



**The Roman Catholic Diocese of Beaumont  
and  
Adopting Employer  
Catholic Charities of Southeast Texas  
Group Benefit Booklet Can Be Found At  
[www.dioceseofbmt.org](http://www.dioceseofbmt.org)**

**Your Employee Benefits**  
provided through  
**Christian Brothers Employee Benefit Trust**



**CHRISTIAN  
BROTHERS  
SERVICES**

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

## **IMPORTANT NUMBERS**

### **PREFERRED PROVIDER ORGANIZATION (PPO)**

Your Member (Employer) has agreed to utilize  
**Aetna Signature Administrators**  
as your Preferred Provider Organization (PPO).

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

**Please visit [www.cbsservices.org/ebsparticipants](http://www.cbsservices.org/ebsparticipants)**

Click on "Find a PPO Provider."

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### **COST CONTAINMENT ADMINISTRATOR**

Cost Containment Administrator for Utilization Management Requirements:

**Nationwide: 1-800-533-5044**

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### **BENEFIT ADVICE**

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

**1-800-807-0400**

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

## **PRESCRIPTION DRUG BENEFITS MANAGER**

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

**Nationwide: 1-800-718-6601**

**Website: [www.medco.com](http://www.medco.com)**

## **Health Risk Management Programs**

### **AccordantCare™ Program**

The AccordantCare™ Program, brought to you by CBEBT and Accordant Health Services, is available at no additional cost and compliments our existing disease management program. This program is designed to meet unique healthcare needs and support members with rare chronic conditions.

### **Care Support Program**

CBEBT has partnered with Healthways, Inc., to offer Care Support. Healthways, Inc. uses claim data to identify members with chronic conditions, such as diabetes, asthma, heart disease and chronic obstructive pulmonary disease. The goals of Care Support include improving the quality of life for Trust participants who live with chronic illness, supporting doctors' treatment plans, and lowering out-of-pocket costs by preventing unnecessary emergency room visits and hospital stays. Enrollment in this program is automatic and is free to CBEBT participants.

### **Free Flu Shot Program**

CBEBT has joined with Maxim Health Systems to offer the Flu Shot Program. Available in October and November, the flu shot program is free to all covered employees and their enrolled dependents.

### **Hearing Aid Discount Program**

CBEBT joined with American Hearing Benefits, Inc. (AHB) to offer significant savings on all styles of digital hearing aids through 1,800 provider locations. This program is available at no charge, and offers free hearing screenings for participants, their spouse, children, parents, and grandparents.

### **Large Case Management**

Large Case Management staff through Principal becomes involved in complex medical cases or during lengthy hospital stays. A nurse is assigned to each case and will communicate with the participant to help them choose the best care options, find resources or providers for needed treatment, and assist in obtaining the care needed to facilitate a quick recovery.

### **NICU Care Management**

Alere provides a care management program for newborns admitted to neonatal intensive care units (NICU). The program promotes high-quality NICU care for each infant through on-site and remote care management by physicians and nurse care managers with extensive NICU experience. The goals of this program include improving infant outcomes and providing education and support to family members. A case manager at The Principal will identify the newborn and refer the case to Alere. This program is provided at no additional cost to CBEBT participants.

### **Prenatal Care Program**

The Prenatal Care Program is available through The Principal. All expectant mothers covered by the Plan are encouraged to enroll in this voluntary program within the first 16 weeks of pregnancy. There is no cost to join. Experienced nurses work with expectant mothers to emphasize early prenatal care and consistent physician contacts. Nurses are available to answer questions and provide support throughout the pregnancy.

**Small Case Management**

Small Case Management staff through Principal becomes involved in less complex cases when home treatment could be provided in lieu of hospitalization, e.g., at home wound care, dressing changes, or IV antibiotic infusions. A nurse will contact the participant directly to help identify needed care and to guide the participant in locating quality care providers at the best cost possible to maximize benefits.

**Tobacco Cessation Program**

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

**Wellness Screenings**

The program, through Wellness Inc., is a wellness screening program designed to alert and educate members on health issues. This early detection/screening program can detect many diseases, disorders, and illnesses long before any symptoms are present. Members who participate in the screening will receive the Wellness Health Coach benefit and the Healthier at Home® self-care book with instructional DVD. Participation in the wellness screening and health coaching programs gives the guidance needed to ensure a healthier, happier life.

## **Vision Discount Program for all Employees Who have Medical Coverage**

A vision discount program through VSP will be provided for all Plan participants who are enrolled for Medical coverage. VSP is a well known national vision plan and this program will allow eligible members to receive a discount when visiting a VSP network doctor. With or without the Plan's Vision coverage, this discount program will reduce your ultimate out of pocket costs. Discounts include:

- 20% discount off the VSP doctor's fee for an exam each calendar year
- 20% discount each calendar year when a pair of glasses and lenses are purchased
- 15% discount off the contact lens fitting and evaluation exam each calendar year
- 20% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives
- 20% off additional prescription glasses and sunglasses
- For contacts, exclusive pricing on annual supplies of popular brands

See [www.cbsservices.org/ebt](http://www.cbsservices.org/ebt) and click on the VSP link for additional information.

**Information from VSP regarding this discount program  
can be found behind this page.**



# MEDICAL AND PRESCRIPTION DRUG

## BENEFIT BOOKLET

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## **I. YOUR ROLE IN CONTROLLING HEALTH CARE COSTS**

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

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

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

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

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

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

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

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

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

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

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

## **II. INTRODUCTION**

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

### **A. Plan Benefits**

Plan Benefits are governed by this benefit description booklet.

### **B. Plan Interpretation**

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

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

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

### **C. Conformity With State Mandates**

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

### **III. HOW TO BE COVERED**

#### **A. Eligibility For Enrollment**

##### **1. When You are Eligible for Coverage**

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

##### **2. When Your Dependents are Eligible for Coverage**

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

##### **3. Newborns - 31-Day Coverage**

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

#### **B. How You Enroll for Coverage**

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

#### **C. When You Become Enrolled for Coverage**

##### **1. Noncontributory Coverage**

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

## 2. Contributory Coverage

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

## 3. Late Enrollment Provisions

### a. Definitions

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

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

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

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

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

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

### **b. Effective Date for Late Enrollees**

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

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

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

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

### **D. Special Enrollment Periods**

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

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

The Special Enrollment Periods are:

- Loss of Other Coverage: A Special Enrollment Period will apply to you or your Dependent if all of the following conditions are met:
  - You or your Dependent were covered under another Group Health Plan or had other Health Insurance Coverage at the time of initial eligibility, and declined enrollment solely due to the other coverage; and
  - The other coverage terminated due to loss of eligibility (including loss due to legal separation, divorce, death, cessation of Dependent status, termination of employment or reduction in work hours, incurring a claim that meets or exceeds the other coverage lifetime limit on all benefits, when the individual no longer resides, lives, or works in a service area and there is no other benefit package available under the other Group Health Plan, or when the other Group Health Plan no longer offers any benefits to a class of similarly situated individuals), or due to termination of employer contributions (or, if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation); and
  - Request for enrollment is made within 31 days after the other coverage terminates or after a claim is denied due to reaching the lifetime limit of all benefits under the other health coverage.

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

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

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

- "Employer contributions" include contributions by any current or former employer (of the individual or another person) who was contributing to the coverage of the individual.
- Newly Acquired Dependents: A Special Enrollment Period will apply to you or your Dependent if:
  - You are enrolled (or are eligible to be enrolled but have failed to enroll during a previous enrollment period); and
  - A person becomes your Dependent through marriage, birth, adoption or Placement for Adoption; and
  - Request for enrollment is made within 31 days after the date of the marriage, birth, adoption, or Placement for Adoption.

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

- In the event of marriage, the date of the request for enrollment; or
- In the event of a Dependent child's birth, the date of such birth; or
- In the event of a Dependent child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.
- Court-Ordered Coverage: A Special Enrollment Period will apply to your Dependent child if:
  - You are enrolled but have failed to enroll the Dependent child during a previous enrollment period; and
  - You are required by a court or administrative order to provide health coverage for the Dependent child; and
  - Request for enrollment is made within 31 days after the issue date of the court or administrative order.

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

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

- Loss of Medicaid or CHIP Coverage: A Special Enrollment Period may apply to you or your Dependent if:
  - You or your Dependent is covered under Medicaid or a Children's Health Insurance Program ("CHIP") and Medicaid or CHIP coverage is terminated as the result of loss of eligibility; and
  - You request special enrollment on an appropriately completed enrollment application within 60 days after the loss of such coverage.

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

**E. Certificate of Creditable Coverage Required by HIPAA**

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

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

**F. Transfer Provision (For Newly Enrolled Employers)**

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

- the amount which would have been paid by the previous carrier had their coverage been continued; or
- the amount payable under this Plan.

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

#### **IV. ELIGIBLE DEPENDENTS**

For Comprehensive Medical and Prescription Drug Benefits, Dependent means:

- your spouse, if not in the Armed Forces and not covered as an Employee; and
- your unmarried natural or legally adopted child less than 26 years of age, if not in the Armed Forces and not eligible as an Employee under this Plan, who is chiefly dependent upon you for support; and
- your unmarried stepchild or any child for whom you have legal guardianship, living with you, if they meet all requirements above and We approve in writing.

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

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

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

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

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

##### **A. Change in Family Status**

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

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

## **V. WHEN YOUR COVERAGE TERMINATES**

### **A. Termination of Coverage**

Coverage for you and your Dependents terminates when:

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

Coverage for a Dependent terminates when:

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

### **B. Continuation Privilege**

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

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

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

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

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

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

## 2. Retiree Continuation Privilege

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

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

- you retire at age 55 or older with at least five consecutive years of Medical coverage under the Plan prior to retirement, and
- you are receiving a Social Security retirement benefit or a retirement benefit from your Member's (Employer's) retirement plan.

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

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

**Note:** If a retiree, or Spouse, is eligible for Medicare and chooses not to purchase Medicare A or B, benefits from this Plan will be reduced. The Plan only provides benefits under the Integration with Medicare provision discussed later in this booklet at page 57.

## 3. Federal Family and Medical Leave Act (FMLA)

### Continuation

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

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

### FMLA and Other Continuation Provisions

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

- are in addition to any other continuation provision of this plan, if any; and
- will run concurrently with any other continuation provisions of this plan for sickness, injury, layoff, or approved leave of absence, if any.

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

## **Eligible Employer**

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

## **Eligible Employee**

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

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

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

## **Mandated Unpaid Leave**

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

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

## **Reinstatement**

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

See your employer for details on this reinstatement provision.

## **Servicemember Family Leave**

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

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

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

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

##### **Continuation**

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

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

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

##### **Reinstatement**

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

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

## **VI. LIFETIME MEDICAL AND PRESCRIPTION DRUG BENEFIT MAXIMUM**

The overall Lifetime Medical and Prescription Drug Benefit Maximum for each Covered Person is \$5,000,000.

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

**VII. SUMMARY OF MEDICAL BENEFITS**

**A. Preferred Provider Organization (PPO)**

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

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

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

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

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

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

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

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

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

<b>Class</b>	<b>Scheduled Benefit</b>
All Enrolled Employees and Dependents	Comprehensive Medical

### **C. Preventive Care Benefit - PPO Providers Only**

Covered Charges will be paid at 100% up to \$1,000 per calendar year for each Covered Person. Benefits are payable only for the following listed services which are performed as part of an annual routine physical and only until the sum of benefits paid for one or more of the listed services reaches the \$1,000 maximum.

When the maximum benefit has been paid, normal Plan benefits will apply. This 100% benefit will include professional reading of lab or x-rays when the test is performed by a PPO provider.

- Physician's Office: Annual Routine Physical Exam  
Annual Routine Gynecological Exam  
Well Child Care  
Immunizations
  
- Annually - Adult: CBC & Chemistry or General Health Panel  
Urinalysis  
Pap Test - thin prep or regular (Female)  
Hemoccult  
Lipid Panel (Complete Cholesterol Screening)
  
- Annually - Age 40+: Mammogram (Female)
  
- Annually - Age 50+: PSA (Male)
  
- Age 50+: Bone Density Study, one every 3 years

### **D. Colonoscopy**

Benefits will be provided for a colonoscopy performed for routine preventive testing once every three years for a Covered Person age 50 or older. The yearly deductible will not apply for routine preventive testing performed by a Preferred Provider facility and physician.

Comprehensive Medical Coverage continues to be provided for services related to a colonoscopy performed for treatment of an illness. Standard Plan benefits will be payable.

### **E. Co-Pay Requirement Amount(s)**

- Any Co-Pay amount required will not count toward satisfaction of the Calendar Year deductible.
- Any Co-Pay amount required will continue to apply after the Out-of-Pocket Expense Maximum is reached.

**F. Deductible Requirement Amount(s)**

- You pay the following Deductibles each Calendar Year:

	<b>Preferred Providers</b>	<b>Other Than Preferred Providers</b>
Per Person .....	\$ 500	\$ 500
Per Family .....	\$ 1,500	\$ 1,500

but not counting more than the Per Person deductible amount above for any one individual in your family. After you satisfy the deductible, We will pay Covered Charges at the rate of payment shown in the Benefits Payable section on the following pages.

**G. Out-of-Pocket Expense Maximum  
per Calendar Year**

	<b>Preferred Providers</b>	<b>Other Than Preferred Providers</b>
Per Person .....	\$ 3,500	\$ 4,500
Per Family .....	\$ 7,000	\$ 9,000

- If the amount you pay for Covered Charges in any one Calendar Year reaches the Out-of-Pocket Expense Maximum shown above, We will pay 100% of additional Covered Charges (except as described above).
- The percent you pay in excess of the Co-Pay amount will be counted toward satisfaction of the Out-of-Pocket Expense Maximum shown, but will not be counted toward satisfaction of the Calendar Year deductible.
- The amounts that DO NOT apply toward your Out-of-Pocket Expense Maximum are:
  - Any Co-Pay amount required; and
  - The percent you pay under “Other Covered State Licensed Practitioners Benefits”; and
  - Penalties incurred for failure to comply with any Utilization Management Requirements; and
  - Co-Pays required from you under the Prescription Drug Benefit, and.
  - The 50% you pay under the Prescription Drug Benefit for tobacco cessation medications.

**H. Medical Care Categories of Covered Charges**

Comprehensive Medical Benefits payable will be based on four Categories of medical care services identified as Categories A, B, C and D. See the Medical Covered Charges section for full description of Covered Charges included under each Category.

**I. Benefits Payable**

Benefits will be payable during a Calendar Year as shown below and will vary depending upon whether or not needed care is received from a Hospital, Physician, or other provider who has contracted with the Preferred Provider Organization network.

Note: Where “Deductible Required” is indicated, you pay a single \$500 per person deductible each Calendar Year (or \$1,500 per family, but not more than \$500 for any one Person.)

<b>Service</b>	<b>Preferred Providers</b>	<b>Other Than Preferred</b>
<b>Category A</b>		
Inpatient Hospital Services		
Rate of Payment .....	80%	60%
Co-Pay Required .....	\$250 per admission	\$500 per admission
Outpatient Hospital Services		
Rate of Payment .....	80%	60%
Deductible Required.....	\$500	\$500
Emergency Hospital Services		
Rate of Payment .....	80%	80%
Co-Pay Required .....	\$100 per visit	\$100 per visit
<b>Category B</b>		
Physician Hospital Services (including surgery and Physician Visits)		
Rate of Payment .....	80%	60%
Deductible Required .....	\$500	\$500
<b>Other Medical Providers</b>		
Rate of Payment .....	80%	60%
Deductible Required .....	\$500	\$500

Service	Preferred Providers	Other Than Preferred
<b>Category C</b>		
Services at home or at a Physician's office or clinic		
Rate of Payment per Visit .....	100% of first \$300 80% thereafter	70%
Co-Pay Required .....	\$30 per visit	---
Deductible Required.....	---	\$500
Allergy Injections at a Physician's Office .....	100%	70%
Co-Pay Required .....	\$5 per visit	---
Deductible Required.....	---	\$500
<b>Category D</b>		
Skilled Nursing Facility, Home Health Care, and Hospice Care Services		
Rate of Payment .....	100%	70%
Deductible Required.....	None	\$500
Other State Licensed Practitioners		
Rate of Payment .....	80%	60%
Deductible Required.....	\$500	\$500
Other Medical Services , i.e, medical equipment, prosthetic appliances, ambulance, and/or supplies		
Rate of Payment .....	80%	60%
Deductible Required.....	\$500	\$500

**J. Medical Emergency**

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

This benefit will only apply if you and/or your covered Dependents reside within your Plan's PPO area.

## **K. Hospital Benefit Reduction**

Comprehensive Medical Benefits payable for Hospital Inpatient Confinement Charges will be reduced by 25%, unless a Hospital Admission Review is requested by you, or a family member, or a Physician prior to, but no later than, the day of admission to a hospital (for other than a Medical Emergency); and for a Medical Emergency, within two business days following a Hospital admission or as soon as reasonably possible thereafter.

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

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

- will not count toward satisfaction of the Out-of-Pocket Expense limits; and
- will not exceed \$2,000 per individual each Calendar Year.

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

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

## **VIII. COMPREHENSIVE MEDICAL COVERAGE**

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

### **A. Comprehensive Medical Payment Qualification**

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

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

### **B. Medical Benefits Payable**

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

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

### **C. Medical Payment Conditions**

Your Comprehensive Medical Plan covers the Prevailing Charges for medical care and services which are considered to be Covered Charges and are for the treatment of an illness or injury. Reimbursement for Covered Charges is based on:

- charges in excess of the Deductible Requirement; and
- charges in excess of the Co-Pay requirement; and
- the payment percentages indicated; and
- the Maximum Payment Limits; and
- any modifications as described in Special Benefit Provisions - Limited.

#### **D. Covered Charges**

Covered Charge(s) means treatment or services:

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

Payment for Covered Charges will be limited to the actual cost to you or one of your Dependents, but only to the extent that the actual cost does not exceed Prevailing Charges.

Payment for Covered Charges not listed shall be determined by Us based on the amount payable for a Covered Charge of a comparable nature.

Covered Charges are based on four Categories of medical care services as described below as Category A, B, C, and D.

## 1. Category A

Category A includes:

- Hospital charges for room and board (but not more than the Private Room Maximum, if confinement is in a private room);
- Hospital charges for services other than room and board;
- Hospital charges for infertility treatment but limited to initial lab tests, hysterosalpingogram, hysteroscopy, pelvic ultrasound, and transvaginal ultrasound for the restoration of fertility or the promotion of conception. Covered Charges may also include corrective surgery if documentation is provided verifying abnormal or non-functioning body processes;
- Hospital charges for a diabetic self-management program for a Covered Person who has been newly diagnosed with Diabetes Mellitus, or has new complications thereof, and such program has been pre-approved by Us;
- Hospital charges for the services of a Registered Nurse, but only when such services are provided while receiving treatment in a Hospital (except as limited under the Special Benefit Provisions - Limited sections beginning at page 29);
- Hospital charges for the services of a licensed physiotherapist, but only when such services are provided while receiving treatment as an inpatient;
- charges by a Physician for pathology, radiology, or the administration of anesthesia while receiving covered treatment at a Hospital (on an inpatient or outpatient basis);
- charges for blood and blood plasma when provided while receiving treatment in a Hospital.

## 2. Category B

Category B includes charges for:

- the services of a Physician including Surgery and Physician Visits, while receiving treatment at a Hospital on an inpatient or outpatient basis (except as limited under the Special Benefit Provisions - Limited sections beginning at page 29);
- the services of an assistant to a surgeon if it is determined the skill level of a Physician is required for such services. Covered Charges for such services will be paid at up to 20% of Prevailing Charges of the covered surgical procedure if the procedure is performed by a Physician or a Health Care Extender;
- the use of a Ambulatory Surgery Center, Birthing Center, free standing facility, or charges from a Physician for use of a surgical room or suite;
- the services of a Registered Nurse, but only when such services are provided by:
  - an advanced practice Registered Nurse in lieu of a Physician; i.e., Certified Nurse Anesthetist, Certified Nurse Midwife, Certified Registered Nurse Practitioner (except as limited under the Special Benefit Provisions – Limited sections beginning at page 29);
- the services of a licensed physiotherapist as limited under the Special Benefits Provisions - Limited section; Physical and Occupational Therapy Benefit at page 34;
- the services of a radiologist, pathologist, or anesthesiologist;
- the services of x-ray and laboratory providers;
- the services of a laboratory provider for genetic testing if the testing meets the Plan's criteria and is pre-approved by Us;
- infertility treatment but limited to initial lab tests, hysterosalpingogram, hysteroscopy, pelvic ultrasound, and transvaginal ultrasound for the restoration of fertility or the promotion of conception. Covered Charges may also include corrective surgery if documentation is provided verifying abnormal or non-functioning body processes;
- the services of a qualified speech therapist to restore or rehabilitate any speech loss or impairment caused by injury or sickness, except a mental, psychoneurotic, or personality disorder or by surgery for that injury or sickness. In the case of congenital defect, speech therapy expenses will be considered only if incurred after corrective surgery for the defect.

### 3. Category C

Category C includes charges for:

- services furnished at a Physician's clinic or office or at your home. Such services include charges from the Physician's clinic or office for a Visit, dressings, supplies, injections, anesthesia, blood, blood plasma, x-ray and laboratory examinations, x-ray, radium, and radioactive isotope therapy, routine physical examinations. Such services at the Physician's clinic will not include charges for surgical rooms or suites, Durable Medical Equipment, or separate charges for use of equipment;
- services at a Physician's clinic or office for genetic testing if the testing meets the Plan's criteria and is pre-approved by Us;
- services at a Physician's clinic or office for an initial visit for the restoration of fertility or the promotion of conception. Covered Charges will include initial lab tests, hysterosalpingogram, hysteroscopy, pelvic ultrasound, and transvaginal ultrasound. Covered Charges may also include corrective surgery if documentation is provided verifying abnormal or non-functioning body processes;
- services at a physician's clinic or office for a diabetic self-management program for a Covered Person who has been newly diagnosed with Diabetes Mellitus, or has new complications thereof. Such program should be pre-approved by Us and the program must be well defined or have received American Diabetes Association approval;
- the services of a Registered Nurse, but only when such services are provided by:
  - an advanced practice Registered Nurse in lieu of a Physician; i.e., Certified Nurse Anesthetist, Certified Nurse Midwife, Certified Registered Nurse Practitioner;
- Dental Services to repair damage to the jaw and sound natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and the Dental Services are completed within twelve months after the accident, and not covered by your dental plan;
- the services of a Health Care Extender. Health Care Extender means a member of a covered provider's staff or allied health practitioner. Medical services must be billed by and delivered under the Direction and Supervision of a provider covered by the Plan.

#### 4. Category D

Category D includes charges for:

- services by a State Licensed Practitioner as limited under the Special Benefit Provisions - Limited section; Other Covered State Licensed Practitioners Benefits at page 32;
- Federal Legend drugs and medicines requiring a Physician's prescription that are not eligible under the Prescription Drug Coverage for Retail Network Pharmacy and Home Delivery Pharmacy;
- transportation by ambulance provided by a Hospital or licensed service to a local Hospital, to the nearest Hospital equipped to furnish needed treatment not available in a local Hospital, or when needed to transition to a more cost effective level of care as determined by Us;
- surgical dressings, casts, splints, braces, crutches, artificial limbs, and artificial eyes;
- rental or purchase of Durable Medical Equipment (DME). The maximum charges eligible for consideration for rental of DME will be limited to the purchase price. When We determine whether to purchase or rent the equipment, We will consider the type of equipment requested, and the condition and length of time for which it will be used. Eligible equipment is a nebulizer, commode, walker, manual wheelchair, or standard hospital-type bed. Other DME may be eligible after Our review, but We must pre-approve the requested equipment;
- repair, adjustment, or replacement of covered purchased Durable Medical Equipment, unless damage results from your or your dependent's negligence or abuse of such equipment;
- oxygen (including rental of equipment for its administration);
- convalescent care in a Skilled Nursing Facility only as described under the Special Benefit Provisions - Limited section; Skilled Nursing Facility Confinement Benefits at page 32;
- Hospice Care only as described under the Special Benefit Provisions – Limited section; Hospice Care Benefits at page 31;
- Home Health Care only as described under the Special Benefit Provisions – Limited section; Home Health Care Benefits at page 30;
- the services of a Registered Nurse, but only when such services are provided during confinement in a Skilled Nursing Facility or when such services are provided as part of Home Health Care or Hospice Care (all described under Special Benefit Provisions – Limited beginning at page 29);
- the services of a licensed physiotherapist, but only when such services are provided during confinement in a Skilled Nursing Facility as described under the Special Benefit Provisions - Limited section; Skilled Nursing Facility Confinement Benefits at page 32.

## 5. Miscellaneous

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

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

## 6. Quest Diagnostics Lab Card Program – Outpatient Laboratory Services

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

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

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

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

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

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

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

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

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

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

## **7. Maternity Benefit**

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

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

## **8. Benefits Payable – Compliance With Federal Law**

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

### **Newborns' and Mothers' Health Protection Act of 1996**

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

### **Women's Health and Cancer Rights Act of 1998**

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

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

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

These benefits are subject to all Plan provisions including the applicable deductible and coinsurance based upon where and by whom services are rendered. Please refer to your Summary of Medical Benefits, beginning on Page 14, for a full description of deductibles and coinsurance percentages.

## **9. Prenatal Care Program**

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

You may enroll by calling 1-800-248-5447, Monday through Friday, 8 a.m. to 5 p.m. Central Time.

## **10. Care Management Program for Newborns**

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

A case manager will identify the newborn and refer case management to ParadigmHealth. There is no cost to you for this program, but a written or verbal consent will be needed for the infant to receive the case management services.

## **11. Prevailing Charges for Multiple Surgical Procedures**

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

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

## **12. Covered Charges for an Assistant during Surgical Procedures**

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

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

**IX. SPECIAL BENEFIT PROVISIONS - LIMITED**

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

Covered Charges exceeding Prevailing Charges are not eligible for payment.

**A. Home Health Care Benefits**

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

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

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

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

- services or supplies not included in the Home Health Care Plan, as defined; or
- the services of any person who normally lives in the Employee or Dependent's home; or
- custodial care (assistance with meeting personal needs or the activities of daily living that does not require the services of a Physician, Registered Nurse, licensed practical nurse, chiropractor, physical therapist, occupational therapist, speech therapist, or other health care professional and includes bathing, dressing, getting in and out of bed, feeding, walking, elimination, and taking of medications); or
- transportation services; or
- more than 100 Home Health Care visits in a calendar year. For this purpose, one visit will be counted for up to four hours of service (in a 24-hour period) by a Home Health Aide and one visit will be counted for each visit by any other person.

See your Summary of Benefits, Category D, for the percentage payable by the Plan for Covered Charges.

Maximum benefit payable per calendar year for eligible charges by a PPO Provider..... \$10,000 per Covered Person

Maximum benefit payable per calendar year for eligible charges by Other Than a PPO Provider ..... \$ 7,000 per Covered Person

**B. Hospice Care Benefits**

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

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

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

All terms are defined under "Definitions."

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

- exceed \$10,000 in Plan benefits for any one Hospice Care Episode; or
- exceed six months for all Hospice benefits due to the same or a related injury or sickness; or
- are for Hospice Care Services not approved by the attending Physician and Us; or
- are for transportation services; or
- are for custodial care (services or supplies provided to assist a person in daily living--e.g., meals and personal grooming); or
- are for Hospice Care Services provided at a time other than during a Hospice Care Episode.

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

See your Summary of Benefits, Category D, for the percentage payable by the Plan for Covered Charges.

Maximum Benefit per Hospice Care Episode..... \$10,000 per Episode and  
\$20,000 per covered Person's Lifetime

**C. Other Covered State Licensed Practitioners Benefits**

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

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

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

Benefits are limited to:

- a maximum payment of \$2,000 per Covered Person per Calendar Year.

See your Summary of Benefits for the percentage payable by the Plan for Covered Charges. The yearly maximum benefit is combined for all covered providers. The percent you pay does not apply toward the Calendar Year Deductible and Out-of-Pocket Expense Maximum.

Maximum Benefit Payable.....\$2,000 per Calendar Year

**D. Skilled Nursing Facility Confinement Benefits**

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

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

Covered Charges for each day will not be more than 50% of the Private Room Maximum of the Hospital in which the Covered Person was confined before the Skilled Nursing Facility confinement. Also, Covered Charges will not include charges for more than 120 days for all Skilled Nursing Facility confinements that result from the same or a related sickness or injury. In addition, Covered Charges will not include any charges after the date the attending Physician stops treatment or withdraws certification. See your Summary of Benefits, Category D, for the percentage payable by the Plan for Covered Charges.

Maximum benefit payable per calendar year for eligible charges by a PPO Provider.....\$10,000 per Covered Person

Maximum benefit payable per calendar year for eligible charges by Other Than a PPO Provider .....\$ 7,000 per Covered Person

**E. Preventive Care Benefits**

Comprehensive Medical Coverage will be limited to charges for routine immunizations and inoculations given as preventive measures against disease, premarital examinations, or routine physical exam charges including outpatient lab and x-ray and other diagnostic procedures when connected with a routine physical exam.

Benefits will be payable the same as any other sickness. However, the Plan does provide a special limited benefit for Preventive Care from PPO Providers. Please refer to your Summary of Medical Benefits for a full description.

**F. Colonoscopy Benefit**

Comprehensive Medical Coverage is provided for services related to a colonoscopy performed for treatment of an illness or for routine preventive testing. If the colonoscopy is performed for routine preventive testing, Covered Charges are limited to once every three years and for a Covered Person age 50 or older. If services are provided by a Preferred Provider, special benefits will apply. Please refer to your Summary of Medical Benefits, Page 15, for a full description.

**G. Natural Family Planning Benefit**

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

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

**H. Orthotic Benefit**

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

Maximum Benefit Payable..... \$500 per Covered Person’s Lifetime

**I. Physical and Occupational Therapy Benefit**

Comprehensive Medical Covered Charges will include charges for physical and/or occupational therapy for services rendered by a Physician, licensed Physical Therapist, or licensed Occupational Therapist. Benefits payable for Treatment or Service performed other than while Hospital inpatient confined, by use of: exercise; application of cold, heat, or electricity; traction; diathermy; ultrasound; or water will be limited to a maximum benefit of \$6,000 each calendar year for each Covered Person. Benefits may include one visit per month for maintenance therapy.

Charges incurred for each Physician Visit at the Physician's office or clinic when physical therapy is performed will be applied toward the calendar year maximum benefit, unless other non-physical therapy services are provided during the office or clinic visit. If other non-physical therapy services are provided during the office or clinic visit, charges incurred for the Physician Visit will not apply toward the calendar year maximum benefit.

Maximum Benefit Payable.....\$6,000 per Calendar Year

## J. Organ and Tissue Transplant Benefits

Transplant Services (for Members and Dependents in the Aetna Signature Administrators<sup>sm</sup> (ASA) PPO Network)

### 1. Institute of Excellence (IOE)

This is a facility that is contracted with Aetna to furnish particular Treatment or Service to you or your Dependent in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such Treatment or Service will be the amount agreed to between Aetna and the IOE.

### 2. Transplant Covered Charges

**Once it has been determined that you or one of your Dependents may require an organ transplant from the list below, you, or your Physician should call the Claims Administrator to discuss coordination of transplant care.** Aetna will coordinate all transplant services. In addition, you must follow the Utilization Management Requirements described in the Utilization Review section. Organ means solid organ; stem cell; bone marrow; and tissue.

Benefits may vary if an Institute of Excellence<sup>TM</sup> (IOE) facility or non-IOE is used. In addition, some Covered Charges listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the required procedure. Treatment or Service of a covered transplant will be covered at the PPO level of benefits only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. **Any Treatment or Service related to transplants that are provided by a facility not specified as an IOE network facility (even if the facility is considered a PPO facility for other types of Treatment or Service) will be covered at the Non-PPO level of benefits.** [See below under Outside the IOE Network for details.] Please read each of the following sections carefully.

Transplant Covered Charges include the following:

- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family. For the purpose of this Transplant Services section, “immediate family” is defined as a first-degree biological relative. This means your or your Dependent’s biological parent, sibling or child.
- Inpatient and outpatient Covered Charges directly related to a transplant.
- Charges made by a Physician or transplant team.
- Charges made by a Hospital, outpatient facility, or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related Treatment or Service provided by the IOE facility during the transplant process. The Treatment or Service may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; Home Health Care, and home infusion services.

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

“Transplant Occurrence” a period of time beginning at the point of evaluation for a transplant and ends either: (1) 180 days from the date of the transplant; or (2) upon the date the transplant recipient is discharged from the Hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one Transplant Occurrence and a summary of Transplant Covered Charges during each phase are:

- 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.
- Pre-transplant/Candidacy Screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family.
- Transplant Event: Includes inpatient and outpatient services for all Transplant-related Covered Charges provided to the transplant recipient and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during the Hospital Inpatient Confinement or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during the transplant recipient’s Hospital Inpatient Confinement or outpatient visit(s); cadaveric and live donor organ procurement.
- Follow-up Care: Includes all transplant Covered Charges; Home Health Care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

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

- Heart;
- Lung;
- Heart/ Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;

- Bone Marrow/Stem Cell transplant;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant; or
- Any other single organ transplant, unless otherwise excluded under this plan.

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

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

### **3. Travel and Lodging Expenses**

If Treatment or Service of a covered transplant is performed in a facility that has been designated as an IOE facility and the facility is more than 100 miles from the transplant recipient's residence, expenses related to travel and lodging for the transplant recipient and one companion will be considered Covered Charges, not to exceed \$10,000 for any one transplant or procedure type, including tandem transplants. This is a combined maximum for the transplant recipient, companion, and donor.

Travel is reimbursed between the transplant recipient'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 costs are reimbursed. Mileage Reimbursement is based upon the Federal Tax Table at the time the expenses were incurred.

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

No benefits will be payable for travel and lodging expenses if services are provided by a facility not specified as an IOE network facility (even if the facility is considered a PPO facility for other types of Treatment or Service).

**4. Outside the IOE Network**

For Transplant Covered Charges provided by any covered provider other than a provider in the IOE network, benefits will be payable at the Non-PPO Provider level of benefits up to the following maximum benefits for each surgery listed below, and up to a lifetime maximum benefit of \$150,000 for you and your Dependents.

Heart.....	\$95,000
Lung .....	\$110,000
Heart/Lung (simultaneous) .....	\$145,000
Simultaneous Pancreas Kidney (SPK)	\$84,000
Pancreas .....	\$65,000
Kidney.....	\$50,000
Liver.....	\$110,000
Intestine.....	\$150,000
Bone Marrow/Stem Cell	
- Autologous .....	\$60,000
- Allogeneic .....	\$100,000

Services subject to the transplant episode and lifetime maximums will include Covered Charges as specified in this section including but not limited to: evaluation; pre-transplant, transplant, and post-transplant care (not including outpatient immunosuppressant drugs); organ donor search, procurement and retrieval; complications related to the procedure and follow-up care for services received during the 12-month period from the date of transplant. Services by a Home Health Care Agency, Skilled Nursing Facility, or Hospice will reduce those provisions.

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

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

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

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

**5. Limitations**

The general Comprehensive Medical limitations as described in this section will apply to Transplant Services. In addition, Transplant Services do not include charges for:

- any Treatment or Service related to the use of embryonic stem cells;

- outpatient drugs, including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence;
- Treatment or Service furnished to a donor when the recipient is not you or your Dependent;
- home infusion therapy after the Transplant Occurrence;
- harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants. Cornea and cartilage transplants are covered under the normal provisions of the Comprehensive Medical section, and are not subject to any conditions set forth in this Transplant Services section.

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

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

## **X. DEDUCTIBLE REQUIREMENT**

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

Any Co-Pays specifically indicated in your summary pages will not apply toward satisfaction of the Deductible Requirement.

### **Family Limit**

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

## **XI. OUT-OF-POCKET EXPENSE MAXIMUM REQUIREMENT**

When the Deductible Requirement Amount(s) plus the percent you pay on Covered Charges reach the Out-of-Pocket Expense Maximums for you and your family in a Calendar Year, all Covered Charges will be reimbursed at 100% for the balance of the Calendar Year. (See the Summary of Benefits, Comprehensive Medical, for the Out-of-Pocket Expense Maximum for you and your family.)

The amounts that DO NOT apply toward your Out-of-Pocket Expense Maximum are:

- Any Co-Pay requirement if applicable; and
- The percent you pay under "Other Covered State Licensed Practitioners"; and
- Penalties incurred for failure to comply with any Utilization Management Requirements; and
- Co-Pays required from you under the Prescription Drug Benefit; and
- The 50% you pay under the Prescription Drug Benefit for tobacco cessation medications.

## **XII. LIMITATIONS OF COMPREHENSIVE MEDICAL BENEFITS**

Comprehensive Medical Benefits will not be paid for:

- a. Treatment or Service that is not a Covered Charge, as defined, for treatment of an illness or injury;
- b. Treatment or Service that is an Experimental or Investigational Measure;
- c. charges that exceed Prevailing Charges;
- d. charges that are billed incorrectly or separately for Treatment or Services that are an integral part of another billed Treatment or Service as determined by Us;
- e. charges for Physician overhead, including but not limited to equipment used to perform a particular Treatment or Service (i.e. laser equipment);
- f. Treatment or Service for foot care with respect to: corns, calluses, trimming of toe nails, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;
- g. Treatment or Service for foot care with respect to: casting, testing, fitting or purchase of orthotics, or any appliance (including orthotics), except as covered under Special Benefit Provisions – Limited, Orthotic Benefit at page 33;
- h. charges for shoes or shoe lifts;
- i. the surgical treatment of obesity including any and all surgical revisions related to this non-covered surgery, even if the Covered Person has other health conditions which might be helped by weight loss or reduction of obesity;
- j. Treatment or Service related to the restoration of fertility or promotion of conception (except as described under Covered Charges);
- k. molecular genetic testing (specific gene identification) for the purposes of health screening or if not part of a treatment regimen for a specific sickness;
- l. charges for storage of blood or blood products;
- m. Treatment or Service for voluntary sterilization or reversal of sterilization;
- n. Treatment or Service for abortion;
- o. Treatment or Service for contraception;
- p. Treatment or Service for sexual dysfunction, except when related to an illness and approved by Us;
- q. Treatment or Service for transsexualism;

- r. charges incurred to improve general physical condition, including, but not limited to programs such as counseling and monitored exercise to improve or maintain general health;
- s. Treatment or Service for behavior modification;
- t. Treatment or Service for marital counseling or social counseling;
- u. Treatment or Service for tobacco cessation or nicotine addiction, except for physician office visits or as provided under Prescription Drug Benefits;
- v. Treatment or Service for gambling addiction, or stress management;
- w. Treatment or Service for educational or instructional purposes (except as described under Covered Charges);
- x. Treatment or Service for educational, training or developmental problems, learning disorders;
- y. Treatment or Service eligible under your Dental Plan;
- z. Dental Services (except as described under Covered Charges);
- aa. Treatment or Service for any form of temporomandibular joint disorder (malfunction, degeneration, or disease related to the joint that connects the jaw to the skull), including but not limited to braces, splints, appliances, or surgery of any type;
- ab. drugs and medicines eligible under the Prescription Drug Coverage for Retail Network Pharmacy and Home Delivery Pharmacy, except as listed under Covered Charges;
- ac. drugs and medicines dispensed by a nursing home or rest home (Note: such drugs are eligible under the Prescription Plan if purchased at a Retail Network Pharmacy or the Home Delivery Pharmacy);
- ad. Treatment or Service for DESI (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness);
- ae. charges for non-prescription drugs; non-prescription vitamins and minerals;
- af. charges for nutritional supplements, special diets, special formula;
- ag. charges for eye examinations for correction of vision or fitting of glasses, vision materials (frames or lenses);
- ah. Treatment or Service for Kerato-Refractive Eye Surgery (surgery to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including but not limited to radial keratotomy and keratomileusis surgery);
- ai. acupuncture or acupressure treatment (except as limited under the Special Benefit Provisions – Limited, Other Covered State Licensed Practitioners Benefits at page 32);

- aj. Treatment or Service for Cosmetic Surgery (except when the surgery results from an accidental injury and is performed within 18 months of that injury);
- ak. Treatment or Service for:
  - human-to-human organ or bone marrow transplants, except as provided under the Special Benefits Provisions- Limited, Organ and Tissue Transplant Benefits beginning on page 35;
  - animal-to-human organ or tissue transplants; or
  - implantation within the human body of artificial or mechanical devices designed to replace human organs;
- al. Treatment or Service for unattended home sleep studies;
- am. any nursing services (except as described under Covered Charges);
- an. Treatment or Service for custodial care;
- ao. Treatment or Service for maintenance therapy or supportive care or when maximum therapeutic benefit (no further objective improvement) has been attained (except as described under Covered Charges);
- ap. charges for sports, employment or immigration physicals;
- aq. charges for transportation or ambulance services except as described under Covered Charges;
- ar. Durable Medical Equipment:
  - used for personal hygiene, comfort, or convenience, whether or not recommended by a Physician, including, but not limited to, air conditioners, humidifiers, diapers, underpads, bed tables, tub bench, shower chair, hooyer lift, gait belts, bedpans, physical fitness equipment, stair glides, elevators, or lift;
  - used for “barrier free” home modifications, whether or not recommended by a Physician, including, but not limited to, ramps, grab bars, or railings;
  - used for non-implantable communication-assist devices, including, but not limited to, communications boards, and computers;
  - which are in excess of the purchase price of the equipment; or
  - which are provided during rental for repair, adjustment, or replacement of components and accessories necessary for the functioning and maintenance of covered equipment, as this is the responsibility of the DME supplier;
- as. charges for comfort or convenience services and supplies;
- at. charges for prone standers, Amigo-type carts, motorized scooters, etc.;
- au. charges for heating pads, heating and cooling units, ice bags or cold therapy units;

- av. charges for devices used specifically as safety items or to affect performance in sport-related activities;
- aw. charges for hearing aids and related charges;
- ax. charges for wigs or hair prostheses;
- ay. delivery charges or taxes;
- az. charges for telephone calls or telephone consultations or missed appointments;
- ba. charges for e-mail communication or e-mail consultation;
- bb. additional charges incurred because care was provided after hours, on a Sunday, holidays or week-end;
- bc. Weekend Admission Charges;
- bd. charges for travel and lodging (except as limited under the Special Benefit Provisions - Limited, Section IX; Organ and Tissue Transplant Benefits beginning on page 35);
- be. charges for which the Covered Person is not legally obligated to pay or which are for medical or dental care furnished without charge, paid for or reimbursable by or through the government of a nation, state, province, county, municipality, or other political subdivision, or any instrumentality or agency of such a government;
- bf. Treatment or Service rendered in a hospital owned or operated by the United States Government, either by the hospital or a physician/dentist employed by it (a) unless the treatment is of an emergency nature, and (b) unless the Covered Person is not entitled to such treatment by reason of his status as a veteran or otherwise;
- bg. Treatment or Service for an injury or sickness which results from war, act of war, or voluntary participation in criminal activities while a Covered Person;
- bh. Treatment or Service for an injury or sickness which arise out of or in the course of employment, and which either entitles the Covered Person to benefits under a Worker's Compensation Act or similar legislation, or would have entitled him to benefits if coverage under such a statute could have been in force on a voluntary or elective basis;
- bi. Treatment or Service provided by any person, hospital, or entity whose charges for medical/dental care, depend on the patients' financial ability to pay or availability of coverage;
- bj. Treatment or Service for the purpose of duplicating or replacing equipment, brace, or supply that is lost or stolen;
- bk. charges which are eligible to be paid by a previous group plan which was replaced by enrollment in the Christian Brothers Employee Benefit Trust;

- bl. Treatment or Service provided outside the United States unless the Covered Person is outside the United States for one of the following reasons:
  - travel, provided the travel is for a reason other than securing medical or dental care diagnosis or treatment;
  - a business assignment by a covered Member (Employer);
  - the Employee is employed by a covered Member (Employer) and working outside the United States; or
  - Full-Time Student status, provided the dependent is either:
    - enrolled and attending an accredited school in a foreign country; or
    - is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit;
- bm. the services of any person in your Immediate Family or any person in your Dependent's Immediate Family;
- bn. Treatment or Service provided by any type of health care practitioner not otherwise provided for in this Plan;
- bo. Treatment or Service that is subject to the Preexisting Conditions Exclusion, except as provided under that section; or
- bp. Treatment or Service incurred after termination of coverage under this Plan.

### **XIII. PREEXISTING CONDITIONS EXCLUSION**

#### **Preexisting Condition Defined**

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

However, pregnancy will not be considered a Preexisting Condition.

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

#### **Exclusion Period**

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

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

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

Exemption for Certain Dependent Children. The Preexisting Condition Exclusion described will not apply to any Dependent child:

- who is the Member's newborn child, or a child newly adopted by the Member (or Placed for Adoption with the Member) prior to the child's attainment of age 18; and
- whose coverage becomes effective under the Plan within the 31-day period immediately following the date of birth, adoption, or Placement for Adoption.

If a Dependent child becomes covered under the Plan other than as described above, that child will also be exempt from the Preexisting Condition Exclusion if:

- the child was covered under another Creditable Coverage as of the last day of the 31-day period beginning with the child's date of birth, adoption or Placement for Adoption (provided the adoption or Placement occurred prior to the child's attainment of age 18); and
- the child has subsequently maintained continuous Creditable Coverage, with no gap in coverage exceeding 63 days.

If any such child's coverage under the Plan terminates and the child later becomes covered again under the Plan, the exemption will continue to apply to the child unless there has been a period of at least 63 days during all of which the child was not covered under any Creditable Coverage.

For the purpose of these provisions, a Waiting Period or HMO Affiliation Period will not be considered a break in Creditable Coverage.

## **Credit for Previous Creditable Coverage**

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

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

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

#### **XIV. EXTENSION OF MEDICAL BENEFITS AFTER TERMINATION OF COVERAGE**

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

- The provisions of the Plan will be applicable to such benefits just as if coverage had not terminated.
- Benefits will be paid for only those Covered Charges which are due to care and treatment of such total disability.
- Charges incurred after termination of coverage will be applied toward satisfaction of the deductible only if they are incurred for care and treatment of such total disability.
- Benefits will normally be payable for all such Covered Charges incurred within the three month period immediately following termination of coverage.
- This extension of benefits will not apply to any charges which are incurred after the occurrence of the first of the following events: (1) the expiration of a number of months equal to the number of months the Covered Person has been covered by the Comprehensive Medical Plan before such termination of coverage; (2) the expiration of three months immediately following termination of coverage; (3) the date the Covered Person becomes covered under any other group, franchise, Blue Cross Blue Shield, other service or prepayment plan, or Medicare.

## **XV. UTILIZATION MANAGEMENT REQUIREMENTS - HOSPITAL**

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

- For Hospital Inpatient Confinement Charges, a Hospital Admission Review is requested by you, a family member, or a Physician prior to, but no later than, the day of admission to a Hospital (for other than a Medical Emergency); and for a Medical Emergency, within two business days following a Hospital admission or as soon as reasonably possible thereafter. If a Hospital Admission Review is not requested in a timely manner as specified above, the 25% reduction in benefits payable will be applied to all Hospital Inpatient Confinement Charges, but only to the charges incurred up to the date a Hospital Admission Review is obtained.

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

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

- A Hospital Admission Review is not required for mother and baby for:
  - A 48-hour Hospital Inpatient Confinement following vaginal delivery; or
  - A 96-hour Hospital Inpatient Confinement following cesarean section.

A request for review by the Cost Containment Administrator of the need for continued Hospital Inpatient Confinement for mother or baby beyond the automatically approved time period stated above must be made by you, a Dependent, or a designated patient representative before the end of that time period.

If a Hospital Admission Review, as specified in this section, is not requested, benefits will be reduced by 25% for Hospital Inpatient Confinement Charges incurred beyond the 48-hour or 96-hour automatically approved Hospital Inpatient Confinement for childbirth.

The 25% reduction in benefits payable is a penalty for failure to comply with the Utilization Management Requirements set forth in this section. **Any such reductions will not exceed \$2,000 per Calendar Year for any one person.**

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

The report (verbal or written) must include the:

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

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

The report (verbal or written) must include the:

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

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

## **XVI. CLAIM PROCEDURES**

### **Claim Forms**

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

### **Prompt Filing**

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

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

Proof of loss sent later will be accepted only if there is reasonable cause for the delay, We are not prejudiced by the delay, and the claim is received no later than two years after date of loss.

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

### **Payment, Denial, and Review**

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

If a claim cannot be processed due to incomplete information, We will either deny the claim or send a written explanation requesting additional information. If additional information is requested and it is not received at the end of 30 calendar days, a decision will be made without it.

**Initial appeal:** If your claim has been denied in whole or in part, you may request an appeal of the denial. Your appeal must be in writing and must state the reason or reasons why you believe the original decision was incorrect. Such appeal must be received by Us within 60 days after your receipt of the notice of denial or at least 60 days from the end of the processing period, if you've heard nothing by that time. Besides having the right to appeal, you or your authorized representative may examine any plan documents related to your claim.

We will make a full and fair review of the claim and notify you in writing of the appeal decision within 60 calendar days of receiving it.

**Plan Committee appeal:** If the initial appeal was denied in whole or in part, you may appeal that decision to the Plan Committee. Your appeal must be in writing and must be received within 60 days after your

receipt of the notice of denial. You may submit written comments, documents, records, and other information relating to the claim. The Plan Committee will make a determination within 60 calendar days unless the appeal cannot be processed due to incomplete information. If more information is needed, the Plan Committee will send a written request for the additional information. Failure to receive the additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request.

**Trustee appeal:** The final decision as to whether a claim is payable to you is made by the Trustees. If you disagree with the Plan Committee's determination, you may appeal that decision to the Appeals Committee of the Board of Trustees. Your appeal must be in writing and must be received within 60 days after your receipt of the notice from the Plan Committee. Your appeal should state the reason or reasons why you believe the Plan Committee decision should be reversed or an exception be made. In connection with your appeal, you may review pertinent documents regarding your claim and submit issues and comments in writing. The Appeals Committee of the Board of Trustees will make a determination within 60 calendar days and will furnish you with written notice of its final decision regarding the appeal. However, in special cases, they may be allowed up to 180 days.

Your appeal must be denied by the Trustees before you can file a civil action or pursue any other legal remedies.

### **Physical Examinations**

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

### **Release of Medical Information**

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

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

## **XVII. COORDINATION WITH OTHER BENEFITS – MEDICAL**

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

### **A. Definitions**

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

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

- any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or employee benefit or other association; and
- any program required or established by state or Federal law, including Medicare Parts A and B (see Medicare rules below); and
- any program sponsored by or arranged through a school or other educational agency; and
- the first-party medical expense provisions of any automobile policy issued under a no-fault insurance statute including the self-insured equivalent of any minimum benefits required by law;

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

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

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

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

## **B. Effect on Benefits**

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

- benefits are payable under any other Plan for the same Allowable Expenses; and
- the rules listed below provide that benefits payable under the other Plan are to be determined before the benefits payable under This Plan.

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

## **C. Order of Benefit Determination**

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

- Nondependent/Dependent. The benefits of a Plan which covers the person for whom benefits are claimed as an Employee, Member, or subscriber (that is, other than as a Dependent) are determined before the benefits of a Plan which covers the person as a Dependent.
- Dependent Child--Parents Not Separated or Divorced. When This Plan and another Plan cover the same child as a Dependent of different persons called "parents," the benefits of the Plan of the parent whose birthday falls earlier in a calendar year are determined before those of the Plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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

- Dependent Child--Separated or Divorced Parents. If two or more Plans cover a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - first, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child; and
  - finally, the Plan of the parent not having custody of the child.

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

- Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules for Dependent children of parents who are not separated or divorced.
- Active/Inactive Employee. The benefits of a Plan which covers a person as an Employee who is neither laid off nor retired, or as that Employee's Dependent, are determined before the benefits of a Plan which covers that person as a laid-off or retired Employee or as that Employee's Dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.
- Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an Employee, Member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.
- Automatic Coverage for a Newborn Child. When This Plan and another Plan both provide benefits, the benefits of the other Plan will be determined before the benefits payable under the Automatic Coverage for a Newborn Child provision of This Plan.
- Continuation/Extension of Benefits. When This Plan and another Plan both provide benefits, the benefits of the plan covering the person as an employee, member or subscriber, or as that person's dependent, will be determined before the benefits payable under This Plan's Extension of Benefits.

#### **D. Medicare Rules**

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

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

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

#### **E. Medicare Exception**

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

Federal law will usually apply in such instances if:

- the benefits are applicable to an active Covered Employee (rather than a Retiree) or to that Covered Employee's spouse; or
- the Covered Employee's Member (Employer) has 20 or more employees.

## **F. Integration With Medicare**

### **(For all Covered Persons where permitted by Law)**

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

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

It works this way:

- In determining a claim payment under This Plan, the first step is to calculate the amount that would be paid if the person had no Medicare coverage. The Covered Charges under This Plan will be limited to the amounts approved by Medicare or no more than the limiting charges as determined by Medicare.
- The above amount is reduced by the Medicare benefits for the expenses upon which the claim under This Plan is based. In determining the Medicare benefits, the person will be assumed to have full Medicare coverage (that is, both Part A and Part B) whether or not the person has enrolled for the full coverage.
- If a provider has chosen not to apply to Medicare to become a participating provider, This Plan will estimate Medicare benefits as if application has been made and was approved. Any benefit payable by the Plan will then be calculated as if Medicare had been paid.

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

## **G. Coordination with HMOs**

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

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

## **H. Coordination with Excess Only or Secondary Only Plans**

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

- excess only of other available benefits; or
- secondary only of other available benefits;

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

**I. Secondary Coverage Under Automatic Coverage for Newborn Child Provision**

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

**J. Exchange of Information**

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

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

**K. Facility of Payment**

We may reimburse any other plan if:

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

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

**L. Right of Recovery**

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

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

## **M. Transfer of Rights**

**(Applicable in California)**

### **1. Applicability**

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

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

### **2. Transfer of Rights**

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

## **N. Covered Person Obligations**

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

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

## **XVIII. SUMMARY OF PRESCRIPTION DRUG BENEFITS**

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

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

#### **Retail Network Pharmacy Copayment for short-term drugs or for the first three (3) times you purchase a long-term maintenance drug:**

- \$100 in each calendar year of any eligible Prescription Drug Charges (either Retail or Home Delivery); then
- \$10 of Generic Prescription Drug Charges for each prescription and each refill; or
- \$30 of all Preferred Brand-Name Prescription Drug Charges for each prescription and each refill (as explained in the description of your “formulary” below); or
- \$50 of all Non-Preferred Brand-Name Prescription Drug Charges for each prescription and each refill.
- For tobacco cessation, the benefit is limited to 50% of Network Pharmacy Price with a Lifetime Maximum benefit of \$750.

#### **Retail Network Pharmacy Copayment beginning with the fourth (4th) time you purchase a long-term maintenance drug:**

- \$100 in each calendar year of any eligible Prescription Drug Charges (either Retail or Home Delivery); then
- \$25 of Generic Prescription Drug Charges for each prescription and each refill; or
- \$75 of all Preferred Brand-Name Prescription Drug Charges for each prescription and each refill (as explained in the description of your “formulary” below); or
- \$125 of all Non-Preferred Brand-Name Prescription Drug Charges for each prescription and each refill/
- For tobacco cessation, the benefit is limited to 50% of Network Pharmacy Price with a Lifetime Maximum benefit of \$750.

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

The allowable charge for prescription drugs obtained at a non-network pharmacy will be 80% of the Retail Network Pharmacy price. Benefits paid will be determined based upon this allowable charge less the appropriate copayment or percentage indicated above.

## **B. Home Delivery Pharmacy (Up to 90-Day Supply)**

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

### **Home Delivery Pharmacy Copayment**

- \$100 in each calendar year of any eligible Prescription Drug Charges (either Retail or Home Delivery); then
- \$25 of Generic Prescription Drug Charges for each prescription and each refill; or
- \$75 of all Preferred Brand-Name Prescription Drug Charges for each prescription and each refill (as explained in the description of your “formulary” below); or
- \$125 of all Non-Preferred Brand-Name Prescription Drug Charges for each prescription and each refill.
- For tobacco cessation, the benefit is limited to 50% of Network Pharmacy Price with a Lifetime Maximum benefit of \$750.

## **YOUR PREFERRED PRESCRIPTIONS ® FORMULARY**

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

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

## **XIX. PRESCRIPTION DRUG COVERAGE**

### **A. Description Of Benefits**

#### **1. Retail Network Pharmacy - Payment Conditions**

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

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

as described in the SUMMARY OF BENEFITS Section.

Benefit payments will be restricted to:

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

#### **2. Home Delivery Pharmacy - Payment Conditions**

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

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

as described in the SUMMARY OF BENEFITS Section.

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

Benefit Payment will be restricted to:

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

## **B. Covered Charges**

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

- Federal Legend Drugs, including self-injectables, vitamins and minerals which may be legally dispensed only upon the written prescription of a Physician; and
- Insulin and supplies for injection of insulin; and
- Federal Legend Drugs for tobacco cessation; benefit is limited to 50% of Network Pharmacy Price with a Lifetime Maximum benefit of \$750.

## **C. Pre-Authorization of Certain Prescription Drugs**

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

- Contraceptives for medical illnesses; such as, but not limited to: Ortho Tri-Cyclen, Lo-Ovral
- CNS Stimulants/Amphetamines; such as, but not limited to: Provigil, Strattera
- Growth Hormones/Receptor Antagonists; such as, but not limited to: Serostim
- Dermatology Agents; such as, but not limited to: Raptiva, Tazorac Cream
- Pulmonary Agents; such as, but not limited to: Xolair
- Red/White Blood Cell Stimulants; such as, but not limited to: Epogen, Neupogen
- Interferons; such as, but not limited to: Betaseron
- Hormone Altering Medications; such as, but not limited to: Lupron, Depo-Provera
- Cancer Medications
- Rheumatoid Arthritis Medications; such as, but not limited to: Enbrel
- Narcotic Pain Medications; such as, but not limited to: Actiq, Fentora

## **D. Limitations for Prescription Drug Coverage**

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

- a. drugs or medicines that are not for a covered illness or injury or which are not approved by the FDA for the treatment of that illness or injury;
- b. drugs or medicines that are an Experimental or Investigational Measure;

- c. drugs or medicines that can be purchased without a Physician's prescription (except those listed under Covered Charges);
- d. any prescription or refill in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date;
- e. any part of a charge for drugs or medicines that exceed the Retail Network Pharmacy price (Retail Network Pharmacy coverage);
- f. drugs or medicines for DESI (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness);
- g. injectable drugs or medicines except self-injectables;
- h. drugs or medicines delivered or administered by the prescriber;
- i. administration of any drug or medicine;
- j. immunization agents, biological sera, blood, blood plasma, or any prescription directing parenteral administration or use;
- k. drugs or medicines covered under the Medical Plan; i.e., Home Health Care Agency, etc.;
- l. drugs or medicines dispensed by a Hospital, Skilled Nursing Facility, rest home, or other institution in which you or one of your Dependents is confined;
- m. drugs or medicines, or any other method, to restore fertilization or promote conception;
- n. drugs or medicines to induce abortion;
- o. drugs or medicines provided for cosmetic purposes;
- p. vitamins and minerals, unless as specified under Covered Charges;
- q. over-the-counter drugs;
- r. nutritional and diet supplements;
- s. diet or appetite suppressants, except when related to an illness and approved by Us;
- t. contraceptives, except when related to an illness and approved by Us;
- u. sexual dysfunction, except when related to an illness and approved by Us;
- v. transsexualism;
- w. anabolic steroids, except when related to an illness and approved by Us;
- x. any drug or medicine to promote hair growth;
- y. any drug containing nicotine or other tobacco deterrent medication, except as specifically covered by the Plan;

- z. devices or appliances, support garments, and other non-medicinal substances, regardless of intended use;
- aa. drugs or medicines prescribed or dispensed by any person in your Immediate Family or any person in your Dependent's Immediate Family;
- ab. drugs or medicines purchased outside the United States unless the Covered Person is outside the United States for one of the following reasons:
  - travel, provided the travel is for a reason other than securing medical or dental care diagnosis or treatment;
  - a business assignment by a covered Member (Employer);
  - the Employee is employed by a covered Member (Employer) and working outside the United States; or
  - Full-Time Student status, provided the dependent is either:
    - enrolled and attending an accredited school in a foreign country; or
    - is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit;
- ac. drugs or medicines for which you or your Dependent have no financial liability or that would be provided at no charge in the absence of coverage or that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law) unless charges are imposed against the Covered Person for such drugs or medicines;
- ad. drugs or medicines provided as the result of an injury arising out of or in the course of any self-employment for wage or profit;
- ae. drugs or medicines provided as the result of a sickness covered by a Workers' Compensation Act or other similar law;
- af. drugs or medicines provided as the result of a sickness or injury that is due to war or act of war or to voluntary participation in criminal activities; or
- ag. drugs or medicines purchased after termination of coverage under this Plan.

#### **E. Brand Name versus Generic**

Most maintenance drugs come in two forms, brand name and generic. Both brand name and generic drugs are covered under the program.

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

## **F. 90 Day Supplies**

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

## **G. How to Order From the Home Delivery Pharmacy**

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

### **1. The Written Prescription**

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

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

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

### **2. Patient Profile/Order Form**

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

### **3. Copayment**

A check or money order for the correct amount of copayment must accompany each order. The copayment amount is described in the SUMMARY OF BENEFITS Section. You may also be able to charge your copayment as explained in the Patient Profile/Order Form.

## **H. Refills or Follow-up Orders**

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

## **I. Special Situations**

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

## **J. Questions**

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

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

**XX. COORDINATION WITH OTHER BENEFITS - PRESCRIPTION DRUGS**

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

## **XXI. REIMBURSEMENT/SUBROGATION - MEDICAL AND PRESCRIPTION DRUG**

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

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

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

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

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

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

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

## XXII. DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

**Covered Charge** means treatment or service which is:

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

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

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

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

- Any other similar coverage permitted under state or federal law or regulations;
- A health benefit plan provided under a State Children's Health Insurance Program (Title XXI of the Social Security Act).

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

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

- periodontal disease (disease of the surrounding and supplemental tissues of the teeth, including deformities of the bone surrounding the teeth); and/or
- malocclusion (abnormal positioning and/or relationship of the teeth); and/or
- craniomandibular or temporomandibular joint disorders; and/or
- ailments or defects of the teeth and supporting tissues and bone (excluding appliances used to close an acquired or congenital opening). However, the term Dental Services will include treatment performed to replace or restore any natural teeth in conjunction with the use of any such appliance.

**Dependent** means:

- your spouse, if not in the Armed Forces, and not covered as an Employee; and
- your unmarried natural or legally adopted child less than 26 years of age, if not in the Armed Forces and not eligible as an Employee under this Plan, who is chiefly dependent upon you for support; and
- your unmarried stepchild or any child for whom you have legal guardianship, living with you, if they meet all the requirements above and We approve in writing.

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

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

**Durable Medical Equipment** means equipment that:

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

**Employee** means an employee of a Participating Member (Employer) whose work week is scheduled for at least 30 hours in a normal work week. Also:

- Employee may include members of religious orders and secular priests.
- Employee does not include independent contractors, volunteers, etc., whose income from the Member (Employer) is not subject to Federal Withholding for wages or FICA.

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

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

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

- Coverage only for accident (including accidental death and dismemberment);
- Disability income insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Coverage issued as a supplement to liability insurance;
- Workers' Compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance (for example, mortgage insurance);
- Coverage for on-site medical clinics;
- Other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits;
- The following benefits if offered separately from medical expense benefits (provided under a separate policy, certificate, or contract of insurance, or otherwise not an integral part of the plan);
  - limited scope dental or vision benefits;
  - benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
  - other similar limited benefits;
- The following benefits if offered as independent, non-coordinated benefits:
  - coverage only for a specified disease or illness;
  - hospital indemnity or other fixed indemnity insurance;

- The following benefits if offered as a separate insurance policy:
  - Medicare Supplement Insurance;
  - coverage supplemental to TRICARE;
  - similar supplemental coverage provided to coverage under a Group Health Plan;
- Health flexible spending arrangement, if the following are satisfied:
  - the maximum benefit from employee and employer contributions for the year does not exceed two times the employee's annual salary reduction;
  - the employee has other group health coverage available that is not limited to Excepted Benefits.

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

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

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature; and
- is in general use in the relevant medical community; and
- is not under scientific testing or research.

**Generic Prescription Drug Charges** mean Covered Charges for pharmaceutical products manufactured and sold under their chemical, common or non-proprietary official name.

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

Direction and supervision means:

- the covered provider bills for and co-signs any progress notes written by the Health Care Extender; or
- there is a legal agreement that places overall responsibility for the Health Care Extender's services on the provider.

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

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

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

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

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

- is required as a result of a sickness or injury; and
- follows a period of Hospital confinement; and
- is a result of the sickness or injury that was the cause of the Hospital confinement; and
- is established in writing by the attending Physician within seven days after Hospital confinement ends; and
- is certified by the attending Physician as a replacement for Hospital confinement that would otherwise be necessary.

**Hospice** means a facility, agency, or service that:

- is licensed, accredited, or approved by the proper regulatory authority to establish and manage Hospice Care Programs; and
- arranges, coordinates, and/or provides Hospice Care Services for a dying Employee or Dependent and their families; and
- maintains records of Hospice Care Services provided and bills for such services on a consolidated basis.

**Hospice Care Episode** means the period of time:

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

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

- inpatient and outpatient care, home care, nursing care, counseling, and other supportive services and supplies provided to meet the physical, psychological, spiritual, and social needs of the dying Employee or Dependent; and
- drugs and medicines (requiring a Physician's prescription) and other supplies prescribed for the dying Employee or Dependent by any Physician who is a part of the Hospice Care Team; and
- instructions for care of the patient, counseling, and other supportive services for the family of the dying Employee or Dependent.

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

- a physician;
- a patient care coordinator (physician or nurse who serves as an intermediary between the program and the attending physician);
- a nurse;
- a mental health specialist;
- a social worker;
- a chaplain; and
- lay volunteers.

**Hospital** means an institution that is:

- operated according to the laws pertaining to hospitals; and
- primarily and continuously engaged in providing inpatient care and treatment through medical, diagnostic, and major surgical facilities, either on its premises or in facilities available to the hospital on a prearranged basis, under the supervision of a staff of doctors and with a 24-hour nursing service; and
- licensed as a hospital by the proper authority of the state in which it is located (if licensing is required by that state);

but not including any institution, or part thereof, that is used primarily as a clinic, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Physician** means Doctor of Medicine; Doctor of Osteopathy; Certified Registered Nurse Anesthetist; Dentist; Certified Midwife; Physician's Assistant; Podiatrist, Psychologist, and Social Worker.

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

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

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

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

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

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

**Psychologist** means a person who is licensed or certified by the State in which he or she practices to provide treatment for mental health, behavioral, alcohol, or drug abuse disorders.

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

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

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

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

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

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

**State Licensed Practitioner** means a Doctor of Chiropractic or a provider who:

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

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

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

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

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

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

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

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

## **XXIII. PLAN INFORMATION**

### **Plan Name:**

Christian Brothers Employee Benefit Trust

### **Plan Sponsor:**

Trustees of Christian Brothers Employee Benefit Trust

c/o Christian Brothers Services

1205 Windham Parkway

Romeoville, IL 60446-1679

### **Plan Year:**

January 1 thru December 31

### **Plan Administrator:**

Christian Brothers Services (appointed by the Trustees)

1205 Windham Parkway

Romeoville, IL 60446-1679

Telephone No. 800-807-0100

EIN No. 36-3884439

### **Plan Costs:**

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

### **Agent for Service or Legal Process:**

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

1205 Windham Parkway

Romeoville, IL 60446-1679

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

**Plan Benefits Provided by:**

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

**Plan Eligibility and Benefits:**

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

**How to File a Claim:**

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

**Plan Trustees:**

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

**DENTAL  
PREFERRED PROVIDER ORGANIZATION (PPO)**

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

**Nationwide: 1-800-832-4450**  
**Website: [www.cbsservices.org/EBS](http://www.cbsservices.org/EBS)**  
*(Click on the Icon for Network Links)*



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

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

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**BENEFIT ADVICE**

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

**1-800-807-0400**

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

# DENTAL BENEFIT BOOKLET

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## **I. INTRODUCTION**

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

### **A. Plan Benefits**

Plan Benefits are governed by this benefit description booklet.

### **B. Plan Interpretation**

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

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

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

### **C. Conformity With State Mandates**

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

## **II. HOW TO BE COVERED**

### **A. Eligibility For Enrollment**

#### **1. When You are Eligible for Coverage**

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

#### **2. When Your Dependents are Eligible for Coverage**

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

#### **3. Newborns - 31-Day Coverage**

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

### **B. How You Enroll for Coverage**

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

### **C. When You Become Enrolled for Coverage**

#### **1. Noncontributory Coverage:**

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

## 2. **Contributory Coverage:**

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

## 3. **Late Enrollment Provisions**

### a. **Definitions**

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

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

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

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

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

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

## **b. Effective Date for Late Enrollees**

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

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

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

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

## **D. Special Enrollment Periods**

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

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

The Special Enrollment Periods are:

- Loss of Other Coverage: A Special Enrollment Period will apply to you or your Dependent if all of the following conditions are met:
  - You or your Dependent were covered under another Group Health Plan or had other Health Insurance Coverage at the time of initial eligibility, and declined enrollment solely due to the other coverage; and
  - The other coverage terminated due to loss of eligibility (including loss due to legal separation, divorce, death, cessation of Dependent status, termination of employment or reduction in work hours, incurring a claim that meets or exceeds the other coverage lifetime limit on all benefits, when the individual no longer resides, lives, or works in a service area and there is no other benefit package available under the other Group Health Plan, or when the other Group Health Plan no longer offers any benefits to a class of similarly situated individuals), or due to termination of employer contributions (or, if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation); and
  - Request for enrollment is made within 31 days after the other coverage terminates or after a claim is denied due to reaching the lifetime limit of all benefits under the other health coverage.

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

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

- "Loss of eligibility" does not include a loss due to failure of the individual to pay contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the health coverage); and
- "Employer contributions" include contributions by any current or former employer (of the individual or another person) who was contributing to the coverage of the individual.
- Newly Acquired Dependents: A Special Enrollment Period will apply to you or your Dependent if:
  - You are enrolled (or are eligible to be enrolled but have failed to enroll during a previous enrollment period); and
  - A person becomes your Dependent through marriage, birth, adoption or Placement for Adoption; and
  - Request for enrollment is made within 31 days after the date of the marriage, birth, adoption, or Placement for Adoption.

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

- In the event of marriage, the date of the request for enrollment; or
- In the event of a Dependent child's birth, the date of such birth; or
- In the event of a Dependent child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.
- Court-Ordered Coverage: A Special Enrollment Period will apply to your Dependent child if:
  - You are enrolled but have failed to enroll the Dependent child during a previous enrollment period; and
  - You are required by a court or administrative order to provide health coverage for the Dependent child; and
  - Request for enrollment is made within 31 days after the issue date of the court or administrative order.

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

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

- Loss of Medicaid or CHIP Coverage: A Special Enrollment Period may apply to you or your Dependent if:
  - You or your Dependent is covered under Medicaid or a Children’s Health Insurance Program (“CHIP”) and Medicaid or CHIP coverage is terminated as the result of loss of eligibility; and
  - You request special enrollment on an appropriately completed enrollment application within 60 days after the loss of such coverage.
- Eligibility for Employment Assistance Under Medicaid or CHIP: A Special Enrollment Period may apply to you or your Dependent if:
  - You or your Dependent become eligible for a Medicaid or CHIP premiums assistance subsidy; and
  - You request special enrollment on an appropriately completed enrollment application within 60 days after you or your dependent is determined to be eligible for assistance.

**E. Certificate of Creditable Coverage Required by HIPAA**

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

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

**F. Transfer Provision (For Newly Enrolled Employers)**

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

- the amount which would have been paid by the previous carrier had their coverage been continued; or
- the amount payable under this Plan.

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

### **III. ELIGIBLE DEPENDENTS**

For Dental Benefits, Dependent means:

- your spouse, if not in the Armed Forces and not covered as an Employee; and
- your unmarried natural or legally adopted child less than 26 years of age, if not in the Armed Forces and not eligible as an Employee under this Plan, who is chiefly dependent upon you for support; and
- your unmarried stepchild or any child for whom you have legal guardianship, living with you, if they meet all requirements above and We approve in writing.

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

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

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

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

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

#### **A. Change in Family Status**

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

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

## **IV. WHEN YOUR COVERAGE TERMINATES**

### **A. Termination of Coverage**

Coverage for you and your Dependents terminates when:

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

Coverage for a Dependent terminates when:

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

### **B. Continuation Privilege**

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

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

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

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

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

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

## 2. Retiree Continuation Privilege

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

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

- you retire at age 55 or older with at least five consecutive years of Dental coverage under the Plan prior to retirement, and
- you are receiving a Social Security retirement benefit or a retirement benefit from your Member's (Employer's) retirement plan.

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

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

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

## 3. Federal Family and Medical Leave Act (FMLA)

### Continuation

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

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

### FMLA and Other Continuation Provisions

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

- are in addition to any other continuation provision of this plan, if any; and
- will run concurrently with any other continuation provisions of this plan for sickness, injury, layoff, or approved leave of absence, if any.

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

## **Eligible Employer**

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

## **Eligible Employee**

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

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

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

## **Mandated Unpaid Leave**

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

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

## **Reinstatement**

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

See your employer for details on this reinstatement provision.

## **Servicemember Family Leave**

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

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

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

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

##### **Continuation**

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

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

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

##### **Reinstatement**

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

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

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**V. SUMMARY OF DENTAL BENEFITS**

Dental Expense Benefits are designed to help pay expenses which otherwise you would have to pay in full for necessary dental care. Coverage for you and your enrolled Dependents is the same.

**A. Maximum Dental Payment Limits**

The maximum benefit payable for all Dental Covered Charges under Dental Care Units 1, 2, and 3 incurred by a Covered Person during the Calendar Year is \$1,000.

**B. Dental Benefits Payable**

Dental Care Benefits are payable for Covered Charges incurred in the calendar year after satisfaction of the Deductible Requirement except, Diagnostic and Preventive Covered Charges shall not be subject to the Deductible Requirement. Reimbursement of Covered Charges shall be payable at the following percentages:

Diagnostic and Preventive Covered Charges	100%	Dental Care Unit 1
Basic Covered Charges	80%	Dental Care Unit 2
Major Covered Charges	50%	Dental Care Unit 3

**C. Deductible Requirements**

There is no deductible requirement under Dental Care Unit 1, Diagnostic and Preventive Covered Charges.

All Dental Covered Charges under Dental Care Units 2 and 3, Basic and Major Covered Charges, are subject to a combined deductible requirement of \$50 per Covered Person per calendar year.

**D. Family Limit**

The maximum family deductible under Dental Care Units 2 and 3, Basic and Major Covered Charges, will be a combined family total of \$150 of covered dental charges per calendar year (but not counting more than \$50 for any one Covered Person in your family).

NOTE: See the Table of Contents to locate the Claims Procedures section of this booklet for important information on filing your dental claims.

**DENTAL BENEFITS ARE NOT PAYABLE FOR DISEASE OR INJURY COVERED BY A WORKERS' COMPENSATION ACT OR SIMILAR LEGISLATION, OR THAT WOULD HAVE BEEN COVERED IF ELECTED.**

**BENEFIT ADVICE**

**PLEASE GIVE US A CALL IF YOU HAVE ANY QUESTIONS ABOUT YOUR DENTAL BENEFITS.**

**1-800-807-0400**

**YOU MAY REFER TO THE CLAIM PROCEDURES SECTION OF THE BOOKLET FOR MORE DETAILED INFORMATION.**

## **VI. DESCRIPTION OF DENTAL BENEFITS**

Dental Expense Benefits are designed to help pay expenses which otherwise you would have to pay in full for necessary dental care. Coverage for you and your enrolled Dependents is the same.

### **A. Maximum Dental Payment Limit**

The maximum benefit payable for all Dental Covered Charges incurred by a Covered Person during the calendar year is shown in the Summary of Benefits.

### **B. Dental Payment Qualification**

To qualify for payment of the benefits provided by your plan you and your Dependents must:

- be covered in that class on the date dental Treatment or Service is received; and
- file a Dental Treatment Plan with Us before treatment begins when charges for a Period of Dental Treatment (other than emergency treatment) are expected to exceed \$300; and
- satisfy the requirements listed in the CLAIM PROCEDURES Section.

### **C. Dental Benefits Payable**

Benefits payable will be as described in this section, subject to:

- all listed limitations; and
- the terms and conditions of:
  - Coordination with Other Benefits; and
  - Reimbursement/Subrogation.

### **D. Deductible Requirement**

Dental Care Benefits are payable for charges incurred in the calendar year after satisfaction of the Deductible Requirement except Diagnostic and Preventive Covered Charges shall not be subject to the Deductible Requirement. Reimbursement of Covered Charges shall be payable as shown in the Summary of Benefits.

The Deductible Requirement per person per calendar year is shown in the Summary of Benefits.

### **E. Family Limit on Deductible**

The maximum family deductible is shown in the Summary of Benefits.

## **VII. DENTAL COVERED CHARGES**

### **A. Dental Payment Conditions**

If you or one of your Dependents receive any Treatment or Service that is listed in the Schedule of Dental Procedures, We will pay Dental benefits for Covered Charges:

- in excess of the deductible amount(s); and
- at the payment percentage(s) indicated; and
- to the Maximum Allowances (indicated in the Schedule of Dental Procedures) and Maximum Payment Limits;

as described in the Dental Summary of Benefits section.

### **B. Deferred Coverage Limits**

**(for requests (1) more than 31 days after the date eligible; or after (2) the date you elect to terminate coverage)**

If you request coverage for you or your Dependent more than 31 days after the date of eligibility, or you elect to terminate coverage and more than 31 days later request to be covered again, during the first 12 months in which coverage is in force, benefits will be limited as follows:

- During the first six months, benefits will be payable only for Dental Care Unit 1 (Preventive Procedures) Covered Charges.
- During the second six months, benefits will be payable only for Dental Care Unit 1 (Preventive Procedures) Covered Charges and Dental Care Unit 2 (Basic Procedures) Covered Charges.

After coverage has been in force for 12 consecutive months, benefits will be payable for charges incurred for Covered Charges under Dental Care Units 1, 2 and 3.

### **C. Covered Charges**

Covered Charges will be the actual cost charged to you or your Dependent for Treatment or Service, but not more than the Maximum Allowances shown in the Schedule of Dental Procedures. Also:

- If We determine that more than one procedure could be performed to correct a dental condition, Covered Charges will be limited to the Maximum Allowance for the least expensive of the procedures that would provide professionally acceptable results.
- Covered Charges will include only those charges for Treatment or Service that begins (see below) while you and your Dependents are covered under this plan.

- Covered Charges will include only those charges for Treatment or Service that is completed while you and your Dependents are covered under the plan (except when the Treatment or Service is covered under the Extended Benefits provision).

**D. Beginning Date for Treatment or Service**

Treatment or Service will be considered to begin:

- for root canal therapy, on the date the pulp chamber is opened and the pulp canal explored to the apex; and
- for crowns, fixed bridgework, inlays, or onlay restoration, on the date the tooth or teeth are fully prepared; and
- for full or partial dentures, on the date the master impression is made; and
- for all other, on the date the Treatment or Service is performed.

**E. Completion Date for Treatment or Service**

Treatment or Service will be considered to be completed:

- for crowns, on the date the crown is seated; and
- for fixed bridgework, on the date the bridge is seated; and
- for inlay or onlay restorations, on the date the inlay or onlay is seated; and
- for complete or partial dentures, on the date the complete or partial denture is seated.

## VIII. SCHEDULE OF DENTAL PROCEDURES

Unless We agree otherwise, Covered Charges will include only charges for procedures listed in the Schedule of Dental Procedures. If a non-listed procedure is accepted, We will determine its Maximum Allowance based on the Maximum Allowance for a listed procedure of comparable nature.

### A. Dental Care Unit 1 - Diagnostic and Preventive Procedures

The Maximum Allowance for each procedure described below will be the actual amount charged to you or your Dependent for Necessary Dental Care, but only to the extent that actual charges do not exceed Prevailing Charges.

#### Dental Procedure

##### 1. Examinations

Oral Examination (evaluation)  
Periodic Examination (evaluation)

Only one of the listed examinations will be covered in any six consecutive months.

##### 2. Emergency Examination

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

##### 3. Radiographs

Full Mouth Survey

Complete series (including bitewings)  
Panoramic

Only one of the listed full mouth surveys will be covered in any 36 consecutive months.

Bitewing

For Dependent children under age 18, only one set will be covered in any six consecutive months.

For adults 18 years of age or older, only one set will be covered in any 12 consecutive months.

Occlusal  
Periapical

## Extraoral X-Rays

Sialography  
TMJ  
Cephalometric film  
Posterior-anterior or lateral skull and facial bone survey  
Other extraoral

Only one of the listed extraoral procedures will be covered in any six consecutive months.

Diagnostic x-rays performed in conjunction with root canal therapy or orthodontic treatment will not be considered Unit 1 Covered Charges.

### **4. Preventive Services**

Prophylaxis (cleaning of teeth)

Covered once in any six consecutive months.

Topical application of fluoride

Applicable only to Dependent children under age 16. Only one application will be covered in any six consecutive months.

Space maintainers

Applicable only to Dependent children under age 16.

Topical application of sealants

Applicable only to first and second permanent molars for Dependent children under age 16. Covered once each tooth in any 24 consecutive months.

### **5. Other Services**

Biopsy of oral tissue  
Palliative treatment

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Histopathologic examination

## **B. Dental Care Unit 2 - Basic Procedures**

The Maximum Allowance for each procedure described below will be the actual amount charged to you or your Dependent for Necessary Dental Care, but only to the extent that actual charges do not exceed Prevailing Charges.

### **Dental Procedure**

#### **1. Restorations**

Fillings (Amalgam, silicate, plastic, or composite, including pin retention when necessary).

Multiple restorations on one surface will be paid as a single filling. Replacement of existing fillings are covered only if at least 24 consecutive months have passed since placement of prior filling, unless required by new decay in an additional tooth surface. Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations.

Stainless steel crown

#### **2. Oral Surgery**

Extraction of teeth

Alveoloplasty

Removal of dental cysts and tumors

Surgical incision and drainage of dental abscess

#### **3. Other surgical procedures**

Tooth reimplantation

Surgical exposure to aid eruption

Surgical repositioning of teeth

Excision of hyperplastic tissue

#### **4. Periodontic Services**

Scaling and root planing (each quadrant)

Covered once each quadrant in any 24 consecutive months.

Periodontal appliance

One appliance is covered in any 36 consecutive months.

Periodontal prophylaxis (including probing, charting, exam, polishing, scaling, root planing and similar maintenance procedures).

Covered only if at least three months have elapsed after completion of active therapeutic scaling and root planing or active surgical periodontal treatment and then not more than once in three consecutive months.

## **5. Periodontal Surgical Procedures**

Gingival flap procedure  
Gingivectomy  
Gingival curettage  
Osseous surgery  
Pedicle soft tissue graft  
Free soft tissue graft  
Osseous Graft

Only one of the listed periodontic surgical procedures is covered for each quadrant in any 24 consecutive months.

## **6. Endodontic Services**

Vital Pulpotomy (for deciduous teeth only)  
Root canal therapy including treatment plan, diagnostic x-rays, clinical procedures, and follow-up care.  
Apexification  
Apicoectomy  
Retrograde filling  
Root resection  
Hemisection

## **7. Anesthesia**

General anesthesia  
IV Sedation

General anesthesia or IV Sedation is covered as a separate procedure only when required for complex oral surgical procedures covered under this plan (and only when performed in a dental office).

## **8. Other Services**

Repairs to bridges and complete or partial dentures  
Adding tooth to partial denture  
Relining or rebasing complete or partial denture (upper or lower)

Covered only if relining or rebasing is done more than 12 months after the initial insertion and then not more than once in any 24 consecutive months.

## Tissue Conditioning

Covered only if at least 12 months have elapsed since the insertion of a complete or partial denture and not more than once in any 24 consecutive months.

## Denture Adjustment

Covered once in any 12 consecutive months and only if at least 12 months have elapsed since the insertion of the denture.

## Recementing

Inlay

Onlay

Crown

Bridge

Space maintainer

Consultation with specialist

Antibiotic drug injection

Pulp vitality test

### **C. Dental Care Unit 3 - Major Procedures**

The Maximum Allowance for each procedure described below will be the actual amount charged to you or your Dependent for Necessary Dental Care, but only to the extent that actual charges do not exceed Prevailing Charges. All procedures listed include one year follow-up care.

#### **Dental Procedure**

##### **1. Restorations**

###### Inlays and onlays

Inlays and onlays are covered only if the tooth cannot be restored by a filling and (for replacements) at least five years (60 consecutive months) have elapsed since the last placement.

###### Labial Veneers

Veneer restorations are covered only if tooth cannot be restored by a filling and (for replacements) at least five years (60 consecutive months) have elapsed since the last placement.

###### Crowns (single restorations only)

- Resin (laboratory)
- Resin, prefabricated
- Resin with nonprecious metal
- Resin with semiprecious metal
- Resin with gold
- Porcelain
- Porcelain with nonprecious metal
- Porcelain with semiprecious metal
- Porcelain with gold
- Gold (3/4 cast)
- Gold (full cast)
- Nonprecious metal (full cast)
- Semiprecious metal (full cast)

Crowns are covered only if the tooth cannot be restored by a filling and (for replacements) at least five years (60 consecutive months) have elapsed since the last placement. Crowns for the primary purpose of periodontal splinting, altering or maintaining vertical dimension, or restoring occlusion are not covered.

Crowns for the replacement of veneer, inlay or onlay are covered only if at least five years (60 consecutive months) have elapsed since the last placement of the restoration. Crowning of implant replacing a tooth missing prior to the effective date is not covered. For persons under 16 years of age, the benefit for crowns on vital teeth is limited to resin or stainless steel crowns.

Cast post and core

Covered only for teeth that have had root canal therapy.

Steel post and composite or amalgam

Covered only for teeth that have had root canal therapy.

## **2. Prosthodontics, Fixed**

Fixed Bridges - initial placement or replacement

Initial placement of fixed bridges to replace teeth which were missing prior to the effective date of the person's coverage will not be covered unless it includes the replacement of a Functioning Natural Tooth extracted while the person is covered under this plan (provided that tooth was not an abutment to an existing partial denture that is less than five years old). In that event, benefits are payable only for the replacement of those teeth which were extracted while covered under the plan.

Replacement of an existing fixed bridge is covered only if the existing bridge is more than five years old (60 consecutive months), and is not serviceable, and cannot be repaired.

## **3. Prosthodontics, Removable**

Complete or partial dentures - initial placement or replacement

Initial placement of complete or partial dentures to replace teeth which were missing prior to the effective date of the person's coverage will not be covered unless it includes the replacement of a Functioning Natural Tooth extracted while covered under this plan.

Replacement of an existing complete or partial denture is covered only if the existing denture is more than five years old (60 consecutive months), and is not serviceable and cannot be repaired.

Covered Charges for complete or partial dentures do not include any additional charges for overdentures or for precision or semi-precision attachments.

## **4. Temporomandibular Joint Disorders (TMJ)**

Treatment, service, or material for TMJ disorder which is not specifically excluded.

## **IX. LIMITATIONS OF DENTAL BENEFITS**

Dental benefits will not be paid for:

- a. Treatment or Service that is not for Necessary Dental Care;
- b. any part of a charge for Treatment or Service that exceeds Prevailing Charges;
- c. the services of any person who is not a Dentist or Dental Hygienist;
- d. any charge related to Treatment or Service at a Hospital (except Treatment or Service for Necessary Dental Care eligible under Temporomandibular Joint Disorders (TMJ));
- e. the services of any person in your Immediate Family or any person in your Dependent's Immediate Family;
- f. personalization of dentures or crowns and any other Treatment or Service that is primarily cosmetic;
- g. Treatment or Service that does not meet professionally recognized standards of quality or that is an Experimental or Investigational Measure;
- h. implants;
- i. Treatment or Service for bone grafts performed in an extraction site;
- j. drugs and medicines (except for antibiotic injections);
- k. bite registration or occlusal analysis;
- l. instruction for plaque control, oral hygiene, or diet;
- m. Treatment or Service to alter or maintain vertical dimension or restore or maintain occlusion;
- n. Treatment or Service for provisional or permanent splinting;
- o. Treatment or Service for the purpose of duplicating or replacing a lost or stolen prosthetic device or appliance;
- p. Treatment or Service that is temporary;
- q. Treatment or Service excluded under the section Deferred Coverage Limits, or
- r. Treatment or Service due to orthodontics;
- s. Treatment or Service covered under the Comprehensive Medical Benefits Plan;

- t. Treatment or Service provided outside the United States unless the Covered Person is outside the United States for one of the following reasons:
  - travel, provided the travel is for a reason other than securing medical or dental care diagnosis or treatment;
  - a business assignment by a covered Member (Employer);
  - the Employee is employed by a covered Member (Employer) and working outside the United States; or
  - Full-Time Student status, provided the dependent is either:
    - enrolled and attending an accredited school in a foreign country; or
    - is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit;
- u. charges for which the Covered Person is not legally obligated to pay or which are for medical or dental care furnished without charge, paid for or reimbursable by or through the government of a nation, state, province, county, municipality, or other political subdivision, or any instrumentality or agency of such a government;
- v. Treatment or Service rendered in a hospital owned or operated by the United States Government, either by the hospital or a physician/dentist employed by it (a) unless the treatment is of an emergency nature, and (b) unless the Covered Person is not entitled to such treatment by reason of his status as a veteran or otherwise;
- w. Treatment or Service for an injury or sickness which results from war, act of war, or voluntary participation in criminal activities while a Covered Person;
- x. Treatment or Service for an injury or sickness which arise out of or in the course of employment, and which either entitles the Covered Person to benefits under a Worker's Compensation Act or similar legislation, or would have entitled him to benefits if coverage under such a statute could have been in force on a voluntary or elective basis;
- y. Treatment or Service provided by any person, hospital, or entity whose charges for medical/dental care, depend on the patients' financial ability to pay or availability of coverage;
- z. charges which are eligible to be paid by a previous group plan which was replaced by enrollment in the Christian Brothers Employee Benefit Trust; or
- aa. Treatment or Service incurred after termination of coverage under this Plan, except as provided by the Plan.

## **X. DEFERRED DENTAL LIMITATION**

If you request coverage for you or your Dependent more than 31 days after the date of eligibility, or you elect to terminate coverage and more than 31 days later request to be covered again, during the first 12 months in which coverage is in force, some dental services will be excluded from coverage during an Exclusion Period..

### **Exclusion Period and Limited Benefits**

- During the first six months, benefits will be payable only for Dental Care Unit 1 (Preventive Procedures) Covered Charges.
- During the second six months, benefits will be payable only for Dental Care Unit 1 (Preventive Procedures) Covered Charges and Dental Care Unit 2 (Basic Procedures) Covered Charges.

After coverage has been in force for 12 consecutive months, benefits will be payable for charges incurred for Covered Charges under Dental Care Units 1, 2 and 3.

Exemption for Certain Dependent Children. The Deferred Dental Limitation described will not apply to any Dependent child:

- who is the Member's newborn child, or a child newly adopted by the Member (or Placed for Adoption with the Member) prior to the child's attainment of age 18; and
- whose coverage becomes effective under the Plan within the 31-day period immediately following the date of birth, adoption, or Placement for Adoption.

If a Dependent child becomes covered under the Plan other than as described above, that child will also be exempt from the Deferred Dental Limitation if:

- the child was covered under another Creditable Coverage as of the last day of the 31-day period beginning with the child's date of birth, adoption or Placement for Adoption (provided the adoption or Placement occurred prior to the child's attainment of age 18); and
- the child has subsequently maintained continuous Creditable Coverage, with no gap in coverage exceeding 63 days.

If any such child's coverage under the Plan terminates and the child later becomes covered again under the Plan, the exemption will continue to apply to the child unless there has been a period of at least 63 days during all of which the child was not covered under any Creditable Coverage.

For the purpose of these provisions, a Waiting Period or HMO Affiliation Period will not be considered a break in Creditable Coverage.

## **Credit for Previous Creditable Coverage**

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

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

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

## **XI. EXTENSION OF DENTAL BENEFITS AFTER TERMINATION OF COVERAGE**

If Dental Expense Coverage under your plan ceases and if you or your Dependents qualify, the Plan will pay for:

- root canal therapy, but only if the pulp chamber was opened and the pulp canal explored to the apex while you or a Dependent were covered under this plan; and
- crowns, bridges, inlays, or onlay restorations, but only if the tooth or teeth were fully prepared while you or a Dependent were covered under this plan; and
- complete or partial dentures, but only if the master impression was made while you or a Dependent were covered under this plan; and

provided the Treatment or Service is received within 60 days after your or a Dependent's coverage terminates.

You or a Dependent will qualify if:

- you or a Dependent would have qualified for benefit payment under this plan had coverage remained in force; and
- the Treatment or Service began while you or a Dependent were covered under this plan; and
- this plan is in force at the time Treatment or Service is received.

However, no extended benefits will be paid for Treatment or Service received on or after the date you or your Dependents become eligible for other group dental expense coverage.

## **XII. CLAIM PROCEDURES**

### **Claim Forms**

Special claim forms are not required to file a claim with Us. Standard industry computerized forms may be used by your providers to submit a claim. When you become covered, you will be issued an identification card. This card should be presented to each provider at the time you or a Dependent receives needed medical care.

### **Prompt Filing**

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

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

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

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

### **Payment, Denial, and Review**

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

If a claim cannot be processed due to incomplete information, We will either deny the claim or send a written explanation requesting additional information. If additional information is requested and it is not received at the end of 30 calendar days, a decision will be made without it

Initial appeal: If your claim has been denied in whole or in part, you may request an appeal of the denial. Your appeal must be in writing and must state the reason or reasons why you believe the original decision was incorrect. Such appeal must be received by us within 60 days after your receipt of the notice of denial or at least 60 days from the end of the processing period, if you've heard nothing by that time. Besides having the right to appeal, you or your authorized representative may examine any plan documents related to your claim.

We will make a full and fair review of the claim and notify you in writing of the appeal decision within 60 calendar days of receiving it.

Plan Committee appeal: If the initial appeal was denied in whole or in part, you may appeal that decision to the Plan Committee. Your appeal must be in writing and must be received within 60 days after your receipt of the notice of denial. You may submit written comments, documents, records, and other information relating to the claim. The Plan Committee will make a determination within 60 calendar days unless the appeal cannot be processed due to incomplete information. If more information is needed, the Plan Committee will send a written request for the additional information. Failure to receive the additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request.

Trustee appeal: The final decision as to whether a claim is payable to you is made by the Trustees. If you disagree with the Plan Committee's determination, you may appeal that decision to the Appeals Committee of the Board of Trustees. Your appeal must be in writing and must be received within 60 days after your receipt of the notice from the Plan Committee. Your appeal should state the reason or reasons why you believe the Plan Committee decision should be reversed or an exception be made. In connection with your appeal, you may review pertinent documents regarding your claim and submit issues and comments in writing. The Appeals Committee of the Board of Trustees will make a determination within 60 calendar days and will furnish you with written notice of its final decision regarding the appeal. However, in special cases, they may be allowed up to 180 days.

### **Dental Examinations**

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

### **Release of Dental or Medical Information**

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

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

### **XIII. COORDINATION WITH OTHER BENEFITS -- DENTAL**

#### **Intent**

The intent of Coordination with Other Benefits is to provide that the sum of benefits paid under This Plan plus benefits paid under all other Plans will not exceed the actual cost charged for a Treatment or Service.

#### **A. Definitions**

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

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

- any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or employee benefit or other association; and
- any program required or established by state or Federal law, including Medicare Parts A and B (see Medicare rules below); and
- any program sponsored by or arranged through a school or other educational agency; and
- the first-party medical expense provisions of any automobile policy issued under a no-fault insurance statute including the self-insured equivalent of any minimum benefits required by law;

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

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

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

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

## **B. Effect on Benefits**

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

- benefits are payable under any other Plan for the same Allowable Expenses; and
- the rules listed below provide that benefits payable under the other Plan are to be determined before the benefits payable under This Plan.

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

## **C. Order of Benefit Determination**

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

- Nondependent/Dependent. The benefits of a Plan which covers the person for whom benefits are claimed as an Employee, Member, or subscriber (that is, other than as a Dependent) are determined before the benefits of a Plan which covers the person as a Dependent.
- Dependent Child--Parents Not Separated or Divorced. When This Plan and another Plan cover the same child as a Dependent of different persons called "parents," the benefits of the Plan of the parent whose birthday falls earlier in a calendar year are determined before those of the Plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
  - However, if another Plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
- Dependent Child--Separated or Divorced Parents. If two or more Plans cover a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - first, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child; and
  - finally, the Plan of the parent not having custody of the child.

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

- Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules for Dependent children of parents who are not separated or divorced.
- Active/Inactive Employee. The benefits of a Plan which covers a person as an Employee who is neither laid off nor retired, or as that Employee's Dependent, are determined before the benefits of a Plan which covers that person as a laid-off or retired Employee or as that Employee's Dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.
- Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an Employee, Member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.
- Automatic Coverage for a Newborn Child. When This Plan and another Plan both provide benefits, the benefits of the other Plan will be determined before the benefits payable under the Automatic Coverage for a Newborn Child provision of This Plan.
- Continuation/Extension of Benefits. When This Plan and another Plan both provide benefits, the benefits of the plan covering the person as an employee, member or subscriber, or as that person's dependent, will be determined before the benefits payable under This Plan's Extension of Benefits.

#### **D. Medicare Rules**

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

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

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

#### **E. Medicare Exception**

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

Federal law will usually apply in such instances if:

- the benefits are applicable to an active Covered Employee (rather than a Retiree) or to that Covered Employee's spouse; or
- the Covered Employee's Member (Employer) has 20 or more employees.

## **F. Integration With Medicare**

**(For all Covered Persons where permitted by Law)**

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

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

It works this way:

- In determining a claim payment under This Plan, the first step is to calculate the amount that would be paid if the person had no Medicare coverage. The Covered Charges under This Plan will be limited to the amounts approved by Medicare or no more than the limiting charges as determined by Medicare.
- The above amount is reduced by the Medicare benefits for the expenses upon which the claim under This Plan is based. In determining the Medicare benefits, the person will be assumed to have full Medicare coverage (that is, both Part A and Part B) whether or not the person has enrolled for the full coverage.
- If a provider has chosen not to apply to Medicare to become a participating provider, This Plan will estimate Medicare benefits as if application has been made and was approved. Any benefit payable by the Plan will then be calculated as if Medicare had been paid.

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

## **G. Coordination with HMOs**

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

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

## **H. Coordination with Excess Only or Secondary Only Plans**

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

- excess only of other available benefits; or
- secondary only of other available benefits;

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

**I. Secondary Coverage Under Automatic Coverage for Newborn Child Provision**

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

**J. Exchange of Information**

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

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

**K. Facility of Payment**

We may reimburse any other plan if:

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

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

**L. Right of Recovery**

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

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

**M. Transfer of Rights**

**(Applicable in California)**

**1 Applicability**

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

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

**2. Transfer of Rights**

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

**N. Covered Person Obligations**

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

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

#### **XIV. REIMBURSEMENT/SUBROGATION - DENTAL**

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

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

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

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

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

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

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

## **XV. DEFINITIONS**

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

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

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

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

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

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

**Dental Hygienist** means a person who works under the supervision of a Dentist and is licensed to practice dental hygiene.

**Dental Treatment Plan** means the Dentist's report of proposed treatment which:

- is written on a form provided by Us; and
- lists the procedures required for the Period of Dental Treatment; and
- shows the charges for each procedure; and
- is accompanied by any diagnostic materials that We might require.

**Dentist** means:

- a person licensed to practice dentistry; and
- a licensed Physician who provides dental Treatment or Service.

**Dependent** means:

- your spouse, if not in the Armed Forces, and not eligible as an Employee; and
- your unmarried natural or legally adopted child less than 26 years of age, if not in the Armed Forces and not eligible as an Employee under this Plan, who is chiefly dependent upon you for support; and
- your unmarried stepchild or any child for whom you have legal guardianship, living with you, if they meet all the requirements above and we approve in writing.

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

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

**Employee** means an employee of a Participating Member (Employer) whose work week is scheduled for at least 30 hours in a normal work week. Also:

- Employee may include members of religious orders and secular priests.
- Employee does not include independent contractors, volunteers, etc., whose income from the Member (Employer) is not subject to Federal Withholding for wages or FICA.

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

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

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

- Coverage only for accident (including accidental death and dismemberment);
- Disability income insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Coverage issued as a supplement to liability insurance;
- Workers' Compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance (for example, mortgage insurance);
- Coverage for on-site medical clinics;
- Other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits;
- The following benefits if offered separately from medical expense benefits (provided under a separate policy, certificate, or contract of insurance, or otherwise not an integral part of the plan);
  - limited scope dental or vision benefits;
  - benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
  - other similar limited benefits;
- The following benefits if offered as independent, non-coordinated benefits:
  - coverage only for a specified disease or illness;
  - hospital indemnity or other fixed indemnity insurance;
- The following benefits if offered as a separate insurance policy:
  - Medicare Supplement Insurance;

- coverage supplemental to TRICARE;
- similar supplemental coverage provided to coverage under a Group Health Plan;
- Health flexible spending arrangement, if the following are satisfied  
:
  - the maximum benefit from employee and employer contributions for the year does not exceed two times the employee's annual salary reduction;
  - the employee has other group health coverage available that is not limited to Excepted Benefits.

**Experimental or Investigational Measures** mean any Treatment or Service, regardless of any claimed therapeutic value not generally accepted by specialists in that particular field of medicine or dentistry, as determined by Us.

**Functioning Natural Tooth** means a Natural Tooth which is performing its normal role in the chewing process in the covered person's upper or lower arch and which is opposed in the person's other arch by another Natural Tooth or prosthetic (i.e. artificial) replacement.

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

**Hospital** means an institution that is:

- operated according to the laws pertaining to hospitals; and
- primarily and continuously engaged in providing inpatient care and treatment through medical, diagnostic, and major surgical facilities, either on its premises or in facilities available to the hospital on a prearranged basis, under the supervision of a staff of doctors and with a 24-hour nursing service; and
- licensed as a hospital by the proper authority of the state in which it is located (if licensing is required by that state);

but not including any institution, or part thereof, that is used primarily as a clinic, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

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

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

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

**Natural Tooth** means any tooth or part of a tooth that is organic and formed by the natural development of the body (i.e. not manufactured).

**Necessary Dental Care** means any treatment, service, or materials prescribed by a Dentist and considered by Us to be:

- necessary and appropriate; and
- not Experimental or Investigational Measures and not in conflict with accepted dental standards.

**Period of Dental Treatment** means all sessions of dental care that result from the same initial diagnosis and any related complications.

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

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

**Physician** means a licensed Doctor of Medicine or Osteopathy.

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

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

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

**Required Contribution/Contributions** means the amount of monies required to make coverage effective. The amount is decided by Us, from time to time.

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

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

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

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

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

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

## **XVI. PLAN INFORMATION**

### **Plan Name:**

Christian Brothers Employee Benefit Trust

### **Plan Sponsor:**

Trustees of Christian Brothers Employee Benefit Trust  
c/o Christian Brothers Services  
1205 Windham Parkway  
Romeoville, IL 60446-1679

### **Plan Year:**

January 1 thru December 31

### **Plan Administrator:**

Christian Brothers Services (appointed by the Trustees)  
1205 Windham Parkway  
Romeoville, IL 60446-1679

Telephone No. 800-807-0100

EIN No. 36-3884439

### **Plan Costs:**

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

### **Agent for Service or Legal Process:**

Managing Director, Employee Benefit Services, the Christian Brothers Employee Benefit Trust  
1205 Windham Parkway  
Romeoville, IL 60446-1679

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

**Plan Benefits Provided by:**

Dental benefits are provided through the Christian Brothers Employee Benefit Trust.

**Plan Eligibility and Benefits:**

See the Table of Contents and the Summary of Benefits section of the booklet to locate description of dental benefits and eligibility requirements.

**How to File a Claim:**

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

**Plan Trustees:**

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