charges)	
MEDICAL BENEFITS	**Plan Pays**	**Covered Person Pays**	**Plan Pays**	**Covered Person Pays**
Wig Due to Chemotherapy Lifetime Maximum Benefit	90% 1 wig	10% after Deductible	70% 1 wig	30% after Deductible
All Other Eligible Expenses	90%	10% after Deductible	70%	30% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Medical Plan for Prescription Drugs obtained from a Non-Participating Provider.	
Retail Pharmacy: 34-day supply or 100 unit dose (whichever is greater)	
Generic Drug	$10 Copay, then 100%
Brand Name Drug	$30 Copay, then 100%
Mail Order Pharmacy: 90-day supply or 300 unit dose (whichever is greater)	
Generic Drug	$20 Copay, then 100%
Brand Name Drug	$60 Copay, then 100%

PRESCRIPTION DRUG CARD PROGRAM

Eligible expenses include Prescription Drugs and medicines prescribed in writing by a Physician and dispensed by a licensed pharmacist, which are deemed necessary for treatment of an Illness or Injury including but not limited to: insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician, diabetic supplies; smoking deterrents (prescription and over-the-counter).

When your prescription is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 34-day supply or 100 unit dose (whichever is greater).

Expenses for injectables that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under this Medical Plan subject to any applicable major medical Network Deductibles and Coinsurance as well as any coverage limitations and exclusions applicable to the major medical component of the Medical Plan. Please refer to the **Eligible Medical Expenses** and the General Limitations and Exclusions section of the Medical Plan.

There is no Coordination of Benefits for prescription drug charges.

NOTE: Coverage, limitations and exclusions for Prescription Drugs will be determined through the Prescription Drug Card Program elected by the Medical Plan Sponsor and will not be subject to any limitations and exclusions under the major medical component of the Medical Plan (except for injectables that are not covered under the Prescription Drug Card Program). For a complete listing of Prescription Drugs available under the Prescription Drug Card Program, as well as any exclusions or limitations that may apply, please contact the Prescription Drug Card Program Manager identified in the General Group Health Plan Information section of this Group Health Care Plan.

Brand Name Drug: Means a trade name medication.

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

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

Claim Determination / Appeal of Prescription Drug Claims
In the event you receive an Adverse Determination following a request for coverage of a prescription benefit claim, you have the right to appeal the Adverse Determination in writing within 180 days of receipt of notice of the initial coverage decision. To initiate an appeal for coverage, you or your Authorized Representative (such as your Physician), must provide in writing, your name, member ID, phone number, the Prescription Drug for which benefit coverage has been denied and any additional information that may be relevant to your appeal. This information should be mailed to Optum Rx, P.O. Box 9472, Minneapolis, MN 55440-9472. You may call Optum Rx at 855-896-9779, if you have any questions. A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. The notice will include the specific reasons for the decision and the plan provisions on which the decision is based. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. To initiate a second level appeal, you or your authorized representative (such as your Physician), must provide in writing, your name, member ID, phone number, the Prescription Drug for which benefit coverage has been denied and any additional information that may be relevant to your appeal. This information should be mailed to Optum Rx, P.O. Box 9472, Minneapolis, MN 55440-9472. You may call Optum Rx at 855-896-9779, if you have any questions. A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for appeal. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. The decision made on your second level appeal is final and binding.

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 72 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 within 48 hours of receipt of the information.

ELIGIBLE MEDICAL EXPENSES

Eligible expenses shall be the charges actually made for services provided to the Covered Person and will be considered eligible only if the expenses are:

(1) Due to Illness or Injury;

(2) Ordered or performed by a Physician;

(3) Medically Necessary; and

(4) Usual and Customary charges.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted. All eligible expenses Incurred at a Participating Provider will be reimbursed to the provider.

(1) **Allergy Services:** Allergy testing, treatment, serum and injections. Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(2) **Ambulance Service:** Local Medically Necessary professional ground or air ambulance service to transport the Covered Person:

   (a) To the nearest Hospital or Skilled Nursing Facility equipped to treat the specific Illness or Injury in an emergency situation; or

   (b) To another Hospital in the area when the first Hospital did not have services required and/or facilities to treat the Covered Person; or

   (c) When Medically Necessary.

   Professional ground or air ambulance charges for convenience are not covered. Air ambulance is covered only when terrain, distance or condition warrants.

   Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(3) **Ambulatory Surgery Center:** Services and supplies provided by an Ambulatory Surgery Center.

(4) **Anesthetics:** Anesthetics and their professional administration.

(5) **Attention Deficit Disorder:** Diagnosis, testing and treatment for Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder (ADD/ADHD).

(6) **Autism:** Charges for diagnosis, care and treatment of autism and autistic spectrum disorders.

(7) **Blood and Blood Derivatives:** Blood, blood plasma or blood components not donated or replaced.

(8) **Breast Pump:** This expense will be covered as Durable Medical Equipment. Covered items may include: (a) a standard electric pump (non-hospital-grade) while you are pregnant or for the duration of breastfeeding, once every 3 years, or (b) a manual breast pump while pregnant or for the duration of breastfeeding, if you have not received an electric or a manual breast pump in the last 3 years, and (c) another set of breast pump supplies if you get pregnant again before you are eligible for a new pump.

(9) **Cardiac Rehabilitation:** Cardiac rehabilitation services which are rendered: (a) under the supervision of a Physician; and (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery or any other medical condition if medically appropriate; and (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a medical care facility.

Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

(10) **Chemotherapy:** Services and supplies related to chemotherapy. Precertification is required for chemotherapy, see the Medical Management section for further details.

(11) **Chiropractic Care/Spinal Manipulation:** Skeletal adjustments, manipulation or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body, including x-rays. Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(12) **Circumcision:** Services and supplies related to circumcision. Circumcision performed while confined in a Hospital following birth will be paid the same as Routine Newborn Care.

(13) **Clinical Trial Programs:** Clinical trial programs for the treatment of children's cancer with respect to those Dependent Children who:

(a) Are covered under the Medical Plan;

(b) Have been diagnosed with cancer prior to their 19th birthday;

(c) Are enrolled in an approved clinical trial program for treatment of children's cancer; and

(d) Are not otherwise eligible for benefits, payments, or reimbursements from any other third party payors or other similar sources.

(14) **Cosmetic Procedures/Reconstructive Surgery:** Cosmetic procedures or Reconstructive Surgery will be considered eligible only under the following circumstances:

(a) For the correction of a Congenital Anomaly for a Dependent Child.

(b) Any other Medically Necessary Surgery related to an Illness or Injury.

(c) Charges for reconstructive breast Surgery following a mastectomy will be eligible as follows:

(i) Reconstruction of the breast on which the mastectomy has been performed;

(ii) Surgery and reconstruction of the other breast to produce symmetrical appearance; and

(iii) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the Covered Person.

(15) **Dental Care:** Dental services and x-rays rendered by Dentist or dental surgeon for:

(a) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

(b) Emergency repair due to Injury to sound natural teeth including the replacement of sound natural teeth.

(c) Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

(d) Excision of benign bony growths of the jaw and hard palate.

(e) External incision and drainage of cellulitis.

(f) Incision of sensory sinuses, salivary glands or ducts.

(g) Removal of impacted teeth.

General anesthesia and Hospital expenses for a person who is: (a) 7 years of age or younger or is developmentally disabled; (b) an individual for which a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition of the Covered Person; or (c) an individual who has sustained extensive facial or dental trauma.

(16) **Diabetic Education:** The following diabetic education and self-management programs: diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes who adhere to the prognosis and treatment regimen prescribed by a Physician.

(17) **Diabetic Supplies:** All Physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes that are not covered under the Prescription Drug Card Program, including therapeutic shoes and inserts.

(18) **Diagnostic Testing, X-ray and Laboratory Services:** Diagnostic testing, x-ray and laboratory services, including services of a professional radiologist or pathologist. Dental x-rays are not eligible expenses, except as specified under Dental Care.

The use of Quest Diagnostics is strictly voluntary. If a Covered Person uses the services of Quest Diagnostics, benefits will be payable as shown in the **Medical Schedule of Benefits**. When a Physician orders laboratory work, the Covered Person should present the Employee insurance card and verbally request to use Quest Diagnostics. The Physician will then collect the specimen and send to Quest Diagnostics. Any Physician can collect specimens and call (800) 343-3140 for courier pick-up and supplies. In the event the Physician does not participate with Quest Diagnostics, simply take the test orders to an approved collection site for the draw.

Collection site locations can be found by calling or by going to the website at:
www.aetna.com/docfind/custom/mymeritain

The use of Quest Diagnostics covers routine outpatient testing. It does NOT cover: (a) testing ordered during hospitalization; (b) lab work needed on an emergency or STAT basis; (c) testing done at another laboratory; or (d) time sensitive esoteric testing such as bone marrow studies and spinal fluid tests.

Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(19) **Durable Medical Equipment:** The rental of wheelchairs, walkers, special Hospital beds, iron lungs and other Durable Medical Equipment subject to the following:

(a) The equipment must be prescribed by a Physician and Medically Necessary; and

(b) The equipment will be provided on a rental basis; however such equipment may be purchased at the Medical Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the equipment; and

(c) Benefits will be limited to standard models as determined by the Medical Plan; and

(d) The Medical Plan will pay benefits for only one of the following unless Medically Necessary due to growth of the Covered Person or if changes to the Covered Person's medical condition requires a different product, as determined by the Medical Plan: a manual wheelchair, motorized wheelchair or motorized scooter; and

(e) If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible subject to prior approval by the Medical Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Medical Plan, are not covered; and

(f) Expenses for the rental or purchase of any type of air conditioner, air purifier or any other device or appliance will not be considered eligible.

Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(20) **Emergency Room Services:** Treatment in a Hospital emergency room, including professional services. Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(21) **Extended Care Facility:** Extended convalescent care provided in an Extended Care Facility, provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Rehabilitation Facility confinement; and (c) is not for Custodial Care.

See the Rehabilitation Facility benefit for services and supplies provided for confinements in a Rehabilitation Facility.

Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(22) **Genetic Testing**: Diagnostic testing of Genetic Information, counseling and BRAC testing deemed Medically Necessary. Genetic testing is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

Eligible expenses will be payment as show in the **Medical Schedule of Benefits.**

(23) **Hearing Aids**: Hearing aids, required for the correction of a hearing impairment, as prescribed by a Physician or Audiologist. A hearing aid consists of a microphone, amplifier, and receiver. Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(24) **Hemodialysis/Peritoneal Dialysis:** Treatment of a kidney disorder by hemodialysis or peritoneal dialysis as an inpatient in a Hospital or other facility or for expenses in an outpatient facility or in the Covered Person’s home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member, but will not be eligible for payment. When home care replaces inpatient or outpatient dialysis treatments, the Medical Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Covered Person’s home as shown under the Durable Medical Equipment benefit.

(25) **Home Health Care:** Services provided by a Home Health Care Agency to a Covered Person in the home. The following are considered eligible home health care services:

(a) Home nursing care;

(b) Services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R. N.);

(c) Physical, occupational, speech, or respiratory therapy if provided by the Home Health Care Agency;

(d) Medical supplies, drugs and medications prescribed by a Physician;

(e) Laboratory services; and

(f) Nutritional counseling by a licensed dietician.

For the purpose of determining the benefits for home health care available to a Covered Person, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each 4 hours of home health aide services shall be considered as one home health care visit.

In no event will the services of a Close Relative, social worker, transportation services, housekeeping services and meals, etc., be considered an eligible expense.

Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(26) **Hospice Care:** Hospice care on either an inpatient or outpatient basis for a terminally ill person rendered under a Hospice treatment plan. The Hospice treatment plan must certify that the person is terminally ill with a life expectancy of 6 months or less.

Covered services include:

(a) Room and board charges by the Hospice.

(b) Other Medically Necessary services and supplies.

(c) Nursing care by or under the supervision of a registered nurse (R.N.).

(d) Home health care services furnished in the patient's home by a Home Health Care Agency for the following:

(i) health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and

(ii) physical and speech therapy.

(e) Counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family.

(f) Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family within 12 months after the patient's death. For the purposes of bereavement counseling, the term "Patient's Immediate Family" means the patient's Spouse, parents, and/or Dependent children who are covered under the Medical Plan.

Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(27) **Hospital Services or Long-Term Acute Care Facility/Hospital:**

(a) Inpatient

Room and board, including all regular daily services in a Hospital or Long-Term Acute Care Facility/Hospital. Care provided in an Intensive Care Unit (including cardiac care (CCU) and burn units).

Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an inpatient basis.

(b) Outpatient

Services and supplies furnished while being treated on an outpatient basis.

Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(28) **Injectables:** Expenses Incurred by an Employee or a Dependent for injectable medicines, such as human growth hormone injections, that are Medically Necessary for the treatment of a covered Illness or injury that is administered by a Physician, under the supervision of a Physician or registered nurse, are otherwise considered eligible in accordance with the **Medical Schedule of Benefits** and are not otherwise excluded under the General Limitations and Exclusions section of the Group Medical Plan, will be payable subject to any applicable Deductible and Coinsurance.

(29) **Maternity:** Expenses Incurred by an Employee or a Dependent Spouse for:

(a) Pregnancy.

(b) Services provided by a Birthing Center.

(c) One amniocentesis test per pregnancy.

(d) Up to 2 ultrasounds per Pregnancy (more than 2 only when it is determined to be Medically Necessary).

(e) Breast pump: See number (8) under Eligible Medical Expenses.

Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to precertify the maternity admission, unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified or a penalty may be applied.

Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(30) **Medical and Surgical Supplies:** Casts, splints, trusses, braces, crutches, dressings, orthotics (excluding foot orthotics), and other Medically Necessary supplies ordered by a Physician.

(31) **Mental Disorders:** Charges for inpatient and outpatient treatment of Mental Disorders, including emergency care, transition day treatment, partial hospitalization, and transitional rehabilitation will be payable as shown in the **Medical Schedule of Benefits**.

(32) **Morbid Obesity:** Charges for the care and treatment of Morbid Obesity (including surgical treatment). Surgical treatment for Morbid Obesity will only be covered if all the following conditions are met:

(a) The Covered Person has either (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy or musculoskeletal dysfunction.

(b) The Covered Person has at least a 24-month history of Morbid Obesity as documented in such person's medical records.

(c) The Covered Person has failed to achieve and maintain significant weight loss and such person has participated in a Physician-supervised nutrition and exercise program for at least 6 months (occurring within the 24-month period prior to the proposed surgical treatment) and such participation is documented in his or her medical records.

(d) The Covered Person must be evaluated by a licensed professional counselor, psychologist or psychiatrist within 12 months prior to the proposed surgical treatment. The evaluation should document the following:

(i) that there is no significant psychological problem that would limit the ability of the Covered Person to understand the procedure and comply with any medical and/or surgical

recommendations;

(ii) any psychological co-morbidities that may be contributing to the Covered Person's inability to lose weight or a diagnosed eating disorder; and

(iii) the Covered Person's willingness to comply with the preoperative and postoperative treatment plans.

(33) **Nutritional Supplements:** Physician-prescribed nutritional supplements or other enteral supplementation necessary to sustain life, including rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation.

Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(34) **Occupational Therapy:** Rehabilitative occupational therapy rendered by a qualified Physician or a licensed occupational therapist under the recommendation of a Physician. Expenses for Maintenance Therapy or therapy primarily for recreational or social interaction will not be considered eligible. Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(35) **Outpatient Pre-Admission Testing:** Outpatient pre-admission testing performed within 7 days of a scheduled inpatient hospitalization or Surgery. Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(36) **Oxygen:** Oxygen and rental of equipment for its administration**.**

(37) **Phenylketonuria:** Special dietary treatment for phenylketonuria (PKU) when recommended by a Physician.

(38) **Physical Therapy:** Physical therapy rendered by a qualified Physician or a licensed physical therapist under the recommendation of a Physician. Maintenance Therapy will not be considered eligible. Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(39) **Physician Services:** Services of a Physician for medical care or Surgery.

(a) Services performed in a Physician's office on the same day for the same or related diagnosis. Services include, but are not limited to: examinations, supplies, injections, x-ray and laboratory tests (including the reading or processing of the tests), cast application and minor Surgery. If more than one Physician is seen in the same clinic on the same day, only one Copay will apply.

(b) Diagnostic x-ray and laboratory services which are ordered on the same day as the office visit, but performed or read at a later date and/or at another facility will be considered a separate benefit and will be payable subject to the Deductible and Coinsurance.

(c) For multiple or bilateral surgeries performed during the same operative session which are not incidental or not part of some other procedure and which add significant time or complexity (all as determined by the Medical Plan) to the complete procedure, the charge considered will be: (i) 100% for the primary procedure; (ii) 50% for the secondary procedure, including any bilateral procedure; and (iii) 50% for each additional covered procedure. This applies to all Surgical Procedures, except as determined by the Medical Plan.

(d) For surgical assistance by an Assistant Surgeon, the charge will be 25% of the Usual and Customary Charge for the corresponding Surgery.

Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**

(40) **Podiatry:** Treatment for the following foot conditions: (a) routine foot care needed due to a diabetic condition; (b) bunions, when an open cutting operation is performed; (c) non-routine treatment of corns or calluses; (d) toenails when at least part of the nail root is removed; or (e) any Medically Necessary Surgical Procedure required for a foot condition.

(41) **Private Duty Nursing:** Private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to the following extent:

(a) Inpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit. Inpatient Private Duty Nursing must be supported by a certification from the attending Physician.

(b) Outpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature. Charges covered for outpatient nursing care billed by a Home Health Care Agency are shown under Home Health Care Services and Supplies. Outpatient private duty nursing care not billed by a Home Health Care Agency must be supported by a certification and a treatment plan from the attending Physician.

(42) **Prosthetic Devices:** Artificial limbs, eyes or other prosthetic devices when necessary due to an Illness or Injury. This benefit includes any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Medical Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Medical Plan, are not covered.

(43) **Pulmonary Therapy:** Pulmonary therapy under the recommendation of a Physician.

(44) **Radiation Therapy:** Radium and radioactive isotope therapy treatment. Precertification is required for radiation therapy, see the Medical Management section for further details.

(45) **Reconstructive Surgery:** See Cosmetic Procedures/Reconstructive Surgery.

(46) **Rehabilitation Facility:** Inpatient care in a Rehabilitation Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Extended Care Facility confinement; and (c) is not for Custodial Care.

See the Extended Care Facility benefit for services and supplies provided for confinements in an Extended Care Facility.

Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(47) **Routine Cancer Screening (POS Provider only):** The following routine cancer screening procedures (as outlined by the American Cancer Society) will be payable as shown in the **Medical Schedule of Benefits**:

Colon and Rectal Exams
Beginning at age 50, both men and women are eligible for these 5 testing schedules:

(a) Yearly fecal occult blood test (FOBT).

(b) Flexible sigmoidoscopy every 5 years.

(c) Yearly fecal occult blood test plus flexible sigmoidoscopy every 5 years.

(d) Double-contrast barium enema every 5 years.

(e) Colonoscopy every 5 years.

Cervical Cancer

(a) Beginning at age 21, annual screenings are eligible every year with the regular Pap test or every 2 years with the new liquid-based Pap test.

(b) Beginning at age 30, women who have had three normal Pap test results in a row may get screened

every 2 to 3 years with either the convention (regular) or liquid-based Pap test. Women who have certain risk factors such as diethylstilbestrol (DES) exposure before birth, HIV infection, or a weakened immune system due to organ transplant, chemotherapy, or chronic steroid use may continue to be screened annually.

(c) Women over 30 may also be screened every 3 years (but not more frequently) with the convention or liquid-based Pap test, plus the HPV DNA test.

(d) Women 70 years of age or older who have had 3 or more normal Pap tests in a row and no abnormal Pap test results in the last 10 years may choose to stop having cervical cancer screening. Women with a history of cervical cancer, DES exposure before birth, HIV infection or a weakened immune system may continue to have screening as long as they are in good health.

(e) Women who have had a total hysterectomy (removal of the uterus and cervix) may choose to stop having cervical cancer screening, unless the surgery was performed as a treatment for cervical cancer or precancer. Women who have had a hysterectomy without the removal of the cervix may continue to follow the guidelines above.

Prostate Cancer

(a) Beginning at age 50, both the prostate-specific antigen (PSA) blood test and digital rectal examination (DRE) may be offered annually to men who have at least a 10 year life expectancy.

(b) Men at high risk (African-American men and men with a strong family history of one or first degree relatives (father, brothers) diagnosed at an early age) may begin testing at age 45.

(c) Men at even higher risk, due to multiple first-degree relatives affected at an early age, may begin testing at age 40.

Endometrial (Uterine) Cancer

(a) For women with or at high risk for hereditary nonpolyposis colon cancer (HNPCC), annual screening may be eligible for endometrial cancer with endometrial biopsy beginning at age 35.

Mammograms

(a) Routine mammograms (both traditional mammograms and breast tomosynthesis (3D mammograms)) may be payable as follows: (a) yearly mammograms starting at age 40 and continuing for as long as a woman is in good health; and (b) clinical breast exams (CBE) may be part of a periodic health exam every 3 years for women in their 20s and 30s and every year for women 40 and over.

BRCA and Genomic Testing

(a) Medically Necessary molecule susceptibility testing for breast and/or epithelial ovarian cancer (BRCA testing) may be covered for high risk adults.
(b) Medically Necessary standard care genomic testing for certain types of cancer may be covered.

If a diagnosis is indicated after any routine screening procedure, the screening will still be payable under the routine cancer screening benefit, however, all charges related to the diagnosis (except the initial screening) will be payable as any other Illness.

(48) **Routine Care (POS Provider Only):** Routine care age 19 and over, including, but not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or inoculations, pap smears, mammograms, colon exams and PSA testing. If a diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other Illness. Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

Any routine cancer screening procedures which fall outside the parameters as listed under Routine Cancer Screenings will be payable under this Routine Care benefit.

(49) **Routine Eye Examination:** Routine eye examination and refraction including the related office visit. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(50) **Routine Newborn Care:** Routine newborn care including Hospital nursery expenses and routine pediatric care while confined following birth will be payable as shown in the **Medical Schedule of Benefits**.

If the newborn is ill, suffers an Injury or requires care other than routine care, benefits will be provided on the same basis as any other eligible expense, provided the newborn is enrolled as an eligible Dependent.

(51) **Second Surgical Opinion:** Voluntary second surgical opinions for elective, non-emergency Surgery when recommended for a Covered Person.

Benefits for the second opinion will be payable only if the opinion is given by a specialist who: (a) is certified in the field related to the proposed Surgery; and (b) is not affiliated in any way with the Physician recommending the Surgery.

If the second opinion conflicts with the first opinion, the Covered Person may obtain a third opinion, although this is not required.

(52) **Sleep Disorders:** Sleep disorder treatment that is Medically Necessary.

(53) **Smoking Cessation:** Smoking cessation programs and office visits will be payable as shown in the **Medical Schedule of Benefits**. Smoking deterrents will be payable as shown in the Prescription Drug Card Program.

(54) **Speech Therapy:** Restorative or rehabilitative speech therapy under the recommendation of Physician and necessary because of loss or impairment due to an Illness, or Surgery or therapy to correct a Congenital Anomaly other than a learning disorder. Speech Therapy for developmental delay will not be considered eligible. Outpatient Speech Therapy will be payable as shown in the **Medical Schedule of Benefits**.

(55) **Temporomandibular Joint Dysfunction (TMJ):** Surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).

The treatment of jaw joint disorders (TMJ) includes conditions of structures linking the jawbone and skull and complex muscles, nerves and other tissues related to the temporomandibular joint.

(56) **Therapeutic Shoes or Inserts:** Services and supplies will be covered as Durable Medical Equipment for members who are diabetic and have severe diabetic foot disease. Covered benefit includes purchase and fitting of either one pair of custom-molded shoes and inserts or one pair of extra-depth shoes each Calendar Year. This benefit will also cover 2 additional pairs of inserts each Calendar Year for custom-molded shoes and 3 pairs of inserts each Calendar Year for extra-depth shoes.

(57) **Transplants (other than those received through the Aetna IOE Program):** Services and supplies in connection with Medically Necessary non-Experimental and/or non-Investigational transplant procedures, subject to the following conditions:

Case Management is REQUIRED for transplant related claims when using the Aetna Network.

(a) A concurring opinion must be obtained prior to undergoing any transplant procedure. This mandatory opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this concurring opinion must be qualified to render such a service either through experience, specialist training, education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual Surgery.

(b) If the donor is covered under this Medical Plan and the recipient is not, then the Medical Plan will cover donor organ or tissue charges for (i) evaluating the organ or tissue; (ii) removing the organ or tissue from the donor. No transportation charges will be considered. This Medical Plan will always

pay secondary to any other coverage. If the donor is not covered under this Medical Plan, reference provision (d). If the recipient is covered under this Medical Plan, eligible medical expenses Incurred by the recipient will be considered eligible.

(c) If both the donor and the recipient are covered under this Medical Plan, eligible medical expenses Incurred by each person will be treated separately for each person.

(d) The Usual and Customary fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology and pathology fees for the removal of the organ, and a Hospital's charge for storage or transportation of the organ will be considered eligible.

Transplant coverage is limited to those transplants that are medically recognized and are non-Experimental/Investigational in nature. Transplants contrary to Church Doctrine are not considered eligible expenses.

See the Aetna Institute of Excellence (IOE) Program section of the Medical Plan with respect to coverage for transplants received through the Aetna IOE Program.

Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

Exclusions:

(a) Non-human and artificial organ transplants.

(b) The purchase price of any of bone marrow, organ, tissue or any similar items which are sold rather than donated.

(c) Transplants which are not medically recognized and are Experimental and/or Investigational in nature.

(d) Transplants contrary to Church Doctrine are not considered eligible expenses.

(58) **Urgent Care Facility:** Services and supplies provided by an Urgent Care Facility. Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(59) **Well Child Care (POS Provider Only):** Routine well child care up to age 19, including, but not limited to, vaccinations and immunizations, routine office visits, developmental assessments, and related laboratory tests and x-rays. Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

(60) **Wigs:** Purchase of a scalp hair prosthesis when necessitated by hair loss due to chemotherapy or radiation. Eligible expenses will be payable as shown in the **Medical Schedule of Benefits**.

AETNA INSTITUTE OF EXCELLENCE (IOE) PROGRAM

The Institute of Excellence (IOE) is a facility that contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE. Your Participating Provider should confirm if there is an Institute of Excellence (IOE) for your condition.

Transplant Expenses
Once it has been determined that you or one of your eligible Dependents may require an organ transplant, you or your Physician must call the Medical Management and Precertification Program Administrator to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements. Organ means solid organ; stem cell; bone marrow and tissue.

Benefits may vary if an IOE facility or a non-IOE facility is used. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered at the Participating Provider level only if performed in a facility that has been designated as an IOE facility or that is an Aetna Participating Provider facility that has a single case rate agreement between an Aetna Participating Provider and Aetna for the type of transplant in question. Any treatment or service related to transplants that are provided by a facility that is not specified as an IOE network facility or that is not an Aetna Participating Provider facility that has a single case rate agreement between an Aetna Participating Provider and Aetna, even if the facility is considered a Participating Provider for other types of services, will be covered at the Non-Participating Provider level. Please read each section below carefully.

Covered Transplant Expenses
Covered transplant expenses include the following:

(1) Charges for activating the donor search process with national registries.

(2) Compatibility testing of prospective organ donors that are immediate family members. For purposes of this section an “immediate” family member is defined as a first-degree biological relative. These are your biological parent, sibling or child.

(3) Inpatient and outpatient expenses directly related to a transplant.

(4) Charges made by a Physician or a transplant team.

(5) Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.

(6) Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant services are typically Incurred during the 4 phases of transplant care described below. Expenses Incurred for one transplant during these 4 phases of care will be considered one transplant occurrence.

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

The 4 phases of one transplant occurrence and a summary of covered transplant expense during each phase are as follows:

(1) Pre-transplant evaluation/screening. Pre-transplant evaluation screening includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.

(2) Pre-transplant candidacy screening. Pre-transplant candidacy screening includes Human Leukocyte Antigen (HLA) typing/compatibility testing of prospective organ donors that are immediate family members.

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

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

One Transplant Occurrence
The following are considered one transplant occurrence:

(1) Heart.

(2) Lung.

(3) Heart/Lung.

(4) Simultaneous Pancreas Kidney (SPK).

(5) Pancreas.

(6) Kidney.

(7) Liver.

(8) Intestine.

(9) Bone marrow/stem cell transplant.

(10) Multiple organs replaced during one transplant surgery.

(11) Tandem transplants (stem cell).

(12) Sequential transplants.

(13) Re-transplant of same organ type within 180 days of first transplant.

(14) Any other single organ transplant, unless otherwise excluded under the Medical Plan.

More Than One Transplant Occurrence
The following are considered more than one transplant occurrence:

(1) Autologous blood/bone marrow transplant followed by allogeneic blood/bone marrow transplant (when not part of a tandem transplant).

(2) Allogeneic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant).

(3) Re-transplant after 180 days of the first transplant.

(4) Pancreas transplant following a kidney transplant.

(5) A transplant necessitated by an additional organ failure during the original transplant surgery/process.

(6) More than one transplant when not performed as part of a planned tandem or sequential transplant (i.e. a liver transplant with subsequent heart transplant).

Limitations
Transplant coverage does not include charges for the following:

(1) Outpatient drugs, including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.

(2) Services and supplies furnished to a donor when recipient is not a Covered Person.

(3) Home infusion therapy after the transplant occurrence.

(4) Harvesting or storage of organs without the expectation of immediate transplant for an existing Illness.

(5) Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing Illness.

(6) Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Medical Plan.

Travel and Lodging Expenses
Travel and lodging expenses will be covered under the Medical Plan subject to the conditions described below.

(1) Distance requirement. The IOE facility must be more than 100 miles away from the patient's residence.

(2) Travel allowances. Travel is reimbursed between the patient's home and the facility for round trip (air, train or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll cost will be reimbursed per IRS guidelines.

(3) Lodging allowances. Reimbursement of expenses Incurred by the patient and any companion for hotel lodging away from home is reimbursed at a rate of $50 per night per person, to a maximum of $100 per night.

(4) Overall maximum. Travel and lodging reimbursement is limited to $10,000 for any one transplant or procedure type, including tandem transplants. This is a combined maximum for the patient, companion and donor.

(5) Companions. One companion is permitted per adult and 2 parents or guardians are permitted per Child.

ALTERNATE BENEFITS

In addition to the benefits specified, the Medical Plan may elect to offer benefits for services furnished by any provider pursuant to a Medical Plan-approved alternate treatment plan, in which case those charges Incurred for services provided to a Covered Person under an alternate treatment plan to its end, will be more cost effective than those charges to be Incurred for services to be provided under the current treatment plan to its end.

The Medical Plan shall provide such alternate benefits at its sole discretion and only when and for so long as it determines that alternate treatment plan is Medically Necessary and cost effective. If the Medical Plan elects to provide alternate treatment plan benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for such Covered Person in any other instance or for other Covered Persons under this Medical Plan in any other instance, nor shall it be construed as a waiver of the Employer's rights to administer this Medical Plan thereafter in strict accordance with its express terms.

GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Medical Plan for expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Medical Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations or other terms of the Medical Plan.

(1) **Abortions:** Expenses related to abortions will not be considered eligible.

(2) **Acupuncture:** Expenses for acupuncture will not be considered eligible.

(3) **Administrative Services:** Expenses for claim forms, shipping and handling, sales tax, and telephone consultations will not be considered eligible.

(4) **After Termination Date:** Expenses which are Incurred after the termination date of your coverage under the Medical Plan will not be considered eligible.

(5) **Alcohol:** Expenses Incurred for services, supplies, care or treatment of an Injury or Illness which occurred as a result of that Covered Person's illegal use of alcohol will not be considered eligible. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for injured Covered Persons other than the person illegally using alcohol. Treatment as specified in the Medical Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(6) **Biofeedback:** Expenses related to biofeedback will not be considered eligible.

(7) **Breast Surgery:** Expenses for treatment of gynecomastia will not be considered eligible.

(8) **Cardiac Rehabilitation:** Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

(9) **Chelation Therapy:** Expenses for chelation therapy will not be considered eligible, unless due to heavy metal poisoning.

(10) **Close Relative:** Expenses for services, care or supplies provided by a person who normally resides in the Covered Person's home or by a Close Relative will not be considered eligible.

(11) **Cognitive and Kinetic Therapy:** Expenses for cognitive therapy and kinetic therapy will not be considered eligible. Cognitive therapy is defined as therapy which embraces mental activities associated with thinking, learning and memory. Kinetic therapy is defined as therapy related to motion or movement (e.g., the study of motion, acceleration or rate of change). This exclusion will not apply to the diagnosis, testing and treatment of ADD, ADHD or autism.

(12) **Complications:** Expenses for care, services or treatment required as a result of complications from a treatment or procedure not covered under the Medical Plan will not be considered eligible.

(13) **Contraceptives:** Expenses for contraceptive procedures and devices, including but not limited to, oral contraceptives, morning after pills, or patches (unless for purposes other than birth control and determined to be Medically Necessary), and the placement or removal of a contraceptive device will not be considered eligible.

(14) **Controlled Substance:** Expenses for services, supplies, care or treatment to a Covered Person for Injury or Illness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician will not

be considered eligible. Expenses will be covered for injured Covered Persons other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(15) **Convenience Items:** Expenses for personal hygiene and convenience items will not be considered eligible.

(16) **Cosmetic Procedures:** Expenses for Cosmetic and reconstructive procedures will not be considered eligible, except as specified under **Eligible Medical Expenses**.

(17) **Counseling:** Expenses for religious, marital, family, or relationship counseling will not be considered eligible, except as specified under Hospice Care.

(18) **Custodial Care:** Expenses for Custodial Care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits.

(19) **Dental Care:** Expenses Incurred in connection with dental care, treatment, x-rays, general anesthesia or Hospital expenses will not be considered eligible, except as specified under **Eligible Medical Expenses**.

(20) **Developmental Delays:** Expenses in connection with the treatment of developmental delays, including, but not limited to speech therapy, occupational therapy, physical therapy and any related diagnostic testing will not be considered eligible. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of ADD, ADHD or autism.

(21) **Elastic Bandages:** Expenses for elastic bandages will not be considered eligible, except for Medically Necessary compression items.

(22) **Exercise Programs:** Expenses for exercise programs for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Medical Plan.

(23) **Experimental and/or Investigational:** Expenses for treatment, procedures, devices, services, supplies, drugs or medicines which are determined to be Experimental and/or Investigational will not be considered eligible. This exclusion will not apply to clinical trial programs covered under **Eligible Medical Expenses** section of the Medical Plan.

This exclusion will also not apply if the treatment the Covered Person is receiving is the only treatment available and/or is considered standard of care and does not violate church doctrine.

(24) **Felony / Illegal Occupation:** Expenses caused or contributed by a Covered Person committing or attempting an assault, felony or criminal act, participating in an illegal occupation, or actively participating in a violent disorder or riot will not be considered eligible. Actively participating does not include being at the scene of a violent disorder or riot while performing their official duties. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

(25) **Foot Care:** Expenses for routine foot care, treatment of weak, unstable or flat feet will not be considered eligible, unless due to a diabetic condition.

(26) **Foot Orthotics:** Expenses for foot orthotics, orthopedic shoes, arch supports or for the exam, prescription or fitting thereof will not be considered eligible. This exclusion does not apply to therapeutic shoes due to a diabetic condition. See coverage under **Eligible Medical Expenses** section of the Medical Plan.

(27) **Governmental Agency:** Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Medical Plan will be primary. Benefits payable under this Medical Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).

(28) **Growth Hormones:** Expenses for growth hormone drugs or stimulants will not be considered eligible, unless deemed Medically Necessary.

(29) **Hair Loss:** Expenses for care and treatment of hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, will not be considered eligible, except as specified under **Eligible Medical Expenses**.

(30) **Hearing Aids:** Expenses for hearing aids (including the fitting thereof) will not be considered eligible unless prescribed by a Physician or an Audiologist, and except as specified under **Eligible Medical Expenses**.

(31) **Home Births:** Expenses related to giving birth at home will not be considered eligible.

(32) **Homeopathic Treatment:** Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.

(33) **Hospital Employees:** Expenses for professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service will not be considered eligible.

(34) **Human Subject Study:** Expenses which are performed subject to the Covered Person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study experiment will not be considered eligible, except for clinical trials as specified under **Eligible Medical Expenses**.

(35) **Hypnotherapy:** Expenses for hypnotherapy will not be considered eligible.

(36) **Infertility:** Expenses for confinement, treatment, testing or services related to infertility (the inability to conceive) or the promotion of conception will not be considered eligible.

(37) **Maintenance Therapy:** Expenses for Maintenance Therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.

(38) **Massage Therapy:** Expenses for massage therapy will not be considered eligible, unless when part of an overall patient treatment plan. Expenses for Rolfing will not be considered eligible.

(39) **Maternity:** Maternity expenses Incurred by a Dependent other than an Employee's Spouse will not be considered eligible.

(40) **Medically Necessary:** Expenses which are determined not to be Medically Necessary will not be considered eligible.

(41) **Missed Appointments:** Expenses for missed appointments will not be considered eligible.

(42) **No Legal Obligation:** Expenses for services provided for which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires this Employer's plan to be primary.

(43) **Not Performed Under the Direction of a Physician:** Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

(44) **Not Recommended by a Physician:** Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.

(45) **Nutritional Supplements:** Expenses for nutritional supplements, special infant formulas, or other enteral supplementation will not be considered eligible, unless received in an inpatient Hospital environment, or as prescribed by a Physician, or as specified under **Eligible Medical Expenses**. Equipment used to administer nutritional supplements or other enteral supplementation may be covered by the Plan.

(46) **Obesity:** Expenses for weight loss programs or treatment of obesity will not be considered eligible, except for Morbid Obesity (see **Eligible Medical Expenses**).

(47) **Occupational Therapy:** Expenses for occupational therapy primarily for recreational or social interaction will not be considered eligible.

(48) **Operated by the Government:** Expenses for treatment at a facility owned or operated by the government will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.

(49) **Outside the United States (U.S.):** Expenses for services or supplies if the Covered Person leaves the United States, the U.S. Territories, or Canada for the express purpose of receiving medical treatment will not be considered eligible.

(50) **Over-the-Counter (OTC) Medication:** Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible.

(51) **Prior to Effective Date:** Expenses which are Incurred prior to the effective date of your coverage under the Medical Plan will not be considered eligible.

(52) **Radioactive Contamination:** Expenses Incurred as the result of radioactive contamination or the hazardous properties of nuclear material will not be considered eligible.

(53) **Recreational and Educational Therapy:** Expenses for recreational and educational services; learning disabilities; behavior modification services; vocational testing or training; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies; will not be considered eligible. Diabetic education is considered eligible as specified under **Eligible Medical Expenses**. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of ADD, ADHD or autism.

(54) **Refractive Errors:** Expenses for radial keratotomy, Lasik Surgery or any Surgical Procedure, including after cataract Surgery, to correct refractive errors of the eye will not be considered eligible.

(55) **Self-Inflicted Injury:** Expenses for Injury or Illness arising out of attempted suicide or an intentional self-inflicted Injury will not be considered eligible. This exclusion will not apply if self-inflicted Injuries result from a medical condition (physical or mental) and the benefits for such Injuries are normally covered under the Medical Plan.

(56) **Sex Transformation:** Expenses for care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change will not be considered eligible. This exclusion includes medications, implants, hormone therapy, Surgery, medical or psychiatric treatment.

(57) **Sexual Dysfunction:** Expenses for services, supplies or drugs related to sexual dysfunction not related to organic disease will not be considered eligible. Expenses for sex therapy will not be considered eligible.

(58) **Sterilization:** Expenses for elective sterilization or the reversal thereof will not be considered eligible.

(59) **Substance Use Disorders:** Inpatient and outpatient treatment and detoxification services for Substance Use Disorder will not be considered eligible.

(60) **Surrogate:** Expenses relating to a surrogate pregnancy of any person who is not covered as an Employee

or as a Spouse under this Medical Plan, including but not limited to pre-pregnancy, conception, pre-natal, childbirth and post-natal expenses, will not be considered eligible.

(61) **Travel:** Expenses for travel will not be considered eligible, except ambulance services as specified under **Eligible Medical Expenses**.

(62) **Usual and Customary Charge:** Expenses in excess of the Usual and Customary Charge will not be considered eligible.

(63) **Vision Care:** Expenses for vision care, including professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices will not be considered eligible, except routine eye exams as specified under **Eligible Medical Expenses.** However, benefits will be provided for initial eyeglass frames and lenses (or one pair of contact lenses) following cataract surgery that implants an Intra Ocular Lens (IOL), if necessary. This does not apply to aphakic patient and soft lenses or sclera shells intended for use as corneal bandages.

(64) **Vitamins:** Expenses for vitamins, minerals and food supplements will not be considered eligible, except as prescribed by a Physician.

(65) **Vocational Testing:** Expenses for vocational testing or training will not be considered eligible.

(66) **Wage or Profit:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for wage or profit (including self-employment) will not be considered eligible.

(67) **War:** Expenses for the treatment of Illness or Injury resulting from a war or any act of war or terrorism, whether declared or undeclared, civil war, hostilities or invasion, or while in the armed forces of any country or international organization will not be considered eligible.

(68) **Weekend Admissions:** Expenses for care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or Saturday will not be considered eligible, unless Surgery is scheduled within 24 hours.

(69) **Workers' Compensation:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Workers' Compensation Law or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Workers' Compensation or similar law and have reached the maximum reimbursement paid under Workers' Compensation or similar law will not be eligible for payment under this Medical Plan.

CLAIM AND APPEAL PROCEDURES

You will receive an Employee identification card which will contain important information, including claim filing directions and contact information. The Employee identification card will show your Participating Provider Network and the Medical Management Administrator.

At the time you receive treatment, show the Employee identification card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by sending it to the address listed on the Employee identification card. Other general information or inquiries should be sent to:

Meritain Health, Inc.
P.O. Box 27810
Minneapolis, MN 55427-0810
(800) 925-2272

Most claims under the Plan will be "post service claims." A "post service claim" is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

(1) The date of service;

(2) The name, address, telephone number and tax identification number of the provider of the services or supplies;

(3) The place where the services were rendered;

(4) The diagnosis and procedure codes;

(5) The amount of charges (including Network repricing information);

(6) The name of the Plan;

(7) The name of the covered Employee; and

(8) The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure or treatment is a Covered Expense before the treatment is rendered, is not a "claim" since an actual written claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Timely Filing
All claims must be filed with the Claims Administrator within 1 year following the date services were Incurred. Claims filed after this time period will be denied.

For Medical, Dental and Vision Claims	For Prescription Drug Claims
Meritain Health P.O. Box 853921 Richardson TX 75085-3921 800-925-2272	OptumRx P.O. Box 9472 Minneapolis, MN 55440-9472 (855) 896-9779 www.optumrx.com

Procedures for all Claims
The Plan's claim procedures are modeled on the Department of Labor's claims procedures regulations.

To receive benefits under the Plan, the claimant (i.e. you and your covered Dependents) must follow the procedures outlined in this section. There are 4 different types of claims: (1) Urgent Care Claims; (2) Concurrent Care Claims; (3) Pre-Service Claims; and (4) Post-Service Claims. The procedures for each type of claim are more fully described below:

(1) **Urgent Care Claims**. If your claim is considered an urgent care claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless you fail to provide sufficient information to determine whether or to what extent, benefits are covered or payable under the Plan. If you fail to provide sufficient information for the Plan to decide your claim, the Plan Administrator will notify you as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A claim for benefits is considered an urgent care claim if the application of the time periods for making non- urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

(2) **Concurrent Care Claims**. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an Adverse Determination. In such a case, the Plan Administrator will notify you of the Adverse Determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that Adverse Determination before reduction or termination of the benefit.

Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies. The Plan Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

(3) **Pre-Service Claims**. For a pre-service claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time to notify you of the Plan's benefit determination for up to 15 days, provided that the Plan Administrator notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Plan Administrator expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(4) **Post-Service Claims**. For a post-service claim, the Plan Administrator will notify you of the Plan's Adverse Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days provided that the Plan Administrator notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received (or any other claim for health benefits that is not a pre-service claim or an urgent care claim).

Manner and Content of Notice of Initial Adverse Determination
If the Plan Administrator denies a claim, it must provide to you in writing or by electronic communication:

(1) An explanation of the specific reasons for the Adverse Determination;

(2) A reference to the Plan provision or insurance contract provision upon which the Adverse Determination is based;

(3) A description of any additional information or material that you must provide in order to perfect the claim;

(4) An explanation of why the additional material or information is necessary;

(5) Notice that you have the right to request a review of the Adverse Determination and information on the steps to be taken if you wish to request a review of the Adverse Determination along with the time limits applicable to a request for review;

(6) A statement describing your right to request a second level appeal, or if applicable, to bring an action for judicial review;

(7) A copy of any rule, guideline, protocol or other similar criterion relied upon in making the Adverse Determination(or a statement that the same will be provided upon your request and without charge); and

(8) If the Adverse Determination is based on the Plan's Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge.

For an Adverse Determination concerning an urgent care claim, the information described in this Section may be provided to you orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to you no later than 3 days after the oral notification.

Internal Review of Initial Adverse Benefit Determination and Appeal Procedures
If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that Adverse Determination under the appeal procedures described below.

You have 180 days after you receive notice of an initial Adverse Determination within which to request a review of the Adverse Determination. For a request for a second level appeal, you have 60 days after you receive notice of an Adverse Determination at the first level of appeal to request a second level appeal of the Adverse Determination.

If you request a review of an Adverse Determination within the applicable time period, the review will meet the following requirements:

(1) The Plan will provide a review that does not afford deference to the Adverse Determination that is being appealed and that is conducted by an appropriate representative of the Plan who did not make the Adverse

Determination that is the subject of the appeal and who is not a subordinate of the individual who made that Adverse Determination.

(2) The appropriate representative of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any Adverse Determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the Adverse Determination that is the subject of the appeal, nor a subordinate of any such individual.

(3) The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan's review of an Adverse Determination, without regard to whether the advice is relied upon in making the Adverse Determination on review.

(4) For a requested review of an Adverse Determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.

(5) The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim and to submit issues and comments relating to the claim in writing to the Plan. The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

All requests for review of initial Adverse Determinations (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P. O. Box 41980
Plymouth, MN 55441-0970

Deadline for Internal Review and Appeal of Initial Adverse Benefit Determinations

(1) Urgent Care Claims. The Plan provides for 2 levels of appeal for urgent care claims. For each level of appeal, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 36 hours after the Plan receives your request for review of the initial Adverse Determination (or of the first-level appeal Adverse Determination).

(2) Pre-Service Claims. The Plan provides for 2 levels of appeal for a pre-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after the Plan receives your request for review of the initial Adverse Determination (or of the first-level appeal Adverse Determination).

(3) Post-Service Claims. The Plan provides for 2 levels of appeal for a post-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial Adverse Determination (or of the first-level appeal Adverse Determination).

Manner and Content of Notice of Decision on Internal Review of Initial Adverse Benefit Determinations
Upon completion of its review of an initial Adverse Determination (or a first-level appeal Adverse Determination), the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an Adverse Determination, the notice will include:

(1) A description of the Plan's decision;

(2) The specific reasons for the decision;

(3) The relevant Plan provisions or insurance contract provisions on which its decision is based;

(4) A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits;

(5) A statement describing your right to request a second level appeal or, if applicable, to bring an action for judicial review;

(6) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to you upon request;

(7) If the Adverse Determination on review is based on a Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances or (b) a statement that such an explanation will be provided without charge upon request.

Calculation of Time Periods for Appeals
For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review of an adverse benefit determination) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

Adverse Determination
For purposes of the Plan's claim procedures, an " Adverse Determination " is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary or appropriate. Adverse Determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

Plan's Failure to Follow Procedures
If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy under state or federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

State Insurance Laws
Nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable state law.

Statute of Limitations for Plan Claims and Appeals
Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Appointment of Authorized Representative
A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Third Party Administrator. However, in connection with a claim involving urgent care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

Physical Examinations
The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition for coverage.

DEFINITIONS

In this section you will find the definitions for the capitalized words found throughout this Medical Plan. There may be additional words or terms that have a meaning that pertains to a specific section and those definitions will be found in that section provided, however, that any such capitalized word shall have such meaning when used in any other section. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Medical Plan. Please refer to the appropriate sections of this Medical Plan for that information.

Affiliated Companies means any of the Medical Plan Sponsor's affiliates, subsidiaries, or divisions may be deleted or added to the Medical Plan upon written notice on or before the date such deletion or addition is effective.

Ambulatory Surgical Center means a free-standing surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations.

Audiologist means a health care professional trained to evaluate, diagnose, and treat hearing loss and related disorders, including balance (vestibular) disorders and tinnitus, and to rehabilitate people with hearing loss and related disorders. An Audiologist must meet any state licensure requirements in the state in which they practice and must be acting within the scope of their license.

Birthing Center means a place licensed as such by an agency of the state. If the state does not have any licensing requirements, it must meet all of the following tests: (1) is primarily engaged in providing birthing services for low risk pregnancies; (2) is operated under the supervision of a Physician; (3) has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital as defined herein if an emergency arises; and (5) has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

Calendar Year means January 1 – December 31.

Close Relative means a Covered Person's Spouse, parent (including step-parents), sibling, child, grandparent or in-law.

Coinsurance has the same meaning as set forth in the section of this Medical Plan entitled "General Overview of the Medical Plan".

Concurrent Care means ongoing care or course of treatment.

Concurrent Review means the Medical Management and Precertification Program Administrator will review all inpatient admissions for a patient's length of stay. The review is based on clinical information received by the Medical Management and Precertification Program Administrator from the provider or facility.

Claims Administrator means the organization providing services to the Employer in connection with the operation of this Medical Plan and performing such other functions, including processing of claims, as may be delegated to it.

Copay has the same meaning as set forth in the section of this Medical Plan entitled "General Overview of the Medical Plan".

Cosmetic means any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease.

Covered Employee means an eligible Employee whose coverage has become effective and has not been terminated.

Covered Expenses means the medical expenses covered pursuant to the terms of this Health Care Plan.

Covered Person means, individually, an eligible Employee or eligible Dependent whose coverage has become effective and has not been terminated.

Custodial Care means care or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Dentist means an individual who is duly licensed to practice dentistry or to perform oral Surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

Dependent is a Covered Person, other than the Employee**,** who is covered by the Medical Plan pursuant to the terms and conditions set forth in the "Eligibility and Enrollment" section of the Medical Plan.

Durable Medical Equipment means equipment that:

(1) Must be ordered by a Physician;

(2) Must not be disposable;

(3) Can withstand repeated use;

(4) Is primarily and customarily used to serve a medical purpose;

(5) Generally is not useful to a person in the absence of an Illness or Injury; and

(6) Is appropriate for use in the home; and

(7) Would have been covered if provided in a Hospital.

Employee is defined in the "Eligibility for Participation" section of the Medical Plan.

Employer means RCAA Administrative Services, Inc., or any successor thereto, and its participating Affiliated Companies.

Endodontic Treatment means procedures for the prevention and treatment of diseases of the dental pulp, pulp chamber, root canal and surrounding periapical structures.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Employer as set forth below.

The Employer must make an independent evaluation of the Experimental or non-Experimental standings of specific technologies. The Employer shall be guided by a reasonable interpretation of Medical Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Employer will be final and binding on the Medical Plan. In addition to the above, the Employer will be guided by the following principles to determine whether a

proposed treatment is deemed to be Experimental and/or Investigational:

(1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or

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

(3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials or is the subject of the research, Experimental, study, Investigational or other arm of on-going Phase III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational; or

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

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

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

Expenses for drugs, devices, services, medical treatments or procedures related to an Experimental and/or Investigational treatment (related services) and complications from an Experimental and/or Investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or Investigational treatment.

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment or procedure is covered under the Medical Plan will be made by and in the sole discretion of the Employer.

This definition will not apply to any treatment the Covered Person is receiving that is the only treatment available and/or is considered standard of care and does not violate church doctrine.

Extended Care Facility: An institution or that part of any institution which operates to provide convalescent or nursing care which: (1) is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; (2) has policies which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more Physicians and one or more registered nurses (R.N.) to govern the skilled nursing care and related medical or other services it provides; (3) has a Physician, a registered nurse (R.N.), or a medical staff responsible for the execution of such policies; (4) has a requirement that the health care of every patient be under the supervision of a Physician, and provides for having a Physician available to furnish necessary medical care in case of emergency; (5) maintains clinical records on all patients; (6) provides twenty-four (24) hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed above, and has at least one registered nurse (R.N.) employed full time; (7) provides appropriate methods and procedures for the dispensing and administering of drugs and injections; (8) in the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature, is licensed pursuant to such law, or is approved by the agency of

the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and (9) meets any other conditions relating to the health and safety of individuals who are furnished services in such institutions or relating to the physical facilities thereof.

FMLA means the Family and Medical Leave Act of 1993, as may be amended from time to time.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Medical Plan (including initial enrollment and continued eligibility) and (2) establishing contribution or premium accounts for coverage under the Medical Plan.

Health Care Professional: A Physician or other Health Care Professional licensed, accredited, or certified to perform specified health services consistent with State law.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended from time to time.

Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions, it: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide healthcare planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient's home; (5) is responsible for administering a home health care program; and (6) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician.

Hospice means an agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements: (1) has obtained any required state or governmental Certificate of Need approval; (2) provides 24-hour-a-day, 7 days-a-week service; (3) is under the direct supervision of a duly qualified Physician; (4) has a nurse coordinator who is a registered nurse (R.N.) with 4 years of full-time clinical experience, at least 2 of which involved caring for terminally ill patients; (5) has a social-service coordinator who is licensed in the jurisdiction in which it is located; (6) is an agency that has as its primary purpose the provision of hospice services; (7) has a full-time administrator; (8) maintains written records of services provided to the patient; (9) the employees are bonded and it provides malpractice and malplacement insurance; (10) is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; (11) provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist or a certified respiratory therapist; and (12) provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

Hospital means a facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat Illnesses or Injuries on an inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has 24-hour-a-day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental Disorders which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home or a similar institution.

The definition of “Hospital” shall be expanded to include those services rendered to a priest by the following

facilities: (a) Guest House; (b) St. Luke Institute; (c) St. John Vianney; (d) Ridgeview Institute of Atlanta, or others as approved by the Archbishop or his designee.

Hour(s) of Service mean each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer (or a related Employer) and each hour for which an Employee is paid, or entitled to payment by the Employer (or a related Employer) for a period of time during which no duties are performed due to vacation, holiday, Illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence, but excluding Hours of Service to the extent that the compensation for those services constitutes income from sources outside the United States or performed as (1) a bona fide volunteer (as defined in Treas. Reg. Section 54.4980H-1(a)(7)) or (2) part of a Federal or State work study program. For purposes of this definition, a related Employer is any entity that must be treated as part of the same “applicable large employer” as the Employer for purposes of Code Section 4980H, as determined at the time that the applicable Hour of Service is performed or credited.

Illness means a disease, sickness, pregnancy or a condition involving bodily or mental disorder of any kind. All disorders which exist simultaneously and are due to the same or related causes shall be considered one Illness.

Incurred means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Injury means a bodily Injury which results independently of Illness and is caused by accidental means. All bodily Injuries sustained in any one accident and all related conditions and recurrent symptoms will be considered one Injury.

Late Enrollee is an eligible Employee or eligible Dependent that does not elect coverage under this Medical Plan during their original 31-day eligibility period. A Special Enrollee is not considered a Late Enrollee.

Legal Guardian is defined in the "Eligibility for Participation" section of the Medical Plan.

Lifetime Maximum means the maximum benefit payable during an individual's lifetime while covered under this Medical Plan. Benefits are available only when an individual is eligible for coverage under this Medical Plan. The Medical Plan may provide for a Lifetime Maximum benefit for specific types of medical treatment. Any Lifetime Maximum will be shown in the applicable **Medical Schedule of Benefits** or the applicable Covered Expenses section of the Medical Plan.

Medical Emergency means medical services and supplies provided after the sudden onset of a medical condition (Injury or Illness) manifesting itself by acute symptoms, including intense pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following: (1) the patient's health would be placed in serious jeopardy; (2) bodily function would be seriously impaired; or (3) there would be serious dysfunction of a bodily organ or part.

Medically Necessary/Medical Necessity means treatment is generally accepted by Physicians in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

(1) "Proven" means the care is not considered Experimental and/or Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA) for general use.

(2) “Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, Injury, Illness or a clinical condition.

(3) "Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Medical Plan.

All criteria must be satisfied. When a Physician recommends or approves certain care it does not mean that care is Medically Necessary.

Medical Plan Administrator means RCAA Administrative Services, Inc., which is sponsoring this Medical Plan for Employees of the Employer. The Medical Plan Administrator may hire persons or firms to process claims and perform other Medical Plan connected services.

Medical Plan Sponsor means RCAA Administrative Services, Inc.

Medical Plan Year means the period from January 1 - December 31 each year.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

Morbid Obesity is defined as a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person, has a body mass index (BMI) of 40 or greater. Treatment for Morbid Obesity is subject to the provisions of the Medical Plan. See **Eligible Medical Expenses**.

Non-Participating Provider means a health care practitioner or health care facility that has not contracted directly with the Medical Plan or an entity contracting on behalf of the Medical Plan to provide health care services to Medical Plan enrollees.

Participating Provider means all participating providers, health professionals, Hospitals, or other organizations having an agreement with Aetna Choice® POS II the Participating Provider Organization (PPO).

Physician means a legally licensed Physician who is acting within the scope of their license and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes, but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Nurse Practitioner, Physician's Assistant, Speech Therapist, Speech Pathologist and Licensed Midwife (if covered by the Medical Plan). An employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Medical Plan.

Plan means The Roman Catholic Archdiocese of Atlanta Group Medical Plan.

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

Qualified Health Plan The following will be considered Qualified Health Plans: (1) a group health plan; (2) health insurance coverage; (3) Medicare; (4) Medicaid; (5) TRI-CARE; (6) an Indian Health Service plan or tribal organization plan; (7) a state risk pool coverage; (8) a federal employees health insurance coverage; (9) a public health plan (this includes plans established or maintained by a state, the U.S. government, a foreign country, a state or federal penitentiary, U.S. Veterans Administration, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the Medical Plan); (10) a Peace Corps plan; (11) the State Children's Health Insurance Program.

Rehabilitation Facility means a facility must meet all of the following requirements: (1) must be for the

treatment of acute Injury or Illness; (2) is licensed as an acute Rehabilitation Facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (5) services are specific to an active written treatment plan; (6) the patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care; (7) nursing services are available 24 hours a day; and (8) the confinement is not for Custodial Care or maintenance care.

Seasonal Employee means an Employee who is hired into a position that recurs annually at about the same time each year for which the customary annual employment is 6 months or less.

Special Enrollee is an eligible Dependent that does not elect coverage under this Plan during their original 31-day eligibility period and who later enrolls in the Medical Plan due to a Special Enrollment Event.

Spouse is defined in the "Eligibility for Participation" section of the Medical Plan.

Substance Use Disorder means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

Surgery or **Surgical Procedure** means any of the following:

(1) The incision, excision, debridement or cauterization of any organ or part of the body and the suturing of a wound;

(2) The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

(3) The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;

(4) The induction of artificial pneumothorax and the injection of sclerosing solutions;

(5) Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;

(6) Obstetrical delivery and dilation and curettage; or

(7) Biopsy.

Urgent Care Facility means a facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Medical Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

Usual and Customary Charge (U&C) means, with respect to Non-Participating Providers, charges made for medical or dental services or supplies essential to the care of the individual will be subject to a Usual and Customary determination. Usual and Customary allowances are based on what is usually and customarily accepted as payment for the same service within a geographical area. In determining whether charges are Usual and Customary, consideration will be given to the nature and severity of the condition and any medical or dental complications or unusual circumstances which require additional time, skill or experience. Limitations for Usual and Customary Charges are not applicable to Participating Providers, or to Non-Participating Providers for Medical Emergency services, including Hospital emergency room treatment and emergency ambulance transportation.

The Roman Catholic Archdiocese of Atlanta
Group Dental and Vision Plan

Plan Document

Group No.: 10974 - DV

Originally Effective: January 1, 2005

Amended and Restated Effective: January 1, 2020

DENTAL AND VISION PLAN
ESTABLISHMENT OF THE DENTAL AND VISION PLAN

The Roman Catholic Archdiocese of Atlanta originally established The Roman Catholic Archdiocese of Atlanta Group Dental and Vision Plan (hereinafter referred to as the "Dental/Vision Plan"), as set forth herein for the exclusive benefit of the Employees of the Employer and their eligible Dependents. The Dental/Vision Plan was originally adopted by the Employer effective as of January 1, 2005. Effective January 29, 2019, the Archdiocese transferred sponsorship of the Plan to RCAA Administrative Services, Inc. (the "Plan Sponsor"), and the Dental/Vision Plan was amended and restated to reflect the change in Plan Sponsor, effective as of February 1, 2019.

The Dental/Vision Plan is hereby amended and restated, effective as of January 1, 2020.

Purpose of the Dental/Vision Plan
This Dental/Vision Plan is written, adopted and operative for the sole and exclusive purpose of providing to the eligible Employees and their eligible Dependents employee welfare benefits as described herein. The Dental/Vision Plan agrees to provide the benefits set forth in the **Dental and Vision Schedule of Benefits** to all Covered Persons in accordance with the provisions and conditions of the Dental/Vision Plan. The Dental/Vision Plan is subject to all conditions and provisions set forth in this document and subsequent amendments, which are made a part of this Dental/Vision Plan. The Dental/Vision Plan is a non-electing church plan in accordance with section 4(b)(2) of the Employee Retirement Income Security Act (ERISA).

This Dental and Vision Plan is a stand-alone Dental and Vision Plan.

NOTE: The dental and vision benefits provided under this Dental/Vision Plan are considered "limited-scope" benefits under the Affordable Care Act, are subject to Dental/Vision Plan maximums, and are provided separately from the medical coverage offered under The Roman Catholic Archdiocese of Atlanta Group Medical Plan. These benefits are provided at no cost to Eligible Employees and their Eligible Dependents.

VISION SCHEDULE OF BENEFITS

Eligible Vision Expenses

(1) Vision Materials (*i.e*., lenses, frames, contacts, etc.) will be eligible for reimbursement up to $250.

Exclusions and Limitations

Subject to the **Dental and Vision Exclusions and Limitations Section**.

This Vision Plan is a stand-alone Vision Plan, and together with the stand-alone Dental Plan is known as the Dental and Vision Plan.

NOTE: The vision benefits provided under this Plan are limited-scope benefits and are offered separately from any medical coverage offered under the Medical Plan. Please note that Medically Necessary vision services are provided under and subject to the terms of the Medical Plan.

DENTAL SCHEDULE OF BENEFITS

DENTAL BENEFITS	**Plan Pays**	**Covered Person Pays** (Subject to Usual & Customary Charges)
CALENDAR YEAR DEDUCTIBLE Per Individual	$0	$50
DENTAL BENEFITS		
Class A Expenses (Preventive Services)	100%	$0
Class B Expenses (Basic Services)	80%	20% after Deductible
Class C Expenses (Major Services)	80%	20% after Deductible
Class D Expenses (Orthodontia)	80%	20% after Deductible
CALENDAR YEAR MAXIMUM BENEFIT (Classes A, B, C, and D Expenses combined per person)	$1,500 (Class A Expenses are not applied to the Calendar Year Maximum for those persons under age 19)	

ELIGIBLE DENTAL EXPENSES

If a Covered Person incurs expenses for a service on the list of "Eligible Dental Expenses," such charges are covered to the extent that they meet all of the following conditions:

(1) Constitute necessary treatment.

(2) Are Incurred while covered under this Dental/Vision Plan.

(3) Are Usual and Customary Charges.

The Dental/Vision Plan will pay for such eligible expenses as shown in the **Dental Schedule of Benefits**.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted.

Deductible
A Deductible is the total amount of eligible expenses as shown in the **Dental Schedule of Benefits**, which must be Incurred by a Covered Person during any Calendar Year before Covered Dental Expenses are payable under the Dental/Vision Plan.

Date Expenses are Incurred
An expense is Incurred when the service is performed, except that it is deemed to be Incurred:

(1) When the impression is taken in the case of dentures or fixed bridgework;

(2) When preparation of the tooth is begun in the case of crown work;

(3) When the pulp chamber is opened in the case of root canal therapy.

Alternative Treatment
The Dental/Vision Plan has an "alternative treatment" clause that limits the Dental/Vision Plan's payment to the most cost effective treatment of a dental condition that provides a professionally acceptable result as determined by national standards of dental practice. If a Covered Person chooses a more expensive treatment according to accepted standards of dental practice to correct a dental condition, the Dental/Vision Plan's payment will be based on the treatment that provides professionally satisfactory results at the most cost-effective level.

Eligible Dental Expenses

Class A-Preventive Services:
(1) Routine oral examinations, including the cleaning and scaling of teeth, are limited to 2 exams per Covered Person each Calendar Year.

(2) X-rays as follows:

  (a) Bitewing x-rays are limited to a set of 4 every 12 months.

  (b) Full mouth and panoramic x-rays are limited to every 36 months, unless special need is shown.

(3) 2 fluoride treatments for Dependent Children under age 19 each Calendar Year.

(4) Sealants on the occlusal surface of a permanent posterior tooth for a Covered Person under age 16, once per tooth in any 36 months.

(5) Space maintainers for a Dependent Children under age 16 to replace primary teeth.

(6) Emergency palliative treatment.

(7) Laboratory tests necessary for the diagnosis or treatment of a covered dental disorder, including, but not limited to, bacteriologic cultures and pulp vitality tests.

(8) Diagnostic cast for Covered Persons – once per 2 year period.

Class B-Basic Services:

(1) Dental x-rays not included in Class A Expenses.

(2) Oral Surgery, except that which is covered under any medical plan.

(3) Periodontic treatment (gum treatments).

(4) Endodontic Treatment, including root canal therapy.

(5) Extractions. This service includes local anesthesia and routine post-operative care.

(6) Recementing bridges, crowns or onlays.

(7) Fillings, excluding gold fillings.

(8) General or local anesthesia upon demonstration of Medical Necessity.

(9) Antibiotic drugs.

(10) Porcelain and stainless steel crowns used in the replacement of deciduous (primary) teeth.

(11) Repair or recementing of inlays, onlays, bridgework, crowns or dentures. Relining or rebasing of dentures more than one year after installation of either the initial or the replacement denture. Limited to one relining or rebasement in any 24 consecutive month period.

(12) Injections of antibiotic drugs and/or application of desensitizing medication.

Class C-Major Services:

(1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

(2) Installation of crowns

(3) Installing precision attachments for removable dentures.

(4) Installing partial, full or removable dentures to replace one or more natural teeth that were extracted while the person was covered for this benefit. This service also includes all adjustments made during 6 months following the installation.

(5) Addition of clasp or rest to existing partial removable dentures.

(6) Initial installation of fixed bridgework to replace one or more natural teeth.

(7) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this will apply only if the existing denture or bridgework was installed at least 5 years prior to its replacement and cannot currently be made serviceable.

Class D-Orthodontic Services

Treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth. These services include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance. Payments for comprehensive full-banded orthodontic treatments are made in installments.

DENTAL AND VISION EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Dental/Vision Plan for Dental Expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Dental/Vision Plan has the right to collect that amount from the payee, the Covered Person, or from future benefits, and any such payment does not waive the written exclusions, limitations or other terms of the Dental/Vision Plan.

(1) **Administrative Costs:** Expenses for administrative costs of completing claim forms or reports or for providing dental records will not be considered eligible.

(2) **After Termination Date:** Expenses which are Incurred after the termination date of your coverage under the Plan will not be considered eligible.

(3) **Alternative Treatment:** Expenses where there are alternate courses of treatment available carrying different fees, the Dental/Vision Plan will provide benefits only for the treatment carrying the lesser fee.

(4) **American Dental Association:** Expenses which do not meet the standards of dental practices accepted by the American Dental Association.

(5) **Close Relative:** Expenses for services, care or supplies provided by a person who normally resides in the Covered Person's home or by a Close Relative will not be considered eligible.

(6) **Cosmetic:** Expenses for services or supplies partially or wholly cosmetic in nature will not be considered eligible.

(7) **Crowns:** Expenses for crowns that are restorable by other means or for the purpose of periodontal splinting will not be considered eligible.

(8) **Department Maintained by an Employer:** Expenses for services received from a Dentist or dental department maintained by an employer, labor union, etc., where the individual is eligible under any group insurance plan will not be considered eligible.

(9) **Duplicate Devices:** Expenses for duplicate prosthetic devices or appliances; expenses for a lost or stolen dental appliance will not be considered eligible.

(10) **Hospital Expenses:** Expenses for hospital expenses will not be considered eligible.

(11) **Implants:** Expenses for tooth implants will not be considered eligible.

(12) **Medical Plan:** Expenses which are covered or excluded under the Medical Plan or expenses which are payable under any medical plan will not be considered eligible.

(13) **Missed Appointments:** Expenses for completion of claim forms, missed appointments or telephone consultations will not be considered eligible.

(14) **Not Listed as Eligible:** Expenses for procedures or restorations other than those listed in the Eligible Dental Expenses section will not be considered eligible.

(15) **Not Performed by a Dentist:** Expenses for treatment by other than a Dentist or physician, except charges for treatment performed under the supervision and direction of a Dentist or physician, by any person duly licensed or certified to perform such treatment under applicable professional statutes and regulations, will not be considered eligible.

(16) **Not Prescribed by a Dentist:** Expenses for services not prescribed as necessary by a physician or Dentist will not be considered eligible.

(17) **Oral Hygiene:** Expenses for oral hygiene, dietary or plaque control programs, or other educational programs will

not be considered eligible.

(18) **Personalization:** Expenses for personalization of dentures will not be considered eligible.

(19) **Prior to Effective Date:** Expenses which are Incurred prior to the effective date of your coverage under the Plan will not be considered eligible.

(20) **Splinting:** Expenses for crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, restoring the bite (occlusion) or are cosmetic will not be considered eligible.

(21) **Take Home Items:** Expenses for mouth guards or take home items will not be considered eligible.

(22) **Temporary Prosthesis:** Expenses for a temporary full prosthesis or for adjustment or relining of a prosthesis within 6 months after the prosthesis is initially furnished will not be considered eligible.

(23) **Temporomandibular Joint Dysfunction (TMJ):** Expenses Incurred for appliances or restorations in connection with Temporomandibular Joint Dysfunction (TMJ) or myofunctional therapy will not be considered eligible. Please see **Eligible Medical Expenses** for Covered Expenses.

(24) **Vision Care:** Expenses for vision care, including professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices that exceed $250 will not be considered eligible for reimbursement. Routine eye exams will be covered as specified under **Eligible Medical Expenses** under the Medical Plan.

(25) **Usual and Customary Charges:** Expenses in excess of the Usual and Customary Charge will not be considered eligible.

DENTAL AND VISION CLAIM AND APPEAL PROCEDURES

You will receive an Employee insurance card which will contain important information, including claim filing directions and contact information. The Employee insurance card you received for your Medical Plan also includes the Dental and Vision Plans showing your Participating Provider Network and the Medical Management Administrator.

At the time you receive treatment, show the Employee insurance card to your provider of service. In many cases, your provider will file the claim for you. You may also file the claim yourself by submitting the required information to

Meritain Health, Inc.
P.O. Box 853921
Richardson, TX 75085-3921
(800) 925-2272

All claims under the Dental/Vision Plan will be "post service claims." A "post service claim" is a claim for a benefit under the Dental/Vision Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Dental/Vision Plan:

(1) The date of service;

(2) The name, address, telephone number and tax identification number of the provider of the services or supplies;

(3) The place where the services were rendered;

(4) The diagnosis and procedure codes;

(5) The amount of charges (including Network repricing information);

(6) The name of the Dental/Vision Plan;

(7) The name of the Covered Employee; and

(8) The name of the patient.

A call from a provider who wants to know if an individual is covered under the Dental/Vision Plan or if a certain procedure or treatment is a Covered Expense before the treatment is rendered, is not a "claim" since an actual written claim for benefits is not being filed with the Dental/Vision Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Timely Filing
All claims must be filed with the Claims Administrator within 1 year following the date services were Incurred. Claims filed after this time period will be denied.

For Dental and Vision Claims
Meritain Health P.O. Box 853921 Richardson, TX 75085-3921 800-925-2272

Procedures for all Claims
To receive benefits under the Dental/Vision Plan, the claimant (i.e. you and your covered Dependents) must follow the procedures outlined in this section.

Post-Service Claims. For a post-service claim, the Dental/Vision Plan Administrator will notify you of the Dental/Vision Plan's Adverse Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Dental/Vision Plan Administrator needs additional time to process a claim, the Dental/Vision Plan Administrator may extend the time for notifying you of the Dental/Vision Plan's benefit determination on a one-time basis for up to 15 days provided that the Dental/Vision Plan Administrator notifies you within 30 days after the Dental/Vision Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received.

Manner and Content of Notice of Initial Adverse Determination
If the Dental/Vision Plan Administrator denies a claim, it must provide to you in writing or by electronic communication:

An explanation of the specific reasons for the denial;

(1) A reference to the Dental/Vision Plan provision or insurance contract provision upon which the Adverse Determination is based;

(2) A description of any additional information or material that you must provide in order to perfect the claim;

(3) An explanation of why the additional material or information is necessary;

(4) Notice that you have the right to request a review of the Adverse Determination and information on the steps to be taken if you wish to request a review of the Adverse Determination along with the time limits applicable to a request for review;

(5) A statement describing your right to request a second level appeal;

(6) A copy of any rule, guideline, protocol or other similar criterion relied upon in making the Adverse Determination (or a statement that the same will be provided upon your request and without charge); and

(7) If the adverse determination is based on the Dental/Vision Plan's Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge.

Internal Review of Initially Denied Claims and Appeal Procedures
If you submit a claim for Dental/Vision Plan benefits and it is initially denied under the procedures described above, you may request a review of that Adverse Determination under the procedures described below. However, please note that vision services under the Group Dental and Vision Plan, including the reimbursement of Vision Materials are not appealable. Any vision services provided under the Medical Plan will be subject to claim procedures of that Plan.

You have 180 days after you receive notice of an initial Adverse Determination within which to request a review of the Adverse Determination. For a request for a second level appeal, you have 60 days after you receive notice of an Adverse Determination at the first level of appeal to request a second level appeal of the Adverse Determination.

If you request a review of an Adverse Determination within the applicable time period, the review will meet the following

requirements:

(1) The Dental/Vision Plan will provide a review that does not afford deference to the Adverse Determination that is being appealed and that is conducted by an appropriate representative of the Dental/Vision Plan who did not make the Adverse Determination that is the subject of the appeal and who is not a subordinate of the individual who made that Adverse Determination.

(2) The appropriate representative of the Dental/Vision Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any Adverse Determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the Adverse Determination that is the subject of the appeal, nor a subordinate of any such individual.

(3) The Dental/Vision Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Dental/Vision Plan in connection with the Dental/Vision Plan's review of an Adverse Determination, without regard to whether the advice is relied upon in making the Adverse Determination on review.

(4) For a requested review of an Adverse Determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Dental/Vision Plan's determination on review, will be transmitted between the Dental/Vision Plan and you by telephone, facsimile or other available similarly expeditious method.

(5) The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information and records relating to the Adverse Determination and to submit issues and comments relating to the Adverse Determination in writing to the Dental/Vision Plan. The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the Adverse Determination regardless of whether the information was submitted or considered in the initial benefit determination.

All requests for review of initial Adverse Determinations (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
P.O. Box 853921
Richardson, TX 75085-3921
(800) 925-2272

Deadline for Internal Review and Appeal of Initially Denied Claims

Post-Service Claims. The Dental/Vision Plan provides for 2 levels of appeal for a post-service claim for Dental and excluding Vision Materials reimbursement. At each level of appeal, the reviewer will notify you of the Dental/Vision Plan's determination on review within a reasonable period of time appropriate to the health circumstances, but in no event later than 30 days after the Dental/Vision Plan receives your request for review of the initial Adverse Determination (or of the first-level appeal Adverse Determination).

Manner and Content of Notice of Decision on Internal Review of Initially Denied Claims
Upon completion of its review of an initial Adverse Determination (or a first-level appeal Adverse Determination), the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an Adverse Determination, the notice will include:

(1) A description of the Dental/Vision Plan's decision;

(2) The specific reasons for the decision;

(3) The relevant Dental/Vision Plan provisions or insurance contract provisions on which its decision is based;

(4) A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Dental/Vision Plan's files which is relevant to your claim for benefits;

(5) A statement describing your right to request a second level appeal or, if applicable, to bring an action for judicial review;

(6) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to you upon request;

(7) If the Adverse Determination on review is based on a Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Dental/Vision Plan to the claimant's medical circumstances or (b) a statement that such an explanation will be provided without charge upon request.

Calculation of Time Periods for Appeals
For purposes of the time periods described in the Dental/Vision Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review of a denied claim) is filed in accordance with the Dental/Vision Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

Adverse Determination
For purposes of the Dental/Vision Plan's claim procedures, an " Adverse Determination " is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Dental/Vision Plan and including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary or appropriate. Adverse Determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

Dental/Vision Plan's Failure to Follow Procedures
If the Dental/Vision Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Dental/Vision Plan internal claim procedures and you will be entitled to pursue any available remedy under State or Federal law on the basis that the Dental/Vision Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

State Insurance Laws
Nothing in the Dental/Vision Plan's claims procedures will be construed to supersede any provision of any applicable State law.

Statute of Limitations for Dental/Vision Plan Claims and Appeals
Please note that no legal action may be commenced or maintained to recover benefits under the Dental/Vision Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Appointment of Authorized Representative
A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Employer or the Claims Administrator. However, in connection with a claim involving urgent care, the Dental/Vision Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Dental/Vision Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Employer, in writing, to the contrary.

DEFINITIONS

In this section you will find the definitions for the capitalized words found throughout this Dental/Vision Plan. There may be additional words or terms that have a meaning that pertains to a specific section and those definitions will be found in that section provided, however, that any such capitalized word shall have such meaning when used in any other section. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Dental/Vision Plan. Please refer to the appropriate sections of this Dental/Vision Plan for that information.

Affiliated Companies means any of the Dental/Vision Plan Sponsor's affiliates, subsidiaries, or divisions may be deleted or added to the Dental Vision Plan upon written notice on or before the date such deletion or addition is effective.

Calendar Year means January 1 – December 31.

Close Relative means a Covered Person's Spouse, parent (including step-parents), sibling, child, grandparent or in-law.

Claims Administrator means the organization providing services to the Employer in connection with the operation of this Dental/Vision Plan and performing such other functions, including processing of claims, as may be delegated to it.

Coinsurance has the same meaning as set forth in the section of this Dental/Vision Plan entitled “General Overview of the Dental/Vision Plan”.

Covered Employee means an eligible Employee whose coverage has become effective and has not been terminated.

Covered Expenses means the dental and/or vision expenses covered pursuant to the terms of this Dental/Vision Plan.

Covered Person means, individually, an eligible Employee or eligible Dependent whose coverage has become effective and has not been terminated.

Dentally Necessary means services or supplies, which are determined by the Dental/Vision Plan Administrator to be:

(1) Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the dental condition, Injury or Illness;

(2) Provided for the diagnosis or direct care and treatment of the dental condition, Injury or Illness;

(3) Within standards of good dental practice within the organized dental community;

(4) Not primarily for the convenience of the Covered Person, the Covered Person’s Dentist or another provider; and

(5) The most appropriate supply or level of service which can safely be provided.

Dental/Vision Plan means The Roman Catholic Archdiocese of Atlanta Group Dental and Vision Plan.

Dental/Vision Plan Administrator means RCAA Administrative Services, Inc., which is sponsoring this Dental/Vision Plan for Employees of the Employer. The Dental/Vision Plan Administrator may hire persons or firms to process claims and perform other Plan connected services.

Dental/Vision Plan Sponsor means RCAA Administrative Services, Inc.

Dentist means an individual who is duly licensed to practice dentistry or to perform oral Surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

Dependent is a Covered Person, other than the Employee**,** who is covered by the Dental/Vision Plan pursuant to the terms and conditions set forth in the "Eligibility and Enrollment" section of the Group Health Care Plan.

Employee is defined in the “Eligibility for Participation” section of the Group Health Care Plan.

Employer means RCAA Administrative Services, Inc., or any successor thereto, and its participating Affiliated Companies.

Endodontic Treatment means procedures for the prevention and treatment of diseases of the dental pulp, pulp chamber, root canal and surrounding periapical structures.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended from time to time.

Hour(s) of Service mean each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer (or a related Employer) and each hour for which an Employee is paid, or entitled to payment by the Employer (or a related Employer) for a period of time during which no duties are performed due to vacation, holiday, Illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence, but excluding Hours of Service to the extent that the compensation for those services constitutes income from sources outside the United States or performed as (1) a bona fide volunteer (as defined in Treas. Reg. Section 54.4980H-1(a)(7)) or (2) part of a Federal or State work study program. For purposes of this definition, a related Employer is any entity that must be treated as part of the same “applicable large employer” as the Employer for purposes of Code Section 4980H, as determined at the time that the applicable Hour of Service is performed or credited.

Incurred means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Late Enrollee is an eligible Employee or eligible Dependent that does not elect coverage under this Dental/Vision Plan during their original 31-day eligibility period. A Special Enrollee is not considered a Late Enrollee.

Legal Guardian is defined in the "Eligibility for Participation" section of the Dental/Vision Plan.

Medically Necessary/Medical Necessity means treatment is generally accepted by Physicians or Dentists in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

(1) "Proven" means the care is not considered Experimental and/or Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA) for general use.

(2) “Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, Injury, Illness or a clinical condition.

(3) "Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Dental/Vision Plan.

All criteria must be satisfied. When a Physician or Dentist recommends or approves certain care it does not mean that care is Medically Necessary.

Orthodontic Treatment means the corrective movement of teeth to treat a handicapping malocclusion of the mouth.

Plan Year means the period from January 1 - December 31 each year.

Seasonal Employee means an Employee who is hired into a position that recurs annually at about the same time each year for which the customary annual employment is 6 months or less.

Special Enrollee is an eligible Dependent that does not elect coverage under this Dental/Vision Plan during their original 31-day eligibility period and who later enrolls in the Dental/Vision Plan due to a Special Enrollment Event.

Spouse is defined in the "Eligibility for Participation" section of the Group Health Care Plan.

Usual and Customary Charge (U&C) means charges made for medical or dental services or supplies essential to the care of the individual will be subject to a Usual and Customary determination. Usual and Customary allowances are based on what is usually and customarily accepted as payment for the same service within a geographical area. In determining whether charges are Usual and Customary, consideration will be given to the nature and severity of the condition and any medical or dental complications or unusual circumstances which require additional time, skill or experience.

Vision Materials means lenses, frames and contacts.