

The Roman Catholic Bishop of Stockton

**Comprehensive Preferred
Medical and Prescription Drug Benefit Plan**

Plan Document and Summary Plan Description (SPD)

Medical and Prescription Benefits

Effective Date: July 1, 2005

Restated Date: July 1, 2020

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**ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION**

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by The Roman Catholic Bishop of Stockton (the "Diocese" or the "Plan Sponsor") as of July 1, 2020, hereby **amends and restates** the Comprehensive Preferred Medical and Prescription Drug Benefit Plan (the "Plan"), which was originally adopted by the Diocese, effective July 1, 2005. Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein (the "Effective Date").

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

The Roman Catholic Bishop of Stockton

By: _____

Name: _____

Date: _____

Title: _____

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Plan benefits are self-funded through a benefit fund or a trust established by the Plan Sponsor with contributions from Participants and/or the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits. Contributions received from Participants are used to cover Plan costs and are expended immediately.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by **The Roman Catholic Bishop of Stockton** and may be inspected at any time during normal working hours by any Participant.

General Plan Information

Name of Plan:	Comprehensive Preferred Medical and Prescription Drug Benefit Plan
Plan Sponsor:	The Roman Catholic Bishop of Stockton 212 N San Joaquin Street Stockton, CA 95202 Phone: 209-466-0636 Fax: 209-463-5937
Plan Administrator: (Named Fiduciary)	The Roman Catholic Bishop of Stockton 212 N San Joaquin Street Stockton, CA 95202 Phone: 209-466-0636 Fax: 209-463-5937
Plan Sponsor ID No. (EIN):	94-1532129
Source of Funding:	Self-Funded
Plan Status:	Non-Grandfathered
Applicable Law:	Federal and the State of California
Plan Year:	July 1 through June 30
Plan Type:	Medical Prescription Drug

Third Party Administrator: Delta Health Systems
PO Box 80
Stockton, CA 95201-3080
Phone: 888-212-1231

Participating Employer(s): The Roman Catholic Bishop of Stockton

Agent for Service of Process: The Roman Catholic Bishop of Stockton
Plan Administrator
212 N San Joaquin Street
Stockton, CA 95202
Phone: 209-466-0636
Fax: 209-463-5937

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Diocese and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Diocese or to interfere with the right of the Diocese to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Diocese with the bargaining representatives of any Employees.

Mental Health Parity

Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Non-Discrimination

No eligibility rules or variations in contribution amounts will be imposed based on an eligible Employee's and his or her Dependent's/Dependents' health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of an eligible Employee's and his or her Dependent's/Dependents' race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Applicable Law

This Plan is a church plan and as such it is exempt from the requirements of Title I and Title IV of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a Federal law regulating Employee welfare and pension plans. The Participants' rights in the Plan are governed by the

plan documents and applicable state law and regulations.

Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participants' rights; and to determine all questions of fact and law arising under the Plan.

Notice Regarding Exemption from Contraceptive Coverage Requirement

The Affordable Care Act (ACA), sometimes called the health care reform law, requires non-grandfathered group health plans to cover and pay for a range of women's preventive health services. This includes contraceptive services.

The law requires health plans to cover all contraceptive methods and sterilization procedures that have been approved by the Food and Drug Administration (FDA), unless the Plan qualifies for an exemption from the contraceptive coverage requirement under the ACA.

The Roman Catholic Bishop of Stockton qualifies for an exemption from the contraceptive coverage requirement and therefore does not cover contraceptive services, except when there is a medical Diagnosis such as endometriosis, as permitted under the ACA and subsequent guidance from the Departments of Health and Human Services, Labor, and Treasury. The Roman Catholic Bishop of Stockton covers all other Women's Preventive Health Services provided for in comprehensive guidelines endorsed by the US Preventive Services Task Force (USPSTF) or supported by the U.S. Health Resources and Services Administration (HRSA).

DEFINITIONS

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in this Definitions section, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Definitions section will help to better understand the provisions of this Plan.

The following words and phrases shall have the following meanings when used in the Plan Document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.**

“Accident”

“Accident” shall mean a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

“Accidental Bodily Injury”

“Accidental Bodily Injury” shall mean an Injury sustained as the result of an Accident due to a traumatic event or due to exposure to the elements.

“Actively At Work” or “Active Employment”

An Employee is “Actively at Work” or in “Active Employment” on any day the Employee performs in the customary manner all the regular duties of his or her occupation at an established business location of the Participating Employer, or at another location to which he or she may be required to travel to perform the duties of his or her employment. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor, as defined by HIPAA, subject to the Plan’s Leave of Absence provisions (including any State-mandated leave). In no event will an Employee be considered Actively at Work if he or she has effectively terminated employment.

“ADA”

“ADA” shall mean the American Dental Association.

“Adverse Benefit Determination”

“Adverse Benefit Determination” shall mean any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant’s eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Explanation of Benefits (EOB)

“Explanation of Benefits” shall mean a statement a health plan sends to a Participant which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

“Affordable Care Act (ACA)”

The “Affordable Care Act (ACA)” means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

“AHA”

“AHA” shall mean the American Hospital Association.

“Allowable Expense(s)”

“Allowable Expense(s)” shall mean the Maximum Allowable Charge for any Medically Necessary and eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations Section herein, this Plan’s Allowable Expenses shall in no event exceed the Other Plan’s Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

“Alternate Recipient”

“Alternate Recipient” shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant’s Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent.

“AMA”

“AMA” shall mean the American Medical Association.

“Ambulatory Surgical Center”

“Ambulatory Surgical Center” shall mean any public or private State licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures, with continuous Physician services and registered professional nursing service whenever a patient is in the facility, and which does not provide service or other accommodations for patients to stay overnight.

“Approved Clinical Trial”

“Approved Clinical Trial” means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The Affordable Care Act requires that if a “qualified individual” is in an “Approved Clinical Trial,” the Plan cannot deny coverage for related services (“routine patient costs”).

A “qualified individual” is someone who is eligible to participate in an “Approved Clinical Trial” and either the individual’s doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

“Routine patient costs” include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of

care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless Out-of-Network benefits are otherwise provided under the Plan.

“Cardiac Care Unit”

“Cardiac Care Unit” shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the treatment of patients who require special medical attention because of their critical condition;
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
4. It contains at least 2 beds for the accommodation of critically ill patients; and
5. It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

“Center(s) of Medical Excellence” (“CME”)

“Center(s) of Medical Excellence” (CME) shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what Network CME are to be used.

Any Participant in need of an organ transplant may contact the Claims Administrator to initiate the pre-certification process resulting in a referral to a CME. Anthem Blue Cross utilization review acts as the primary liaison with the CME, patient and attending Physician for all transplant admission taking place at a CME.

Additional information about this option, as well as a list of CME, is available on the Anthem Blue Cross Website.

“Certificate of Coverage”

“Certificate of Coverage” shall mean a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

“Child(ren)”

“Child” shall mean, in addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an “eligible foster Child,” which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction, or any other Child for whom the Employee has obtained legal guardianship. A “legal guardian” is a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

“CHIP”

“CHIP” refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

“CHIPRA”

“CHIPRA” refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

“Chiropractic Care”

“Chiropractic Care” shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

“Claim Determination Period”

“Claim Determination Period” shall mean each Plan Year.

“Claimant”

“Claimant” shall mean a Participant of the Plan, or entity acting on his or her behalf, authorized to submit claims to the Plan for processing, and/or appeal an Adverse Benefit Determination.

“Clean Claim”

A “Clean Claim” is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well.

“Coinsurance”

“Coinsurance” shall mean a cost sharing feature of many plans, which requires a Participant to pay out-of-pocket a prescribed portion of the cost of Covered Expenses. The defined Coinsurance that a Participant must pay out-of-pocket is based upon his or her health plan design. Coinsurance is established as a predetermined percentage of the Maximum Allowable Charge for covered services and usually applies after a Deductible is met in a Deductible plan.

“Copayment” or “Copay”

“Copayment” or “Copay” shall mean a dollar amount per visit the Participant pays to the Provider for health care expenses. In most plans, the Participant pays this after he or she meets his or her Deductible limit.

“Cosmetic Surgery”

“Cosmetic Surgery” shall mean any Surgery, service, Drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

“Covered Expense”

“Covered Expense” means the Maximum Allowable Charge for a Medically Necessary service, treatment or supply, meant to improve a condition or participant’s health, which is eligible for coverage in this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least

costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

“Covered Mental Health Service Providers”

“Covered Mental Health Service Providers” are physicians and associated visits which are limited and subject to the Summary of Benefits and terms of this document. Psychiatrists (M.D.), psychologists (Ph.D.) or counselors licensed to provide individual psychotherapy without supervision in the State they are practicing, may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

“Custodial Care”

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

“Deductible”

“Deductible” shall mean the amount of expenses for Covered Services that a Participant must pay for him or herself before the Plan will begin its payments.

“Dentist”

“Dentist” shall mean an individual holding a D.D.S. or D.M.D. degree, licensed to practice dentistry in the jurisdiction where such services are provided.

“Dependent”

“Dependent” shall mean one or more of the following person(s):

1. An Employee’s lawfully married spouse possessing a marriage license who is not divorced from the Employee. For purposes of this section, “marriage or married” means a legal union between one man and one woman as husband and wife. The Plan Administrator has discretionary authority to interpret these terms, and to determine spousal status as defined herein, to the extent allowed by law;
2. An Employee’s Child who is less than 26 years of age. **NOTE: Coverage for a Dependent Child will continue until the end of the calendar month he/she turns 26 years of age;**
3. An Employee’s Child, regardless of age, who is mentally or physically incapable of sustaining his or her own living. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age under the bullets above. The deadline for submission of written proof of incapacity and dependency is 60 days following the original eligibility date for a new or re-enrolling Employee. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next 2 years after such date. After such 2 year period, the Plan may require such proof, but not more often than once each year.

“Dependent” does not include any person who is an active duty member of the armed forces of any Country or who is a resident of a Country outside the United States.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.

NOTE: Tax treatment for certain dependents. Federal tax law generally does not recognize former spouses or Legally Separated spouses as dependents under the federal tax code unless the spouse, partner, or child otherwise qualifies as a dependent under the Internal Revenue Code §152. Therefore, the Employer may be required to automatically include the value of the health care coverage provided to any of the aforementioned individuals, who may be covered under this Plan as eligible Dependents, as additional income to the Employee.

“Detoxification”

“Detoxification” shall mean the process whereby an alcohol-intoxicated person or person experiencing the symptoms of Substance Abuse is assisted, in a facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with Drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

“Diagnosis”

“Diagnosis” shall mean the act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data. Diagnosis shall also mean the findings resulting from such act or process.

“Diagnostic Service”

“Diagnostic Service” shall mean a test or procedure performed for specified symptoms to detect or to monitor a Disease or condition. It must be ordered by a Physician or other professional Provider.

“Disease”

“Disease” shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any worker’s compensation law, occupational Disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness, Illness or Disease.

“Drug”

“Drug” shall mean insulin and prescription legend Drugs. A prescription legend Drug is a Federal legend Drug (any medicinal substance which bears the legend: “Caution: Federal law prohibits dispensing without a prescription”) or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law) and which, in either case, is legally obtained from a licensed Drug dispenser only upon a prescription of a currently licensed Physician.

“Durable Medical Equipment”

“Durable Medical Equipment” shall mean equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an Illness or Injury; and
4. Is appropriate for use in the home.

“Emergency”

“Emergency” shall mean a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator’s discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

“Emergency Medical Condition”

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“Emergency Medical Condition” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

“Employee”

NOTE: *Contracted kindergarten through eighth grade and high school teachers hired on a contract date of August 1st are eligible for coverage with no Service Waiting Period. If hired any other time than an August 1st contract, the Service Waiting Period applies.*

“Employee” shall mean a benefits eligible employee who is employed by the Employer and regularly scheduled to work an average of at least 30 hours per week (i.e. Non-variable Hour Employee) or a Variable Hour Employee who has averaged at least 30 hours per week for a complete Measurement Period and is currently in a Stability Period, as determined by the Plan Sponsor. An Employee will remain eligible throughout the Stability Period regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an employee in accordance with the Patient Protection and Affordable Care Act (as amended).

The following definitions are associated with the Code Section 4980H (Employer Shared Responsibility) as enacted under the Affordable Care Act:

Full-time Employee or Full-time Employment shall mean, with respect to a calendar month, an Employee who is employed an average of at least 30 hours per week with the Employer.

Hour of Service shall mean each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the employer; and each hour for which an Employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Measurement Period shall mean a period of time selected by the Employer during which Variable Hour Employee’s and/or Ongoing Employee’s Hours of Service are tracked to determine his or her employment status for benefit purposes.

Initial Measurement Period - for a newly hired Variable Hour Employee, this Measurement Period will start from the date of hire and ends after 12 consecutive months of service.

Standard Measurement Period - for Ongoing Employees, this Measurement Period will last for 12 consecutive months.

New Employee shall mean an Employee who has not been employed for at least one complete Standard Measurement Period, or who is treated as a New Employee following a period during which the Employee was credited with zero Hours of Service.

Non-Variable Hour Employee shall mean an Employee reasonably expected at the time of hire to work 30 hours per week.

Ongoing Employee shall mean an Employee who has been employed by the Employer for at least one complete Measurement Period.

Seasonal Employee shall mean an Employee who is hired into a position for which the customary annual employment is six months or less.

Stability Period shall mean a period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period and is used by the Employer as part of the Look-back Measurement Method. The Stability Period is a 12-month period in which the Variable Hour Employee's and/or Ongoing Employee's eligibility status is fixed.

Variable Hour Employee shall mean an Employee, based on the facts and circumstances at the Employee's start date, whose reasonable expectation of average hours per week cannot be determined.

“Employer”

“Employer” is The Roman Catholic Bishop of Stockton.

“Essential Health Benefits”

“Essential Health Benefits” shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription Drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic Disease management; and pediatric services, including oral and vision care.

The determination of which benefits provided under the plan are Essential Health Benefits shall be made in accordance with the benchmark plan of the State of Utah as permitted by the Departments of Labor, Treasury, and Health and Human Services.

“Exclusion”

“Exclusion” shall mean conditions or services that this Plan does not cover.

“Experimental” and/or “Investigational”

“Experimental” and/or “Investigational” (“Experimental”) shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A Drug, device, or medical treatment or procedure is Experimental:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
 - a. Maximum tolerated dose;

- b. Toxicity;
 - c. Safety;
 - d. Efficacy; and
 - e. Efficacy as compared with the standard means of treatment or diagnosis; or
3. If reliable evidence shows that the consensus among experts regarding the Drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
- a. Maximum tolerated dose;
 - b. Toxicity;
 - c. Safety;
 - d. Efficacy; and
 - e. Efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

- 1. Only published reports and articles in the authoritative medical and scientific literature;
- 2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same Drug, device, or medical treatment or procedure; or
- 3. The written informed consent used by the treating facility or by another facility studying substantially the same Drug, device, or medical treatment or procedure.

Subject to a medical opinion, if no other Food and Drug Administration (FDA) approved treatment is feasible and as a result the Participant faces a life or death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

“Family Unit”

“Family Unit” shall mean the Employee, his or her spouse and Children.

“Final Internal Adverse Benefit Determination”

“Final Internal Adverse Benefit Determination” shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

“FMLA”

“FMLA” shall mean the Family and Medical Leave Act of 1993, as amended.

“FMLA Leave”

“FMLA Leave” shall mean a leave of absence, which the Diocese is required to extend to an Employee under the provisions of the FMLA.

“GINA”

“GINA” shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

“Habilitation/Habilitative Services”

“Habilitation/Habilitative Services” shall mean health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

“Health Breach Notification Rule”

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“Health Breach Notification Rule” shall mean 16 CFR Part 318.

“HIPAA”

“HIPAA” shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

“Home Health Care”

“Home Health Care” shall mean the continual care and treatment of an individual if:

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided;
2. The treatment plan covering the Home Health Care service is established and approved in writing by the attending Physician; and
3. The Home Health Care is the result of an Illness or Injury.

“Home Health Care Agency”

“Home Health Care Agency” shall mean an agency or organization which provides a program of home health care and which:

1. Is approved as a Home Health Care Agency under Medicare;
2. Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
3. Meets all of the following requirements:
 - a. It is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home;
 - b. It has a full-time administrator;
 - c. It maintains written records of services provided to the patient;
 - d. Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
 - e. Its Employees are bonded and it provides malpractice insurance.

“Hospital”

“Hospital” shall mean an Institution that meets all of the following requirements:

1. It provides medical and Surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;
2. It is under the supervision of a staff of Physicians;
3. It provides 24-hour-a-day nursing service by registered nurses;
4. It is duly licensed as a Hospital, except that this requirement will not apply in the case of a State tax-supported Institution;
5. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type Institution, or an Institution which is supported in whole or in part by a Federal government fund; and
6. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

“Hospital” shall also have the same meaning, where appropriate in context, set forth in the definition of “Ambulatory Surgical Center.”

“Illness”

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"Illness" shall have the meaning set forth in the definition of "Disease."

"Impregnation and Infertility Treatment"

"Impregnation and Infertility Treatment" shall mean any services, supplies or Drugs related to the Diagnosis or treatment of infertility.

"Incurred"

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

"Injury"

"Injury" shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

"Inpatient"

"Inpatient" shall mean any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for Room and Board is made by the Hospital.

"Institution"

"Institution" shall mean a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, Residential Treatment Facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, or any other such facility that the Plan approves.

"Intensive Care Unit"

"Intensive Care Unit" shall have the same meaning set forth in the definition of "Cardiac Care Unit."

"Intensive Outpatient Services"

"Intensive Outpatient Services" shall mean programs that have the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured "crisis intervention programs," "psychiatric or psychosocial rehabilitation," and some "day treatment."

"Leave of Absence"

"Leave of Absence" shall mean a leave of absence of an Employee that has been approved by his or her Participating Employer, as provided for in the Participating Employer's rules, policies, procedures and practices.

"Legal Separation" and/or "Legally Separated"

"Legal Separation" and/or "Legally Separated" shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

"Mastectomy"

"Mastectomy" shall mean the surgical removal of all or part of a breast.

"Maximum Allowable Charge"

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The “Maximum Allowable Charge” shall mean the benefit payable for a specific coverage item or benefit under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

With respect to Non-Network Emergency Services, the Plan allowance is the greater of:

- The negotiated amount for In-Network Providers (the median amount if more than one amount to In-Network Providers).
- The Plan’s normal Non-Network payable amount after consideration of the criteria described below (reduced for cost-sharing).
- The amount that Medicare Parts A or B would pay (reduced for cost-sharing).

If and only if there is no negotiated rate for a given claim, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer’s retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge.

The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator’s discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

“Medical Child Support Order”

“Medical Child Support Order” shall mean any judgment, decree or order issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant’s Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

“Medically Necessary”

“Medically Necessary”, “Medical Necessity” and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant’s Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant’s Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Plan Participant’s medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant’s Sickness or Injury without adversely affecting the Plan Participant’s medical condition.

1. Its purpose must be to restore health;
2. It must not be primarily custodial in nature;
3. It is ordered by a Physician for the Diagnosis or treatment of a Sickness or Injury; and
4. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date

of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not necessarily mean that it is "Medically Necessary." In addition, the fact that certain services are specifically excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that all other services are "Medically Necessary."

To be Medically Necessary, all of the above criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

"Medical Record Review"

"Medical Record Review" is the process by which the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the medical record review and audit results.

"Medicare"

"Medicare" shall mean the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

"Mental Health Parity Act (MHPA) of 1996 and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions"

"The Mental Health Parity Provisions" shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1. The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

"Mental or Nervous Disorder"

"Mental or Nervous Disorder" shall mean any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

“National Medical Support Notice” or “NMSN”

“National Medical Support Notice” or “NMSN” shall mean a notice that contains the following information:

1. Name of an issuing State child support enforcement agency;
2. Name and mailing address (if any) of an Employee who is a Participant under the Plan;
3. Name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s); and
4. Identity of an underlying Child support order.

“Network” or “In-Network”

“Network” or “In-Network” shall mean the medical provider network the Plan contracts with to access discounted fees for service for Participants. The Network Provider will be identified on the Participants identification card.

“No-Fault Auto Insurance”

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

“Non-Network” or “Out-of-Network”

“Non-Network” or “Out-of-Network” shall mean the facilities, Providers and suppliers that do not have an agreement with a designated Network to provide care to Participants.

“Non Network Fee Schedule (NNFS)”

“Non Network Fee Schedule (NNFS)” is a fee schedule used to re-price Non-Network claims.

“Open Enrollment Period”

“Open Enrollment Period” shall mean the months of May and June in each Plan Year.

“Other Plan”

“Other Plan” shall include, but is not limited to:

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering the Participant;
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Worker’s compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

“Out of Area”

“Out of Area” shall mean a geographic area, as determined by the Plan Administrator, at the time each Participant becomes eligible for coverage under this Plan.

“Outpatient”

“Outpatient” shall mean treatment including services, supplies, and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician’s office, laboratory, or x-ray facility, an Ambulatory Surgical Center, or the patient’s home.

“Partial Hospitalization”

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“Partial Hospitalization” shall mean medically directed intensive, or intermediate short-term mental health and Substance Abuse treatment, for a period of less than twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program.

“Participant”

“Participant” shall mean any Employee or Dependent who is eligible for benefits (and enrolled) under the Plan.

“Patient Protection and Affordable Care Act (PPACA)”

The “Patient Protection and Affordable Care Act (PPACA)” means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See “Affordable Care Act”).

“Physician”

“Physician” shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), psychiatrist or midwife.

“Plan Year”

“Plan Year” shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary. The Plan Year shall be July 1 to June 30 each year.

“Pre-Admission Tests”

“Pre-Admission Tests” shall mean those Diagnostic Services done prior to scheduled Surgery, provided that:

1. The tests are approved by both the Hospital and the Physician;
2. The tests are performed on an Outpatient basis prior to Hospital admission; and
3. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the Surgery.

“Preferred Provider Organization (PPO)”

“Preferred Provider Organization (PPO)” shall mean an organization that contracts with a network of providers from which the health plan Participant can choose. Participants do not need to select a primary care physician (PCP) and do not need referrals to see other providers in the network.

“Pregnancy”

“Pregnancy” shall mean carrying a Child, resulting childbirth or miscarriage. The Plan considers Pregnancy as a Sickness for the purpose of determining benefits.

“Preventive Care”

“Preventive Care” shall mean certain Preventive Care services.

To comply with the ACA, and in accordance with the recommendations and guidelines, plans shall provide In-Network coverage for all of the following:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).

4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found at the following websites:

<https://www.healthcare.gov/coverage/preventive-care-benefits/>;
<https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>;
<https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>;
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
<https://www.hrsa.gov/womensguidelines/>.

For more information, Participants may contact the Plan Administrator / Employer. **NOTE:** *The Roman Catholic Bishop of Stockton has a religious objection to providing coverage for certain contraceptive services that would otherwise be required to be covered. The Roman Catholic Bishop of Stockton qualifies for an exemption from the contraceptive coverage requirement and therefore does not cover certain contraceptive services, except when there is a medical Diagnosis such as endometriosis, as permitted under the ACA and subsequent guidance from the Departments of Health and Human Services, Labor, and Treasury.*

“Prior Plan”

“Prior Plan” shall mean the coverage provided on a group or group-type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

“Prior to Effective Date” or “After Termination Date”

“Prior to Effective Date” or “After Termination Date” are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan (unless continuation of benefits applies).

“Privacy Standards”

“Privacy Standards” shall mean the applicable standards for the privacy of individually identifiable health information, pursuant to HIPAA.

“Provider”

“Provider” shall mean a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

“Psychiatric Hospital”

“Psychiatric Hospital” shall mean an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician;
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
3. It is licensed as a psychiatric Hospital;
4. It requires that every patient be under the care of a Physician; and
5. It provides 24-hour-a-day nursing service.

The term Psychiatric Hospital does not include an Institution, or that part of an Institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

“Qualified Medical Child Support Order” or “QMCSO”

“Qualified Medical Child Support Order” or “QMCSO” is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan.

“Rehabilitation”

“Rehabilitation” shall mean treatment(s) designed to facilitate the process of recovery from Injury, Illness, or Disease to as normal a condition as possible.

“Rehabilitation Hospital”

“Rehabilitation Hospital” shall mean an Institution which mainly provides therapeutic and restorative services to Sick or Injured people. It is recognized as such if:

1. It carries out its stated purpose under all relevant Federal, State and local laws;
2. It is accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities; or
3. It is approved for its stated purpose by Medicare.

“Residential Treatment Facility”

“Residential Treatment Facility” shall mean a facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug or Substance Abuse disorders or mental illness.

“Room and Board”

“Room and Board” shall mean a Hospital’s charge for:

1. Room and linen service;
2. Dietary service, including meals, special diets and nourishment;
3. General nursing service; and
4. Other conditions of occupancy which are Medically Necessary.

“Security Standards”

“Security Standards” shall mean the final rule implementing HIPAA’s Security Standards for the Protection of Electronic Protected Health Information (PHI), as amended.

“Service Waiting Period”

“Service Waiting Period” shall mean an interval of time during which the Employee is in the continuous, Active Employment of his or her Participating Employer.

“Sickness”

“Sickness” shall have the meaning set forth in the definition of “Disease.”

“Skilled Nursing Facility”

“Skilled Nursing Facility” shall mean a facility that fully meets all of the following requirements:

1. It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician.
3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.

6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial Care, educational care or care of Mental or Nervous Disorders.
7. It is approved and licensed by Medicare.

“Substance Abuse” and/or “Substance Use Disorder”

“Substance Abuse” and/or “Substance Use Disorder” shall mean any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

“Substance Abuse Treatment Center”

“Substance Abuse Treatment Center” shall mean an Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

“Surgery”

“Surgery” shall mean any of the following:

1. The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
3. The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
4. The induction of artificial pneumothorax and the injection of sclerosing solutions;
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
6. Obstetrical delivery and dilatation and curettage; or
7. Biopsy.

“Surgical Procedure”

“Surgical Procedure” shall have the same meaning set forth in the definition of “Surgery.”

“Third Party Administrator”

“Third Party Administrator” shall mean the claims administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims. The Third Party Administrator is not an insurer of health benefits under this Plan, is not a fiduciary of the Plan, and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Third Party Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan.

“Total Disability”

“Total Disability” shall mean an individual is determined as being disabled for Social Security purposes and provides such evidence to the Plan of the determination as the Plan Administrator may, in its sole discretion, require.

“Totally Disabled”

“Totally Disabled” shall have the same meaning set forth in the definition of “Total Disability.”

“Uniformed Services”

“Uniformed Services” shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

“USERRA”

“USERRA” shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”).

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ELIGIBILITY FOR COVERAGE

Eligibility for Individual Coverage

Each Non-Variable Hour Employee will become eligible for coverage under this Plan with respect to himself or herself on the first day of the month following the date of hire, provided the Employee has begun work for his or her Participating Employer.

Each Variable Hour Employee who has averaged the requisite Hours of Service, as defined herein, will become eligible for coverage under this Plan with respect to himself or herself upon completion of a complete Measurement Period. Coverage shall begin on the first day of the Stability Period, as defined herein.

NOTE: *Contracted kindergarten through eighth grade and high school teachers hired on a contract date of August 1st are eligible for coverage with no Service Waiting Period. If hired any other time than an August 1st contract, the Service Waiting Period applies.*

Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of this Plan.

Reinstatement of Coverage

An Employee who is terminated and rehired will be treated as a New Employee upon rehire only if the Employee was not credited with an Hour of Service with the Employer (or any member of the controlled or affiliated group) for a period of at least 13 consecutive weeks immediately preceding the date of rehire.

A Variable Hour Employee who is terminated and rehired will be treated as a continuing Employee upon rehire only if the Employee break in service did not exceed 13 weeks.

Upon return, coverage will be effective on the first of the month following the date of rehire, so long as all other eligibility criteria are satisfied.

Exception: Reinstatement of Coverage After Layoff due to COVID-19

This Plan provides employer-sponsored continuation of coverage due to 2019 Novel Coronavirus (COVID-19) leave or furlough (see the "Continuation of Coverage" section for more information). If the Employee is laid off due to COVID-19, and is subsequently rehired, the following applies:

- If the Employee is rehired or returns to an eligible class within 12 months of the date his or her coverage ended due to COVID-19, then coverage for the Employee and his or her previously covered Dependents may be reinstated, provided the Employee requests such reinstatement within 31 days of the date he or she returns to work or to an eligible class. Coverage will be reinstated on the first of the month. (For example, if the Employee is rehired on May 28th, his or her coverage will become effective on June 1st. If the Employee is rehired on June 10th, his or her coverage will become effective on July 1st).

Eligibility Dates for Dependent Coverage

Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage for himself or herself under the Plan;
2. The date coverage for his or her Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan; and
3. The first date upon which he or she acquires a Dependent.

In order for an Employee's Dependent to be covered under the Plan the Employee must be enrolled for

coverage under the Plan.

Effective Dates of Coverage; Conditions

The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. Enrollment Application (paper or electronic as applicable). Coverage for an Employee or his or her Dependents must be requested by the Employee on a form (either paper or electronic as applicable) furnished by the Plan Administrator and will become effective on the date such Employee or Dependents are eligible, provided the Employee has enrolled for such coverage on a form satisfactory to the Plan Administrator within the 31-day period immediately following the date of eligibility.
2. Birth of Dependent Child. A newborn Child of a covered Employee will be considered eligible and will be covered from the moment of birth for a period of 31 days only. For coverage to continue beyond this period, the Employee must submit a written application to the Plan to enroll the Child within the limited 31 day period (i.e. period from the moment of birth). The application must also be accompanied by any required contribution, ongoing, as the case may be. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent.
3. Newly Acquired Dependents. If an Employee acquires a Dependent while the Employee is eligible for coverage, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible, provided application is made to the Plan within 31 days of the date of initial eligibility and required contributions are made.
4. Requirement for Employee Coverage. No coverage for Dependents of an Employee will become effective unless the Employee is, or simultaneously becomes, eligible for coverage for himself or herself under the Plan.
5. Coverage as Both Employee and Dependent. No person may be simultaneously covered under this Plan as both an Employee and a Dependent.
6. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.

Special and Open Enrollment

The Plan provides special enrollment periods that allow Employee's to enroll in the Plan, even if they declined enrollment during an initial or subsequent eligibility period.

Loss of Other Coverage

If an Employee declined enrollment for himself or herself or his or her Dependents (including his or her spouse) because of other health coverage, he or she may enroll for coverage for himself or herself and/or his or her Dependents if the other health coverage is lost. The Employee must make written or electronic request (as applicable) for special enrollment within 31 days of the date the other health coverage was lost. For example, if the Employee loses his or her other health coverage on September 15, he or she must notify the Plan Administrator and apply for coverage by close of business on October 16.

The following conditions apply to any eligible Employee and Dependents:

An Employee may enroll during this special enrollment period:

1. If the Employee is eligible for coverage under the terms of this Plan;
2. The Employee is not currently enrolled under the Plan;

3. When enrollment was previously offered, the Employee declined because of coverage under another group health plan or health insurance coverage. The Employee must have provided a written statement that other health coverage was the reason for declining enrollment under this Plan; and
4. If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

An Employee who is already enrolled in a benefit package may enroll in another benefit package under the Plan if a Dependent of that Employee has a special enrollment right in the Plan because the Dependent lost eligibility for other coverage. The Employee must make written application for special enrollment in the new benefit package within 31 days of the date the other health coverage was lost.

The Employee is not eligible for this special enrollment right if:

1. The other coverage was continuation of coverage and the Employee did not exhaust the maximum time available to him or her for that continuation of coverage; or
2. The other coverage was lost due to non-payment of requisite contribution / premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request (including the Participant's enrollment form, either paper or electronic as applicable, in the case of enrollment) is received by the Plan.

New Dependent

If an Employee acquires a new Dependent as a result of marriage, legal guardianship, a foster child being placed with the Employee, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and his or her Dependents during a special enrollment period. The Employee must make written or electronic request (as applicable) for special enrollment no later than 31 days after he or she acquires the new Dependent. For example, if the Employee is married on September 15, he or she must notify the Plan Administrator and apply for coverage by close of business on October 16.

The following conditions apply to any eligible Employee and Dependents:

An Employee may enroll himself or herself and/or his or her eligible Dependents during this special enrollment period if:

1. The Employee is eligible for coverage under the terms of this Plan; and
2. The Employee has acquired a new Dependent through marriage, legal guardianship, a foster child being placed with the Employee, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for the Employee and his or her Dependent(s) will be effective at 12:01 A.M.:

1. For a marriage, on the first day of the first calendar month following enrollment;
2. For a legal guardianship, on the date on which such Child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child;
3. In the case of a foster child being placed with the Employee, on the date on which such Child is placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction;
4. For a birth, on the date of birth; or
5. For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

Additional Special Enrollment Rights

Employees and Dependents who are eligible but not enrolled are entitled to enroll under the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written or electronic request, as applicable (including the Participant's enrollment form, either paper or electronic as applicable, in the case of enrollment) is received by the Plan.

Open Enrollment

Participants may enroll for coverage during Open Enrollment Periods. Coverage for Participants enrolling during an Open Enrollment Period will become effective on July 1, unless the Employee has not satisfied the Service Waiting Period, in which event coverage for the Employee and his or her Dependents will become effective on the day following completion of the Service Waiting Period.

"Open Enrollment Period" shall mean the months of May and June in each Plan Year.

Qualified Medical Child Support Orders

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO"), not including an ex-stepchild or ex-stepchildren, if such an individual is not already covered by the Plan as an Eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent.

"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for Child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical Child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. Name of an issuing State child support enforcement agency;
2. Name and mailing address (if any) of an Employee who is a Participant under the Plan or eligible for enrollment;
3. Name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s); and
4. Identity of an underlying Child support order.

"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or

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recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";
2. a. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;
b. Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan's default option (if any); and
3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated Dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Plan Participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
 - a. Whether the Child is covered under the Plan; and
 - b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

A Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Acquired Companies

Eligible Employees of an acquired company who are Actively at Work and were covered under the prior plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition.

Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Service Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

Genetic Information Nondiscrimination Act (“GINA”)

“GINA” prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term “genetic information” means, with respect to any individual, information about:

1. Such individual’s genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a Disease or disorder in family members of such individual.

The term “genetic information” includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include Dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

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TERMINATION OF COVERAGE

Termination Dates of Individual Coverage

The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. The last day of the month in, or with respect to which, he or she requests that such coverage be terminated, provided such request is made on or before such date, unless prohibited by law (i.e., when election changes cannot be made due to Internal Revenue Code Section 125 "change in status" guidelines)." **NOTE: The Employer offers these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and a voluntary termination must comply with the requirements of the Code and the cafeteria plan;**
3. The last day of the month for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing;
4. The last day of the month in which he or she ceases to be eligible for such coverage under the Plan;
5. The last day of the month in which the termination of employment occurs;
6. The last day of the month following the end of the Stability Period for Variable Hour Employees, if the Employee failed to qualify during the previous Measurement Period; or
7. Immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. Upon the discontinuance of coverage for Dependents under the Plan;
3. The date of termination of the Employee's coverage for himself or herself under the Plan;
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing;
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
 - a. Cessation of such inability;
 - b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
 - c. Upon the Child's no longer being dependent on the Employee for his or her support;
6. The day immediately preceding the date such person ceases to be a Dependent, except for Dependent Children, as defined herein, except as may be provided for in other areas of this section;
7. The last day of the month in which such person ceases to be a Dependent Child, as defined herein, except as may be provided for in other areas of this section or within this document; or
8. Immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Certificates of Coverage

Certificates of Coverage will be provided upon request at any time while the individual is covered under the Plan and up to 24 months after the individual loses coverage under the Plan.

SUMMARY OF BENEFITS

General Limits

Payment for any of the expenses listed below is subject to all Plan Exclusions, limitations and provisions. All coverage figures, if applicable, are after the out-of-pocket Deductible has been satisfied. Benefits for Pregnancy expenses are paid the same as any other Sickness.

Failure to comply with Utilization Management will result in a higher cost to Participants. "Utilization Management" includes Hospital pre-admission certification, continued stay review, length-of-stay determination and discharge planning. These programs are designed to ensure that Medically Necessary, high-quality patient care is provided and enables maximum benefits under the Plan. See pre-certification requirements in the section entitled "Cost Containment."

Services that Require Pre-Certification

The following services will require Pre-certification (or reimbursement from the Plan may be reduced):

1. Inpatient Hospitalization;
2. Transplant Candidacy Evaluation and Transplant (organ and/or tissue). A Center of Medical Excellence (CME) must be utilized;
3. Home Health Services;
4. Durable Medical Equipment;
5. Temporomandibular Joint Services;
6. Scheduled Air Ambulance;
7. Participation in Approved Clinical Trials. A Center of Medical Excellence (CME) must be utilized;
8. Inpatient Rehab program (such as Cardiac, Chemical Dependency, Pain Management, Pulmonary);
9. Residential Treatment Facility Programs for Mental Health and/or Substance Abuse;
10. Skilled Nursing Facility stays. Participants must be admitted to the Skilled Nursing Facility within 14 days of an active Hospital stay. This benefit is limited to 100 days per Plan Year;
11. Use of Implantable Devices;
12. Infusion Services; and
Prescription Specialty Drugs.

Remember that although the Plan will automatically pre-certify a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, it is important that the Participant has his/her Physician call to obtain Pre-certification if there is a need to have a longer stay.

Pre-certification does not verify eligibility for benefits nor guarantee benefit payments under the Plan. It is the Participant's responsibility to verify that the above services have been pre-certified as outlined below.

Cost Containment

Pre-Certification Procedures

The Inpatient Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that Inpatient Hospital care is needed, it is the Participant's responsibility to call the Pre-certification department at its toll-free number, which is 800-274-7767. The review process will continue, as outlined below, until the Participant is discharged from the Hospital.

Urgent Care or Emergency Admissions:

If a Participant needs medical care for a condition which could seriously jeopardize his or her life, he or she should obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

If a Participant must be admitted on an Emergency basis, the Participant, or an individual acting on behalf of the Participant, should follow the Physician's instructions carefully and contact the pre-certification department as follows:

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1. For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department must be made within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient; and
2. For Emergency admissions on a weekday, a call to the pre-certification department must be made within 24 hours after the admission date, by or on behalf of the covered patient.

The Plan will require notice within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient. Such a claim shall then be deemed to be a Post-service Claim.

Non-emergency Admissions:

For Inpatient Hospital stays that are scheduled in advance, a call to the pre-certification department should be completed as soon as possible before actual services are rendered. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the admission request. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board-certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

Pre-Certification Penalty

The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to notify the pre-certification department of any services listed in the section entitled "Services that Require Pre-Certification," allowed charges will be reduced by \$250 for Room and Board, Hospital miscellaneous services, and any other charges related to that confinement which are billed by the Hospital. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

NOTE: If a Participant's admission or service is determined to not be Medically Necessary, he or she may pursue an appeal by following the provisions described in the Claims Procedures; Payment of Claims section of this document. The Participant and Provider will be informed of any denial or non-certification in writing.

Network and Non-Network Provider Arrangement

The Plan contracts with medical provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Participants use a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:

- a. The Network Provider level of benefits is payable when a Participant receives Emergency care either Out of Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency.
2. If the charge billed by a Non-Network Provider for any covered service is higher than the Maximum Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee.
3. To receive benefit consideration, Participants must submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.
4. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

Third Party

Balance Billing

In the event that a claim submitted by a Network or non-Network Provider is subject to a medical bill review or medical chart audit and some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator, although the Plan has no control over any Provider's actions, including balance billing.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Participant is responsible for any applicable payment of Coinsurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Choice of Providers

The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other healthcare Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Third Party Administrator. The delivery of medical and other healthcare services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other healthcare Provider. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Network Provider Information

The PPO Network Providers are merely independent contractors; neither the Plan nor the Plan

Administrator make any warranty as to the quality of care that may be rendered by any PPO Network Provider.

A current list of PPO Providers is available, without charge, through the Third Party Administrator's website (located at www.deltahealthsystems.com). The PPO Network Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a PPO Network Provider before receiving services. Please refer to the Participant identification card for the PPO website address.

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that exceed the Maximum Allowable Charge or services that are not Medically Necessary, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

Transition of Care

If a Participant is under the care of a Non-Network Provider at the time of joining the Plan, there are a limited number of medical conditions that may qualify for transition of care. If transitional care is appropriate, specific treatment by a Non-Network Provider may be covered at the Network level of benefits for a limited period of time. The Third Party Administrator will review and approve or deny such requests.

Alternate Course of Treatment

Certain types of conditions, such as spinal cord Injuries, cancer, AIDS or premature births, may require long-term, or perhaps lifetime, care. The claims selected will be evaluated as to present course of treatment and alternate care possibilities.

If the Plan Administrator should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, subject to the applicable benefit maximum(s) set forth in this Plan, even if these expenses normally would not be eligible for payment under the Plan. In the event the Participant and the attending Physician select a more expensive course of treatment, coverage under the Plan will be based upon the charge allowed for the alternate, less expensive, course of treatment.

Case Management

Case management is a preemptive coordination of a Participant's care in cases where the medical condition is or is expected to be serious, chronic, or when the cost of treatment is expected to be significant. This program provides for a case manager who monitors Participants and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same Diagnosis.

Medical Benefit Summary

Summary of Medical Benefits – PPO Plan

The following benefits are per Participant per Plan Year (July – June). All benefits are subject to the Maximum Allowable Charge.

	Network	Non-Network	Limits
Deductible* 1. Individual 2. Family Unit *Deductible applies to all benefits, unless otherwise stated below.	\$500 \$1,000	\$1,500 \$3,000	The Network and Non-Network Deductible do not cross-accumulate to one another.
Maximum Out-of-Pocket ¹ 1. Individual 2. Family Unit	\$2,500 \$7,500 The Network Maximum Out-of-Pocket includes prescription Drug Copays and Coinsurance.	\$10,000 \$20,000	The Network and Non-Network Maximum Out-of-Pocket do not cross-accumulate to one another.

Covered Medical Expenses:	Network	Non-Network	Limits ²
1. Acupuncture	\$25.00 Copay	\$25.00 Copay	20 visits per Plan Year-
2. Allergy Services a. Office Visit b. Injections c. Serum	\$25.00 Copay 80% 80%	50% 50% 50%	Deductible waived for office visit
3. Ambulance	80%	80%	Pre-certification required for air ambulance Non-Network is paid at the Network benefit level for Emergencies
4. Ambulatory Surgical Center	80%	50%	Pre-certification required for some services identified on the Anthem prior

Covered Medical Expenses:	Network	Non-Network	Limits²
			authorization list; Deductible applies
5. Anesthesia	80%	50%	After Deductible
6. Approved Clinical Trial, Routine Patient Costs	100%, Deductible Waived	100%, Deductible Waived	
7. Birthing Center	80%	50%	Consider as Outpatient Hospital service
8. Blood & Plasma	80%	50%	
9. Chiropractic Care α. X-rays 80% Network β. X-rays 50% Non-Network	\$25 Copay	50%	12 visits per Plan year (x-rays are not included in this maximum); Deductible applies

- 1 Includes Deductibles, Coinsurance, and Copays. Excludes amounts over the Maximum Allowable Charge.
- 2 These limits are in addition to all other Plan Exclusions, limitations and provisions and set forth in this Plan. Please review the Plan carefully to determine benefits available.

Covered Medical Expenses:	Network	Non-Network	Limits²
10. COVID-19. Testing for the 2019 Novel Coronavirus (COVID-19)	100%, Deductible waived	100%, Deductible waived	Subject to Medical Necessity guidelines
11. COVID-19. Treatment of the 2019 Novel Coronavirus (COVID-19)	100%, Deductible waived	100%, Deductible waived	Subject to Medical Necessity guidelines
12. Durable Medical Equipment Includes oxygen and related supplies and surgical dressing	80%	50%	Pre-certification required for some services identified on the Anthem prior authorization list
13. Glaucoma, Cataract Surgery and Lenses (one set)	80%	50%	
14. Hearing Devices	80%	50%	

Covered Medical Expenses:	Network	Non-Network	Limits²
15. Home Health Care	80%	Not covered	100 visits per Plan Year Pre-certification required
16. Hospice Care (includes Bereavement Counseling) a. 24-hour Continuous Home Care b. General Inpatient Care c. Inpatient Respite Care d. Pre-hospice consultation e. Routine home care	80% 80% 80% Deductible waived 100% Deductible waived 100% Deductible waived	Not covered	Pre-certification required
17. Hospital* a. Inpatient Treatment b. Outpatient Treatment	\$250 Copay/80% 80%	50% 50%	Pre-certification required
18. Impregnation and Infertility Treatment	Not covered	Not covered	
19. Newborn Physician Care	\$250 Copay/80% Deductible waived	50%	
20. Outpatient Diagnostic X-ray and Lab	80%	50%	
21. Outpatient Emergency Services – Emergency Room a. Emergency b. Non-Emergency c. Emergency Room Physicians	\$200 Copay Deductible waived 80%	\$200 Copay Deductible waived 80%	Non-Network is paid at the Network benefit level for Emergencies

³ These limits are in addition to all other Plan Exclusions, limitations and provisions and set forth in this Plan. Please review the Plan carefully to determine benefits available.

22. Physician Services			
a. Office Visit	\$25 Copay Deductible waived	50%	
b. Lab, x-rays and Surgery	80%	50%	
23. Pregnancy Expenses	80%	50%	

Covered Medical Expenses:	Network	Non-Network	Limits⁴
24. Preventive Care – Well Adult Care			
a. Routine Physical Exam –	100% Deductible waived	Not Covered	Allowed 1 time per Plan year
b. Mammograms – <i>must be over age 40, unless Medically Necessary</i>	100% Deductible waived		Allowed every 1-2 Plan years for women over 40
c. Pap Smears	100% Deductible waived		
d. Prostate Exam – <i>must be over age 50, unless Medically Necessary</i>	100% Deductible waived		
e. Routine Immunizations	100% Deductible waived		
f. Colonoscopy	100% Deductible waived		Allowed every 5-10 Plan Years over age 50
25. Preventive Care – Well Child Care			
a. Exam	100% Deductible waived	Not covered	
b. Immunizations/Lab/Diagnostic/X-ray	100% Deductible waived		
26. Private Duty Nursing	80%	Not covered	100 visits per Plan Year for all Home Health Services Pre-certification required for all home health
27. Prosthetics and Orthotics	80%	50%	

4 These limits are in addition to all other Plan Exclusions, limitations and provisions and set forth in this Plan. Please review the Plan carefully to determine benefits available.

28. Psychiatric Expenses			
a. Residential Treatment	\$250 Copay/80%	50%	
b. Inpatient	\$250 Copay/80%	50%	Pre-certification required
c. Partial Day Program	80%	50%	Pre-certification required
d. Outpatient Physician	\$25 Copay; Deductible waived	50%	
e. Inpatient Physician	80%	50%	
29. Second Surgical Opinions	100% Deductible waived for office services	50%	
30. Skilled Nursing Facility	80%	50%	100 days per Plan Year Pre-certification required
Covered Medical Expenses:	Network	Non-Network	Limits⁵
31. Substance Abuse Benefits			
a. Residential Treatment	\$250 Copay/80%	50%	Pre-certification required
b. Inpatient	\$250 Copay/80%	50%	Pre-certification required
c. Partial Day Program	80%	50%	
d. Outpatient Physician	\$25 Copay; Deductible waived	50%	
e. Inpatient Physician	80%	50%	
32. Surgery	80%	50%	
33. Telemedicine	\$10 Copay; Deductible waived	N/A	Only covered for certain Network Providers
34. Temporomandibular Joint Disorder (TMJ)	Payable as services rendered	Payable as services rendered	Pre-Certification required

Covered Medical Expenses:	Network	Non-Network	Limits ⁵
35. Therapy <ul style="list-style-type: none"> a. Chemotherapy b. Occupational Therapy c. Physical Therapy d. Radiation Therapy e. Respiration Therapy f. Speech Therapy 	80% \$25 Copay \$25 Copay 80% \$25 Copay \$25 co-pay	50% 50% 50% 50% 70%	A treatment plan is required for occupational therapy, physical therapy, respiration therapy, and speech therapy; Deductible applies

36. Transplants	80%	Not covered	<p>CME required</p> <p>Pre-certification required</p> <p>Travel for transplants— coverage is limited to \$130 round trip, up to 5 trips, if Transplant Center is 60 miles or more from the home zip code. Transplant lodging is covered for one hotel room, double occupancy, for Participant and one companion not to exceed \$150/day for pre-surgical visit and follow-up visit up to two days/trip, and \$150/day for duration of Participant's surgery up to 4 days when documentation is provided. \$10,000 lifetime maximum, all transplants combined.</p>
37. All Other Covered Services	80%	50%	

⁵ These limits are in addition to all other Plan Exclusions, limitations and provisions and set forth in this Plan. Please review the Plan carefully to determine benefits available.

Summary of Prescription Drug Benefits – PPO Plan

The following benefits are per Participant:

Covered Prescription Drug Expenses:	Participating Pharmacy ⁶	Limits ⁷
<u>Pharmacy Option:</u>		
Copayment, per prescription or refill, for generic	\$10	See Prescription Drug Benefits
Copayment, per prescription or refill, for formulary name brands after \$150 per Participant Plan Year Deductible	\$25	
Copayment, per prescription or refill, for non-formulary name brands after \$150 per Participant Plan Year Deductible	\$40	
Coinsurance, per prescription or refill, for specialty	20% up to a maximum of \$150 per prescription after Deductible	
<u>Mail Order Option:</u>		
Copayment, per prescription or refill, for generic	\$20	See Prescription Drug Benefits
Copayment, per prescription or refill, for name brands ⁸	\$50	
Copayment, per prescription or refill, for non-formulary name brands	\$80	

⁶ 100% payment by Plan after Copayment.

⁷ These limits are in addition to all other Plan Exclusions, limitations and provisions set forth in this Plan. Please review the Plan carefully to determine benefits available.

⁸ Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated “dispense as written” or similar indication.

MEDICAL BENEFITS

Medical Benefits

These medical benefits will be payable as shown in the Summary of Benefits or as otherwise outlined in this Plan. Subject to the Plan's provisions, limitations and Exclusions, the following are covered medical benefits:

1. **Acupuncture.** Charges for acupuncture, limited to 20 visits per Plan Year;
2. **Allergy Services.** Charges related to the treatment of allergies;
3. **Ambulance.** Transportation by professional ambulance, including approved available air and train transportation (excluding chartered air flights), to a local Hospital or transfer to the nearest facility having the capability to treat the condition, if the transportation is connected with an Inpatient Confinement;
4. **Ambulatory Surgical Center.** Services of an Ambulatory Surgical Center for Medically Necessary care provided;
5. **Anesthesia.** Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff;
6. **Birthing Center.** Services of a Birthing Center for Medically Necessary care provided within the scope of its license;
7. **Blood/Blood Derivatives.** Charges for blood and blood plasma (if not replaced by or for the patient), including blood processing and administration services. The Plan shall also cover processing, storage, and administrative services for autologous blood (a patient's own blood) when a Participant is scheduled for Surgery that can be reasonably expected to require blood;
8. **Chemotherapy.** Charges for chemotherapy, including materials and services of technicians;
9. **Chiropractic Care.** Spinal adjustment and manipulation, x-rays for manipulation and adjustment and other modalities performed by a Physician or other licensed practitioner, as limited in the Summary of Benefits, as applicable. Refer to Summary of Benefits for visit limits;
10. **COVID-19 (2019 Novel Coronavirus).** Covered Expenses associated with testing for and treatment of COVID-19 include the following:
 - *Diagnostic Tests.* The following items are covered at 100%, deductible waived, as provided in the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and notwithstanding any otherwise-applicable Medical Necessity or Experimental and/or Investigational requirements, and do not require Pre-Certification. These items are paid at the negotiated rate, if one exists. If no negotiated rate exists, the Plan will pay the cash price publicly posted on the Provider's website, or such other amount as may be negotiated by the Provider and Plan.
 - In vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 (including all costs relating to the administration of such in vitro diagnostic products) which satisfy **one** of the following conditions:
 - that are approved, cleared, or authorized by the FDA;
 - for which the developer has requested or intends to request emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;

- that are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
 - that are deemed appropriate by the Secretary of Health and Human Services.
 - Items and services furnished during an office visit (including both in-person and telehealth), urgent care visit, or emergency room visit which results in an order for or administration of an in vitro diagnostic product described above. Such items and services must relate to the furnishing of such diagnostic product or evaluation of the individual for purposes of determining the need for such product.
- *Qualifying Coronavirus Preventive Services.* The following items are covered at 100%, deductible waived, and do not require Pre-Certification.
 - An item, service, or immunization that has in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force; and
 - An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
- *Inpatient Hospital Quarantines.* There may be times when Participants with the virus need to be quarantined in a Hospital private room to avoid infecting other individuals. These patients may not meet the need for acute inpatient care any longer but may remain in the Hospital for public health reasons. Such charges will not be denied solely because otherwise-applicable Medically Necessary requirements would not indicate a need for a private room.
- *Telehealth and Other Communication-Based Technology Services.* Participants can communicate with their doctors or certain other practitioners without going to the doctor’s office in person. This is recommended if a Participant believes he or she has COVID-19 symptoms.
- *Requests for Prescription Refills.* When considering whether to cover a greater-than-30-day supply of drugs, the Plan and its Prescription Drug Plan Administrator will, on a case-by-case, basis, consider each request and make decisions based on the circumstances of the patient.
- *Non-Emergency Ambulance Transportation.* The Plan will cover limited, Medically Necessary, non-emergency ambulance transportation relating to COVID-19 Diagnosis or treatment.

The above benefits are specific to Diagnosis and treatment of COVID-19. Participants who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan’s guidelines;

11. **Dental Services—Accident Only.** Charges made for a continuous course of dental treatment started within 12 months from the date of the Injury to sound natural teeth. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
12. **Diagnostic Tests; Examinations.** Charges for x-rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy and other diagnostic tests and procedures;
13. **Durable Medical Equipment, Supplies, and Surgical Dressings.** Charges for rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin-Dependent diabetics. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for:
 - a. Any purchases without its advance written approval;
 - b. Replacements or repairs; or
 - c. The rental or purchase of items which do not fully meet the definition of “Durable Medical Equipment”;
14. **Foot Disorders.** Surgical treatment of foot disorders, including associated services, performed by a licensed Physician (excluding routine foot care);

15. **Glaucoma.** Treatment of glaucoma when Medically Necessary, cataract Surgery and one set of lenses (contacts or frame-type) following the surgery;

16. **Gleevec.** Gleevec, for treatment of any of the following conditions:

- a. CML myeloid blast crisis;
- b. CML accelerated phase; or
- c. CML in chronic phase after failure of interferon treatment;

Prior authorization is required. In order to obtain such authorization, information from the patients' Physician indicating the condition being treated must be submitted to the Plan;

17. **Hearing Aids.** Hearing aids or examinations for the prescription or fitting of hearing aids;

18. **Home Health Care.** Charges for Home Health Care services and supplies are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be required. The Diagnosis, care, and treatment must be certified by the attending Physician and be contained in a home health care plan. Refer to Summary of Benefits for visit limits. Charges by a Home Health Care Agency.

- a. Registered Nurses or Licensed Practical Nurses;
- b. Certified home health aides under the direct supervision of a Registered Nurse;
- c. Registered therapist performing physical, occupational or Speech Therapy;
- d. Physician calls in the office, home, clinic or Outpatient department;
- e. Services, Drugs and medical supplies which are Medically Necessary for the treatment of the Plan Participant that would have been provided in the Hospital, but not including Custodial Care; and
- f. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

NOTE: Transportation services are not covered under this benefit;

19. **Hospice Care.** Charges relating to Hospice Care, provided the Plan Participant has a life expectancy of 6 months or less, subject to the maximums, if any, stated in the Summary of Benefits. Covered Hospice expenses are limited to:

- a. Room and Board for Confinement in a Hospice;
- b. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness;
- c. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
- d. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.);
- e. Home health aide services;
- f. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide;
- g. Medical social services by licensed or trained social workers, Psychologists or counselors;
- h. Nutrition services provided by a licensed dietitian;
- i. Respite care; and
- j. Bereavement counseling, which is a supportive service provided by the Hospice team to Plan Participants in the deceased's family after the death of the Terminally Ill person, to assist the Plan Participants in adjusting to the death;

20. **Hospital.** Charges made by a Hospital for:

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- a. Inpatient Treatment
 - i. Daily Semi-Private Room and Board charges;
 - ii. Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges;
 - iii. General nursing services; and
 - iv. Medically Necessary services and supplies furnished by the Hospital, other than Room and Board
- b. Outpatient Treatment
 - i. Emergency room;
 - ii. Treatment for chronic conditions;
 - iii. Physical Therapy treatments;
 - iv. Hemodialysis; and
 - v. X-ray, laboratory and linear therapy;

21. **Mastectomy.** The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The new Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

- a. Reconstruction of the breast on which the Mastectomy has been performed;
- b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas.

The reconstruction of the breast will be done in a manner determined in consultation with the attending Physician and the patient.

This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with you and your attending Physician;

22. **Medical Supplies.** Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes, but including syringes for diabetic and allergy diagnosis, and lancets and chemstrips for diabetics;

23. **Mental Health and Substance Abuse Benefits.** Benefits are available for Inpatient or Outpatient care for mental health and Substance Abuse conditions, including individual and group psychotherapy, psychiatric tests, and expenses related to the Diagnosis when rendered by a covered Provider.

Benefits are available for Residential Treatment Facility, Partial Hospitalization, and Intensive Outpatient Services;

24. **Newborn Care.** Hospital and Physician nursery care for Newborns who are children of the Employee or spouse and properly enrolled in the Plan, as set forth below. Benefits will be provided under the Child's coverage, and the Child's own Deductible and Coinsurance provisions will apply:

- a. Hospital routine care for a Newborn during the Child's initial Hospital Confinement at birth;

- and
- b. The following Physician services for well-baby care during the Newborn's initial Hospital Confinement at birth:
 - i. The initial Newborn examination and a second examination performed prior to discharge from the Hospital; and
 - ii. Circumcision.

NOTE: The Plan will cover Hospital and Physician nursery care for an ill Newborn as any other medical condition, provided the Newborn is properly enrolled in the Plan. These benefits are provided under the baby's coverage;

25. **Nursing Services.** Services of a Registered Nurse or Licensed Practical Nurse;
26. **Occupational Therapy.** Rehabilitation treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing Outpatient facility. Physician's treatment plan is required;
27. **Oral Surgery.** Oral Surgery in relation to the bone, including tumors, cysts and growths, not related to the teeth and extraction of soft tissue impacted teeth by a Physician or Dentist;
28. **Pathology Services.** Charges for Pathology Services;
29. **Physical Therapy.** Rehabilitation treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed Outpatient therapy facility. Physician's treatment plan is required;
30. **Physician Services.** Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations;
31. **Pregnancy Expenses.** Dependent Children are eligible for coverage for any expenses in connection with Pregnancy. **NOTE:** *Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.*

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers 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 attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending provider" include a plan, Hospital, managed care organization, or other issuer.

Benefits are payable in the same manner as for medical or Surgical care of an Illness, shown in the "Summary of Benefits" and this section, and subject to the same maximums (if any);

32. **Preventive Care.** Charges for preventive care services. This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer In-Network coverage for certain preventive services without cost-sharing.

Benefits mandated through the ACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive

Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).

See the following websites for more details:

<https://www.healthcare.gov/coverage/preventive-care-benefits/>;
<https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>;
<https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>;
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
<https://www.hrsa.gov/womensguidelines/>.

NOTE: *The Preventive Care services identified through the above links are recommended services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100% for Non-Network Providers if there is no Network Provider who can provide a required preventive service.*

Preventive and Wellness Services for Adults and Children - In compliance with section 2713 of the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

Women’s Preventive Services - With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) not otherwise addressed by the recommendations of the United States Preventive Service Task Force (USPSTF), which will be commonly known as HRSA’s Women’s Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women’s services to the list of mandatory preventive services:

1. Well-woman visits.
2. Gestational diabetes screening.
3. Human papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing.
4. Sexually transmitted infection counseling.
5. Human Immunodeficiency Virus (HIV) screening and counseling.
6. Breastfeeding support, supplies and counseling.
7. Domestic violence screening and counseling.

A description of Women’s Preventive Services can be found at:
<http://www.hrsa.gov/womensguidelines/> or at the websites listed above.

NOTE: *The Roman Catholic Bishop of Stockton has a religious objection to providing coverage for certain contraceptive services that would otherwise be required to be covered. The Roman Catholic Bishop of Stockton qualifies for an exemption from the contraceptive coverage requirement and therefore does not cover certain contraceptive services, except when there is a medical Diagnosis such as endometriosis, as permitted under the ACA and subsequent guidance from the Departments of Health and Human Services, Labor, and Treasury.*

33. **Prosthetics, Orthotics.** Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not

including charges for repair or maintenance. Orthotic devices, but excluding orthopedic shoes and other supportive devices for the feet;

34. **Radiation Therapy.** Charges for radiation and dialysis therapy and treatment;
35. **Respiration Therapy.** Respiration therapy services, when rendered in accordance with a Physician's written treatment plan;
36. **Routine Patient Costs for Participation in an Approved Clinical Trial.** Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, as defined under the ACA, provided:
 - a. The clinical trial is approved by any of the following:
 - i. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
 - ii. The National Institute of Health.
 - iii. The U.S. Food and Drug Administration.
 - iv. The U.S. Department of Defense.
 - v. The U.S. Department of Veterans Affairs.
 - vi. An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.
 - b. The research institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.
37. **Second Surgical Opinions.** Charges for second surgical opinions;
38. **Skilled Nursing Facility.** Charges made by a Skilled Nursing Facility or a Convalescent Care Facility, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury (excluding Drug addiction, chronic brain syndrome, alcoholism, senility, intellectual disability or other Mental or Nervous Disorders) for which the Plan Participant is confined. Refer to Summary of Benefits for visit limits;
39. **Speech Therapy.** Speech therapy, for Rehabilitation purposes, by a Physician or qualified speech therapist, when needed due to a Sickness or Injury (other than a functional nervous disorder) or due to surgery performed as the result of a Sickness or Injury, excluding Speech Therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders. Physician's treatment plan is required;
40. **Surgery.** Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:
 - a. Multiple procedures adding significant time or complexity will be allowed at:
 - i. 100% of the Maximum Allowable Charge for the first or major procedure;
 - ii. 50% of the Maximum Allowable Charge for the secondary and subsequent procedures;
 - b. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at 100% of the Maximum Allowable Charge for the major procedure, and 50% of the Maximum Allowable Charge for the secondary or lesser procedure;

- c. The Maximum Allowable Charge for services rendered by an assistant surgeon will be limited to 25% of the Maximum Allowable Charge identified for the surgeon's service;
 - d. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative session;
41. **Surgical Treatment of Jaw.** Surgical treatment of Diseases, Injuries, fractures and dislocations of the jaw by a Physician or Dentist;
42. **Telemedicine.** Telemedicine services from a Provider. Telemedicine refers to the utilization of services received from a remote Provider, rather than an in-person office visit, for the Diagnosis, treatment or management of a covered medical condition.
43. **Temporomandibular Joint Disorder.** Charges for the diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofascial pain dysfunction or orthognathic treatment. If a Physician or Dentist recommends treatment for or in connection with temporomandibular joint disorders, myofascial pain dysfunction or orthognathic treatment, a Participant must submit the treatment plan, including x-rays and study models, for pre- determination of benefits under the Plan. The pre determination of benefits is required before any course of treatment is begun. The Plan Administrator will determine if the treatment is a Covered Expense and will notify the Participant. If treatment is begun before the pre-determination of benefits, no benefits are payable under the Plan;
44. **Transplants.** Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:
- a. Bone marrow;
 - b. Heart;
 - c. Lung;
 - d. Heart and lung;
 - e. Liver;
 - f. Pancreas;
 - g. Kidney;
 - h. Cornea; and
 - i. Skin.

In addition, the Plan will cover any other transplant that is not Experimental.

Recipient Benefits

Covered Expenses will be considered the same as any other Sickness for Employees or Dependents as a recipient of an organ or tissue transplant. Covered Expenses include:

- a. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;
- b. Services and supplies furnished by a Provider; and
- c. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

Surgical, storage and transportation costs , including donor medical expenses, directly related to the procurement of an organ or tissue used in a transplant described herein will be covered. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue;

Donor Benefits

The Plan covers donation-related services for actual or potential donors, whether or not they are Participants, as long as the transplant recipient is a Participant. The Plan will cover these costs,

provided such costs are not covered in whole or in part by any other source other than the donor's family or estate. This includes, but is not limited to, other insurance, including self-funded medical plans, grants, foundations, and government programs.

45. **Wigs.** Charges associated with the initial purchase of a wig after chemotherapy or radiation therapy. Limited to \$500 every 36 months.

PRESCRIPTION DRUG BENEFITS

Covered Prescription Drug Expenses - PPO Plan:	Participating Pharmacy ⁹	Non- Participating Pharmacy
Pharmacy Option:		
Copayment, per prescription or refill, for generic	\$10	\$10 + 25%
Copayment, per prescription or refill, for formulary name brands after \$150 per Participant Plan Year Deductible ¹⁰	\$25	\$25 + 25%
Copayment, per prescription or refill, for non-formulary name brands after \$150 per Participant Plan Year Deductible	\$40	\$40 + 25%
Mail Order Option:		
Copayment, per prescription or refill, for generic	\$20	Not covered
Copayment, per prescription or refill, for formulary name brands ¹⁰	\$50	Not covered
Copayment, per prescription or refill, for non-formulary name brands	\$80	Not covered
Coinsurance, per prescription or refill, for specialty	20% up to a maximum of \$150 per prescription	Not covered

Participating pharmacies (“Participating Pharmacies”) have contracted with the Plan to charge Participants reduced fees for covered Drugs. Integrated Prescription Management (IPM) is the administrator of the prescription Drug plan. Participants will be issued an identification card to use at the pharmacy at time of purchase. Participants will be held fully responsible for the consequences of any pharmacy identification card after termination of coverage. No reimbursement will be made when a Drug is purchased from a non-Participating Pharmacy or when the identification card is not used.

⁹ 100% payment by Plan after Copayment.

¹⁰ Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated “dispense as written” or similar indication.

The Mail Order Option is available for maintenance medications (those that are taken for long periods of time, such as Drugs sometimes prescribed for heart Disease, high blood pressure, asthma, etc.). Because of the volume buying, Walgreens, the mail order pharmacy, is able to offer Participants significant savings on their prescriptions.

The Copayment and/or Coinsurance amounts are applied to each charge and is shown on the Summary of Benefits, above. The Copayment and Coinsurance amounts apply toward the medical plan out-of-pocket maximum.

Covered Expenses

The following are covered under the Plan:

1. **Acne Control;**
2. **Allergy Sera.** Charges for allergy sera;
3. **Compounded Prescriptions.** All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity;
4. **Diabetes.** Insulins, insulin syringes and needles, diabetic supplies – legend, and glucose test strips, when prescribed by a Physician;
5. **Gleevec.** Gleevec, for treatment of any of the following conditions:
 - a. CML myeloid blast crisis;
 - b. CML accelerated phase; or
 - c. CML in chronic phase after failure of interferon treatment;
6. **Immunizations.** Immunization agents or biological sera;
7. **Immunologicals.** Charges for Immunologicals (vaccines);
8. **Injectables.** A charge for injectables; and
9. **Legend Drugs.**
 - a. Class V Drugs;
 - b. Diabetic Supplies;
 - c. Diagnostics; and
 - d. Pre-natal vitamins.

Limitations

The benefits set forth in this section will be limited to:

1. **Dosages.**
 - a. With respect to the Retail Option, any one prescription is limited to a 30-day supply. Prescriptions through Walgreens are for 30-90 day supplies; and
 - b. With respect to the Mail Order Option, any one prescription is limited to a 90-day supply; and
2. **Refills.**
 - a. Refills only up to the number of times specified by a Physician; and
 - b. Refills up to one year from the date of order by a Physician.

Exclusions

In addition to the General Exclusions the following are not covered by the Plan:

1. **Abortifacients.**
2. **Adagen;**
3. **Alcohol/Substance Abuse Medications.** Alcohol/Substance Abuse medications unless in a Substance Abuse program;
4. **Alprolix, BeneFix, Rixubis and Ixinity;**
5. **Anorexiant.** Anorexiant (weight-loss Drugs) when associated with the diagnosis of morbid

- obesity;
6. **Austedo**;
 7. **Blood and Blood Plasma.** Charges for Blood and Blood Plasma, except as covered under medical;
 8. **Cerdelga**;
 9. **Contraceptives.** Charges for contraceptives and contraceptive devices;
 10. **Cosmetic Agents.** Cosmetic agents for wrinkles, frown lines, and depigmentation;
 11. **Drug Efficacy Study Implementation (DESI) Drugs.** Charges for DESI Drugs;
 12. **Diacomit**;
 13. **Egrifta**;
 14. **Elaprase**;
 15. **Excluded Items.** Any charge excluded under “General Limitations and Exclusions,” or “Summary of Benefits”;
 16. **Exondys**;
 17. **Experimental Drugs.** Experimental Drugs and medicines, even though a charge is made to the Participant;
 18. **Fertility Agents.** Charges for fertility agents;
 19. **Firdapse**;
 20. **Galaford**;
 21. **Growth Hormones.** Charges for growth hormones. Pre-authorization is required;
 22. **Hep C – Sovaldi**;
 23. **Hep C Mavyret**;
 24. **Hep C Epclusa**;
 25. **Impotency.** A charge for impotency medication, including Viagra™;
 26. **Ingrezza**;
 27. **Institutional Medication.** A Drug or medicine that is to be taken by a Participant, in whole or in part, while confined in an Institution, including any Institution that has a facility for dispensing Drugs and medicines on its premises;
 28. **Investigational Use Drugs.** A Drug or medicine labeled “Caution – limited by Federal law to investigational use;”
 29. **Juxtapid**;

30. **Korlym**;
31. **Legend Drugs.**
 - a. Legend Drugs with over-the-counter equivalents; and
 - b. Vitamins, except to the extent required by the Affordable Care Act;
22. **Luxturna**;
23. **Medical Devices and Supplies.** Charges for legend and over-the-counter medical devices and supplies;
24. **No Charge.** A charge for Drugs which may be properly received without charge under local, State or Federal programs;
25. **Non-Insulin Syringes/Needles.** Charges for non-insulin syringes and needles;
26. **Non-Prescription Drug or Medicine.** A Drug or medicine that can legally be bought without a prescription, except for injectable insulin;
27. **Northera**;
28. **Occupational.** Prescriptions necessitated due to an occupational activity or event occurring as a result of an activity for wage or profit;
29. **Over-the-Counter Drugs.** Charges for over-the-counter Drugs;
 - a. Class V Drugs;
 - b. Diabetic Supplies;
 - c. Diagnostics;
 - d. Medical Devices and Supplies;
 - e. Pre-natal vitamins; and
 - f. Vitamins, except to the extent required by the Affordable Care Act;
30. **Oxervate**;
31. **Rogaine.** Charges for Rogaine (topical minoxidil);
32. **Smoking Deterrents.** A charge for Drugs or aids for smoking cessation, including, but not limited to, nicotine gum and smoking cessation patches;
33. **Spinraza, Zolgensma & Vyndaqel**;
34. **Steroids.** Anabolic steroids;
35. **Tegsedi**;
36. **Xyrem**; and
37. **Vitamins.** Vitamins, except pre-natal vitamins.

Excluded Medications: These are medications that are excluded and/or considered non-formulary which may include, but are not limited to, the classification as specialty medications. Excluded/non-formulary medications include medications that may be considered part of a “program or therapy” and are excluded from coverage consideration or classification as part of the prescription drug formulary. Please contact IPM

at 877-846-3397 to determine if a medication is covered.

New to Market Medications: IPM applies a 12-month exclusivity period for new medications approved by the FDA. New medications released by the FDA will be subject to an exclusion period for formal review. Exceptions to this exclusion period may be made on a case-by-case basis after committee review. For questions about new medications to market, please contact IPM at 877-846-3397.

Walgreens Specialty Pharmacy: The Plan utilizes Walgreens Specialty Pharmacy as the primary pharmacy for specialty medication fills. Specialty medications require prior authorizations and IPM and Walgreens Specialty Pharmacy will apply coverage determination as appropriate. If a Participant is prescribed a specialty medication, his or her Provider may electronically send the prescription to Walgreens Specialty Pharmacy or call 888-782-8443 to begin the prior authorization process. Questions about the specialty prescription process may be directed to IPM at 877-846-3397.

GENERAL AND MEDICAL LIMITATIONS AND EXCLUSIONS

This section applies to all benefits provided under any section of this Plan. This Plan does not cover any charge for care, supplies, treatment, and/or services:

Abortion. Expenses Incurred directly or indirectly whether Medically Necessary or elective are not covered;

Administrative Costs. That are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation;

After the Termination Date. That are Incurred by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation;

Alcohol. Involving a Participant who has taken part in any activity made illegal either due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Plan Participants other than the person partaking in an activity made illegal due to the use of alcohol, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

Biofeedback. Biofeedback;

Broken Appointments. That are charged solely due to the Participant's having failed to honor an appointment;

Cochlear Implants. That are for cochlear implants and/or exams for their fitting;

Confined Persons. That are for services, supplies, and/or treatment of any Participant that were Incurred while confined and/or arising from confinement in a prison, jail or other penal Institution with said confinement exceeding 24 consecutive hours;

Cosmetic Surgery. That Incurred in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Illness; (c) because of congenital Disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9);

Custodial Care. That do not restore health or are provided mainly as a rest cure or for maintenance care, unless specifically mentioned otherwise;

Deductible Applicable. That are not payable due to the application of any specified Deductible provisions contained herein;

Education or Training Program. Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;

Error. That are required to treat injuries that are sustained or an Illness that is contracted, including infections and complications, while the Plan Participant was under, and due to, the care of a Provider wherein such illness, Injury, infection or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense;

Excess. That are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Maximum Allowable Charge, based upon the Plan Administrator's determination as set forth by and within the terms of this document;

Experimental. That are Experimental or Investigational;

Eye Refractions. Eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Disease or Injury);

Government. That are expenses to the extent paid, or which the Participant is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government;

Government-Operated Facilities. That are:

1. Services furnished to the Covered Person in any veterans Hospital, military Hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments.
2. Services or supplies which can be paid for by any government agency, even if the patient waives his rights to those services or supplies.

NOTE: *This Exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government Hospital to Dependents of active duty armed service personnel or armed service retirees and their Dependents. This Exclusion does not apply where otherwise prohibited by law;*

Hypnosis. Expenses related to the use of hypnosis;

Illegal Acts. Arising from or caused during the commission of any illegal act for which the participant could be incarcerated for any period of time. It is not necessary for an arrest to occur, charges to be filed, incarceration to occur, or a conviction to be had for this Exclusion to apply. The Plan Administrator has discretionary authority to determine whether an illegal act has occurred. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

Illegal Drugs or Medications. That are services, supplies, care or treatment to a Participant for Injury or Sickness Incurred while the Participant was voluntarily taking or being under the influence of any controlled substance, Drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Participants other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

Immediate Family Member. That are rendered by a member of the immediate Family Unit or person residing in the same household;

Impregnation and Infertility Treatment. Following charges related to Impregnation and Infertility Treatment: artificial insemination, diagnostic infertility testing; fertility Drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency Drugs such as Viagra™, in-vitro fertilization, surrogate mother (unless the surrogate The Roman Catholic Bishop of Stockton

is a Participant, in which case the Preventive Care and/or Pregnancy expenses will be covered in accordance with the Plan provisions), donor eggs;

Incurred by Other Persons. For expenses actually incurred by other persons;

Medical Necessity. That are not Medically Necessary;

Military Service. That are related to conditions which are determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law;

Negligence. For Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician;

Nicotine Addiction. Nicotine withdrawal programs, facilities, Drugs or supplies, except as specified under Preventive Care;

No Legal Obligation. That are provided to a Participant for which the Provider of a service customarily makes no direct charge, or for which the Participant is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the Participant or this benefit plan, may be liable for necessitating the fees, care, supplies, or services;

Non-Prescription Drugs. For drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription Drug must be covered under Preventive Care, subject to the Patient Protection and Affordable Care Act;

Not Acceptable. That are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA);

Not Actually Rendered. That are not actually rendered;

Not Specifically Covered. That are not specifically covered under this Plan;

Nutritional Supplements. Charges for nutritional supplements, except as specified under Preventive Care;

Occupational. Charges related to any Injury or Disease arising out of, or in the course of, any employment for salary, wage or profit, if such Injury or Disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if the Plan Administrator provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by the Plan Administrator for the treatment of such Injury or Disease;

Organ Transplants. Expenses related to donation of a human organ or tissue, except as specifically provided;

Orthopedic Shoes. Orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet;

Other than Attending Physician. Other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Disease, and performed by an appropriate Provider;

Personal Convenience Items. Equipment that does not meet the definition of Durable Medical Equipment, including air conditioners, humidifiers and exercise equipment, whether or not recommended by a The Roman Catholic Bishop of Stockton

Physician;

Postage, Shipping, Handling Charges, Etc. Any postage, shipping or handling charges which may occur in the transmittal of information to the Third Party Administrator; including interest or financing charges.

Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein;

Professional (and Semi-Professional) Athletics (Injury/Illness). That are in connection with any Injury or Illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice;

Prohibited by Law. To the extent that payment under this Plan is prohibited by law;

Provider Error. Required as a result of unreasonable provider error;

Radial Keratotomy. Radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses;

Routine Patient Costs for Participation in an Approved Clinical Trial. For costs for participation in an Approved Clinical Trial. The following items are excluded from approved clinical trial coverage under this Plan:

1. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
4. A cost associated with managing an Approved Clinical Trial.
5. The cost of a health care service that is specifically excluded by the Plan.
6. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

If one or more participating Providers do participate in the Approved Clinical Trial, the qualified plan Participant must participate in the Approved Clinical Trial through a participating, Network Provider, if the Provider will accept the Participant into the trial.

The Plan does not cover routine patient care services that are provided outside of this Plan's health care Provider Network unless Non-Network benefits are otherwise provided under this Plan.

Routine Physical Examinations. Routine or periodic physical examinations, related x-ray and laboratory expenses, and nutritional supplements, except as provided in the Summary of Benefits;

Self-inflicted. That are the result of intentionally self-inflicted Injuries or Illnesses. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

Sex Assignment/Reassignment. Related to a sex assignment or sex reassignment operation;

Sexual Dysfunction. Therapy or Surgery. For sexual dysfunctions or inadequacies that do not have psychological or organic basis;

Subrogation, Reimbursement, and/or Third Party Responsibility. Of an Injury or Sickness not payable

by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions;

Travel. That are for travel, whether or not recommended by a Physician, except as specifically provided herein;

Unreasonable. That are not reasonable in nature or in charge (see definition of Maximum Allowable Charge), or are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es);

Vitamins. Vitamins, except as specified under Preventive Care; and

War. That are Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression, when the Participant is a member of the armed forces of any Country, or during service by a Participant in the armed forces of any Country. This Exclusion does not apply to any Participant who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

With respect to any Illness or Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Illness or Injury if the Illness or Injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

CLAIMS PROCEDURES

The procedures outlined below must be followed by Participants to obtain payment of health benefits under this Plan.

Health Claims

All claims and questions regarding health claims should be directed to the Third Party Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Participant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Participant has not incurred a Covered Expense or that the benefit is not covered under the Plan, or if the Participant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and Exclusions.** Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Claimant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Internal Adverse Benefit Determination. If the Claimant receives notice of a Final Internal Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Claimant then has the right to request an independent external review. The external review procedures are described below.

A Participant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Internal Adverse Benefit Determination. If the Participant receives notice of a Final Internal Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Participant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Participant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. Pre-service Claims. A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. However, if the Plan does not require the Participant to obtain approval of

a medical service prior to getting treatment, then there is no “Pre-service Claim.” The Participant simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

A “Pre-service Urgent Care Claim” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant’s ability to regain maximum function, or, in the opinion of a physician with knowledge of the Participant’s medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

The Plan does not require the Participant to obtain approval of any urgent care or Emergency medical services or admissions prior to getting treatment for an urgent care or Emergency situation, so there are no “Pre-service Urgent Care Claims” under the Plan. The Participant simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Pre-admission certification of a non-emergency Hospital admission is a “claim” only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Participant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. A “Concurrent Claim” arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:
 - a. The Plan determines that the course of treatment should be reduced or terminated; or
 - b. The Participant requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Participant simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

3. Post-service Claims. A “Post-service Claim” is a claim for a benefit under the Plan after the services have been rendered.

When Claims Must Be Filed

Claims (which must be Clean Claims) must be filed with the Third Party Administrator within 12 months of the date charges for the service(s) were incurred. Claims filed later than that date shall be denied. Benefits are based upon the Plan’s provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided.

A Pre-service claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is received by the Third Party Administrator in accordance with the Plan’s procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Third Party Administrator, together with the industry standard claim form:

1. The date of service;

2. The name, address, telephone number and tax identification number of the Provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. Any applicable pre-negotiated rate;
6. The name of the Plan;
7. The name of the covered Employee; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan.

The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the Participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

Upon receiving a Clean Claim, the Plan Administrator shall notify the Participant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims:

- a. If the Claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
- b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
- c. The Claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:
 - The Plan's receipt of the specified information.
 - The end of the period afforded the Claimant to provide the information.
- d. If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Claimant may request an expedited review under the external review process.

2. Pre-service Non-urgent Care Claims.

- a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- b. If the Participant or a Provider has not provided all of the information needed to process the claim (a Clean Claim has not been submitted), then the Participant will be notified as to what specific information is needed as soon as possible. The Participant will be notified of a determination of benefits within a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).

3. Concurrent Claims:

- a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments, the Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
 - b. Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Participant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.
 - c. Request by Participant Involving Non-urgent Care. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).
 - d. Request by Claimant Involving Rescission. With respect to rescissions, the following timetable applies:
 - Notification to Claimant 30 days
 - Notification of Adverse Benefit Determination on appeal 30 days
4. Post-service Claims:
- a. If the Participant has provided a Clean Claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
 - b. If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.
5. Extensions:
- a. Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
 - b. Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
 - c. Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Plan Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A reference to the specific portion(s) of the Plan Document upon which a denial is based;
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;
5. A description of the Plan's review procedures and the time limits applicable to the procedures;
6. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;
7. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Participant, free of charge, upon request);
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided to the Participant, free of charge, upon request.
10. In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Participants one hundred and eighty (180) days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 180 day timeframe;
2. Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. The opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
5. For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was

- submitted or considered in the prior benefit determination;
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
 7. Upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
 8. If applicable, a discussion of the basis for disagreeing with the disability determination made by either (a) the Social Security Administration; or (b) an independent medical expert that has conducted a full medical review of the Claimant if presented by the Claimant in support of the claim.
 9. That a Claimant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Claimant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.
 10. That a Claimant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

Requirements for Appeal

The Participant must file an appeal of a post-service claim in writing within 180 days following receipt of the notice of an adverse benefit determination.

For pre-service urgent care claims, if the Plan Participant chooses to initiate an appeal orally, the Plan Participant may telephone:

Anthem Blue Cross
Phone: 800-274-7767

Oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, the Participant's appeal must be addressed as follows:

1. For Pre-service Claims:

Participants should refer to their identification card for the name and address of the utilization review administrator. All pre-service claims must be sent to the utilization review administrator. Oral appeals should be submitted in writing as soon as possible after it has been initiated.

2. For Post-service Claims. To file any appeal in writing, the Claimant's appeal must be addressed as follows:

Delta Health Systems
P.O. Box 1931
Stockton, CA 95201
Phone: 1-800-422-6099

It shall be the responsibility of the Participant or authorized representative to submit an appeal under the provisions of the Plan. Any appeal must include:

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1. The name of the Employee/Participant;
2. The Employee/Participant's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Participant with notification, with respect to Pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit determination on review, setting forth:

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. The specific reason or reasons for the denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;
3. Reference to the specific portion(s) of the summary plan description on which the denial is based;
4. Upon request, the identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
5. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;
6. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Participant upon request. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request;

7. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
8. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
9. A description of the Plan's review procedures and the time limits applicable to the procedures;
10. If the Adverse Benefit Determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided free of charge upon request;
11. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Participants with the internal claims and appeals and external review processes;
and
12. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review

The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

Deemed Exhaustion of Internal Claims Procedures and De Minimis

Exception to the Deemed Exhaustion Rule

A Claimant will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Claimant may proceed immediately to the external review program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Claimant must adhere to them before participating in the external review program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Claimant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant, and the violation is not reflective of a pattern or practice of non-compliance.

If a Claimant believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Claimant may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the external reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Claimant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations, applies only to:

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1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer.
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is an external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

1. Request for external review. The Plan will allow a Claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
 - a. The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided.
 - b. The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination).
 - c. The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the final regulations.
 - d. The Claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.
3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Third Party Administrator to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.
4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide

coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a Claimant to make a request for an expedited external review with the Plan at the time the Claimant receives:
 - a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of a standard internal appeal under the final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal.
 - b. A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.
2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the Claimant of its eligibility determination.
3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.
4. Notice of final external review decision. The Plan's (or Third Party Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and the Plan.

Appointment of Authorized Representative

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

Autopsy

The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, The Roman Catholic Bishop of Stockton
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Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits

All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

Assignments

For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Participant of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Copayments and Coinsurance amounts, to a medical Provider. If a Provider accepts said arrangement, the Provider's rights to receive Plan benefits are equal to those of the Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Copayments, and Coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Participant of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Participant, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. A medical Provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

Non U.S. Providers

Medical expenses for care, supplies, or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a "Non U.S. Provider") are payable under the Plan, subject to all Plan Exclusions, limitations, maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non U.S. Provider;
2. The Participant is responsible for making all payments to Non U.S. Providers, and submitting receipts to the Plan for reimbursement;
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;
4. The Non U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
5. Claims for benefits must be submitted to the Plan in English.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or Exclusions, or should otherwise not have been paid by the Plan. As such, this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover

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the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or Dependent on whose behalf such payment was made.

A Plan Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within 2 years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his Covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the plan participant for any outstanding amount(s).

Medicaid Coverage

A Participant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Participant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Participant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

Limitation of Action

A Claimant cannot bring any legal action against the Plan for a claim of benefits until 90 days after all appeal processes have been exhausted. After 90 days, if the Claimant wants to bring a legal action against the Plan, he or she must do so within 2 years of the date he or she is notified of the final decision on the final appeal or he or she will lose any rights to bring such an action against the Plan.

COORDINATION OF BENEFITS

Benefits Subject to This Provision

This provision shall apply to all benefits provided under any section of this Plan.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

1. Any primary payer besides the Plan;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. worker's compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies and will exclude benefits subject to the Exclusions in this Plan up to the maximum amount available to the Participant under applicable state law, regardless of a Participant's election of lesser coverage amount. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their names, titles or classifications.

Allowable Expenses

"Allowable Expenses" shall mean the Maximum Allowable Charge for any Medically Necessary and eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations Section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

"Claim Determination Period"

"Claim Determination Period" shall mean each Plan Year.

Effect on Benefits:

Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered secondary regardless of the individual's election under personal injury protection (PIP) coverage with the automobile

insurance carrier regarding priority of payment.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan;
2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;
3. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
 - a. When the parents are separated or are divorced, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or
 - b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a dependent child; and

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.
5. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any Other Plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the

extent of such payments, this Plan shall be fully discharged from liability.

Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents. Please see the Recovery of Payments provision above for more details.

MEDICARE

Applicable to Active Employees and Their Spouses Ages 65 and Over

An Active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the section entitled "Coordination of Benefits"). If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare-approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Plan Participants Who Are Covered Under This Plan

If any Participant is enrolled in Medicare coverage because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of the Participant's Medicare entitlement, regardless of the date of enrollment, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

SUBROGATION, REIMBURSEMENT AND THIRD PARTY RECOVERY

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed. The Roman Catholic Bishop of Stockton

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) ("Incurred") prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.

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

Separation of Funds

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

Wrongful Death

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
9. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct

the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

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

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

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability

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

MISCELLANEOUS PROVISIONS

Clerical Error/Delay

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

Conformity With Applicable Laws

This Plan shall be deemed to automatically be amended to conform as required by any applicable law, equitable principle, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, Exclusions, or statutes of limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

Fraud

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire Family Unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30 day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

Headings

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

Pronouns

Unless the context otherwise demands, words importing any gender shall be interpreted to mean any or all genders.

Word Usage

Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

No Waiver or Estoppel

The Roman Catholic Bishop of Stockton
Comprehensive Preferred Medical and Prescription Drug Benefit Plan
Plan Document and Summary Plan Description

No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver of or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan. The amount of the Participant's contribution will be determined from time to time by the Plan Administrator.

Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Participant for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Written Notice

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents. See the Recovery of Payments provision for full details.

Statements

All statements made by the Diocese or by a Plan Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Plan Participant.

Any Plan Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Plan Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Protection Against Creditors

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the Third Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be retained by this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Third Party Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan, pursuant to any applicable State laws(s).

PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services. The claims processing and other technical services delegated to the Third Party Administrator notwithstanding, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

Plan Administrator

The Plan is administered by the Plan Administrator, and in accordance with these provisions. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

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

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a Third Party Administrator to pay claims;
9. To establish and communicate procedures to determine whether a Medical Child Support Order

- is a QMCSO;
10. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
 11. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust Agreement (if any). This includes amending the benefits under the Plan.

Any amendment to the Plan that is not made effective at the beginning of a normal Plan Year by integration into a full Plan Document restatement, including suspension and/or termination, shall follow the amendment procedure outlined in this section. The amendment procedure is accomplished by a separate, written amendment decided upon and/or enacted by resolution of the Plan Sponsor's directors or officers (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law.

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor. As it relates to distribution of assets upon termination of the Plan, any contributions paid by Participants will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the Employer.

Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of 31 days from the date written notice is given.

CONTINUATION OF COVERAGE

Employer Continuation Coverage

Eligible Participants may seek to continue coverage upon the occurrence of any of the following:

1. Total Disability Leave: Coverage will continue for 12 months following termination of Active Employment; or
2. Leave for Medical and Family Care Purposes (see "Leave for Medical and Family Care Purposes (LMFCP)" section below); or
3. COVID-19 Leave or Furlough: Coverage will continue for Employees and/or their covered Dependents on leave or furlough due to COVID-19, through December 31, 2020. **NOTE:** *Employees that are laid off are terminated from this Plan.*

The above noted leave(s) run concurrently with USERRA or any State-mandated family or medical leave, and/or any other applicable leaves of absence, as applicable and subject to applicable law. At the end of the period(s) listed above, the Participant's coverage will be deemed to have terminated for purposes of Continuation Coverage.

Leave For Medical and Family Care Purposes (LMFCP)

Leave for Medical and Family Care Purposes ("LMFCP") is a Leave of Absence, taken without salary or wages for a serious health condition that makes the Employee unable to perform his or her job; for the birth of a Child; care of a mentally or physically impaired Child over 18; the placement of a Child with the Employee for adoption or foster care; or to care for a parent, Child or spouse who has a serious health condition. A serious health condition is an illness, injury, impairment or physical or mental condition that involves inpatient care in a hospital or continuing treatment by a health care Provider.

Eligibility. At any time it regularly employs fifty (50) or more persons, Employer will provide regular full-time and regular part-time Employees who have been employed by the Employer for at least twelve (12) months, has worked at least 1,250 hours for Employer during the twelve (12) month period immediately preceding the leave; and works at a location where the Employer has at least fifty (50) Employees within seventy-five (75) miles with leave for LMFCP. Eligibility for leave for family care purposes for the birth of a Child, adoption or placement of a foster child expires twelve (12) months from the birth, adoption or placement date.

Maximum Length of Leave. The maximum length of LMFCP is twelve (12) weeks of leave within any twelve (12) month period.

Leave for family care purposes shall be no more than twelve (12) weeks when taken in conjunction with four months leave due to pregnancy disability. After an Employee completes a leave due to pregnancy disability, an Employee may request leave for family care purposes to stay home and care for the Child. The Employee may take a maximum of three (3) months LMFCP in addition to the four (4) months leave due to pregnancy disability already taken. Pregnancy disability leave must be certified by a Physician's note.

Spouses who are both employed by the Employer are limited to a total of twelve (12) weeks leave for family care purposes for the birth, adoption or foster care of a Child, or to care for a seriously ill parent.

Intermittent or reduced leave is permitted if medically necessary for serious health condition of parent, Child, spouse, or Employee as certified by a Physician. Only the amount of time the Employee takes off can be counted as leave for family care purposes. An Employee on a reduced leave may be transferred temporarily to a different job, with equivalent pay and benefits, that would better accommodate recurring periods of leave.

The length of the leave must be determined and certified in writing by a Physician and is not to exceed twelve (12) weeks. The Employee is required to inform his or her supervisor of the status of the leave and any changes in the expected date of return. Supervisors should notify the Human Resources Department of any changes in the Employee's return date. Employees not returning to work on the date in the Physician's

release may be considered to have voluntarily resigned unless other arrangements have previously been made.

Procedure to Request Leave. Employees requesting LMFCP should provide a written request for approval to the Employee's supervisor at least thirty (30) days in advance of foreseeable leave (i.e., birth of Child, adoption), or with as much advance notice as is practicable.

For leave to care for an ill parent, spouse, Child or self, Employer requests that a written request for approval of LMFCP include a written statement from the Physician certifying: (1) the date on which the serious health condition commenced; (2) the duration of condition; (3) appropriate medical facts; (4) that the Employee is needed to care for the seriously ill individual; or that the Employee is unable to perform the functions of the position; and (5) an estimate of amount of time Employee is needed to care for the family member.

Benefits. When on an authorized LMFCP, medical, dental, life, long-term disability, and pension premiums will be paid for by the Employer to the extent described in this section.

LMFCP is an unpaid leave except to the extent that other sources of pay are available. Examples of such pay could include accrued and unused sick, vacation, or personal leave, State Disability Insurance, or Workers' compensation. Leaves for the birth, adoption, or foster care placement of a Child must be concluded within one year of the birth, adoption, or placement. Employees are required to use all but one week of available vacation and all personal leave for all LMFCP. Employees are required to use available sick leave for leave for medical purposes because of their own serious health condition and may elect to use available sick leave for other types of leaves for medical and family care purposes.

Employees on LMFCP accrue benefits such as sick leave and vacation only when paid leave is being substituted for unpaid leave and only if the Employee would otherwise be entitled to such accrual. Employees on an unpaid Leave of Absence will not receive holiday pay. Employees on an authorized LMFCP will not be treated differently than other Employees if decisions are made at the Employer to reorganize, reassign, or lay off positions during the time the Employee is on LMFCP. Employers must be very careful about making decisions affecting the terms and conditions of employment for Employees on an authorized Leave of Absence.

Reemployment. Employees on LMFCP for twelve (12) weeks are assured of reinstatement to their former positions or to jobs of like status and pay upon return to work. Employees absent more than twelve (12) weeks cannot be assured of return to their positions or similar jobs and may be terminated.

The maximum time normally granted for LMFP is twelve (12) weeks. Under exceptional circumstances, Employer may approve written requests for medical leave extension. The feasibility of continuing employment is based on Employer needs and budget constraints.

Continuation During USERRA

Participants who are absent from employment because they are in the Uniformed Services, and who are on active military duty, must be offered the right to continue health care benefits. If the military leave orders are for a period of 30 days or less, Participants cannot be required to pay more than the normal Participant contribution amount. After this period, Participants may elect to continue their coverage under this Plan for up to 24 months and Participants cannot be required to pay more than 102 percent of the full contribution amount during that time.

To continue coverage, Participants must comply with the terms of the Plan, including election during the Plan's annual enrollment period, and pay their contributions. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her Dependents' coverage be reinstated immediately upon his or her return to The Roman Catholic Bishop of Stockton

employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their participating Employer for information concerning their eligibility for USERRA and any requirements of the Plan.

Continuation Coverage

“Continuation Coverage” is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a “Qualifying Event.” Life insurance, accidental death and dismemberment benefits and weekly income or long term disability benefits (if a part of the Employer’s plan) are not considered for continuation.

Qualifying Events

A qualifying event is any of those listed below if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of continuation of coverage. After a Qualifying Event, Continuation Coverage must be offered to each person who is a “Qualified Participant.” The Employee, the Employee’s spouse, and the Employee’s Dependent Children could become Qualified Participants if coverage under the Plan is lost because of the Qualifying Event.

A covered Employee (meaning an Employee covered under the Plan) will become a Qualified Participant if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced; or
2. The employment ends for any reason other than gross misconduct.

The spouse of a covered Employee will become a Qualified Participant if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The spouse dies;
2. The spouse’s hours of employment are reduced;
3. The spouse’s employment ends for any reason other than his or her gross misconduct;
4. The spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. The spouse becomes divorced or legally separated from his or her spouse.

Dependent Children will become Qualified Participants if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies;
2. The parent-covered Employee’s hours of employment are reduced;
3. The parent-covered Employee’s employment ends for any reason other than his or her gross misconduct;
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The Child stops being eligible for coverage under the Plan as a Dependent Child.

If a proceeding in bankruptcy is filed with respect to **The Roman Catholic Bishop of Stockton** and that bankruptcy results in the loss of coverage of any retired Employee, spouse, surviving spouse, and Dependent Children covered under the Plan, such member will become a Qualified Participant with respect to the bankruptcy.

Employer Notice of Qualifying Events

When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the covered Employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Continuation Coverage Administrator of the Qualifying

Event.

Employee Notice of Qualifying Events

Each covered Employee or Qualified Participant is responsible for providing the Continuation Coverage Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee (or former Employee) from his or her spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Participant has become entitled to Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Participant entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of Continuation Coverage; and
5. Notice that a Qualified Participant, with respect to whom a notice described above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The Continuation Coverage Administrator is:

BASICpacific
3001 Lava Ridge Ct #160
Roseville, CA 95661
Phone: 800-574-5448
Website: www.basiconline.com

A form of notice is available, free of charge, from the Continuation Coverage Administrator and must be used when providing the notice.

Deadline for providing the notice

For Qualifying Events described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;
2. The date on which the Qualified Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
3. The date on which the Qualified Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Continuation Coverage Administrator.

For the disability determination described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA;
2. The date on which a Qualifying Event occurs;
3. The date on which the Qualified Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Continuation Coverage Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Participant is no longer disabled;
or
2. The date on which the Qualified Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Continuation Coverage Administrator.

The notice must be postmarked (if mailed), or received by the Continuation Coverage Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend Continuation Coverage is lost, and if the person is electing Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending Continuation Coverage, such Coverage will end on the last day of the initial 18 month coverage period.

Who Can Provide the Notice

Any individual who is the covered Employee (or former Employee), a Qualified Participant with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Participant, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Participants with respect to the Qualifying Event.

Required Contents of the Notice

The notice must contain the following information:

1. Name and address of the covered Employee or former Employee;
2. Identification of the initial Qualifying Event and its date of occurrence, if the person is already receiving Continuation Coverage and wishes to extend the maximum coverage period;
3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Participant or loss of disability status);
4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of spouse and Dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of spouse and Dependent child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age);
7. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Participant, name and address of the disabled Qualified Participant, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Participant who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or legal separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit

the copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or legal separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the Continuation Coverage Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Continuation Coverage Administrator in the request, the Continuation Coverage Administrator may reject the notice if it does not contain enough information for the Continuation Coverage Administrator to identify the plan, the covered Employee (or former Employee), the Qualified Participants, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing Continuation Coverage

Complete instructions on how to elect Continuation Coverage will be provided by the Continuation Coverage Administrator within 14 days of receiving the notice of the Qualifying Event. The individual then has 60 days in which to elect Continuation Coverage. The 60 day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If Continuation Coverage is not elected in that 60 day period, then the right to elect it ceases.

Each Qualified Participant will have an independent right to elect Continuation Coverage. Covered Employees may elect Continuation Coverage on behalf of their spouses, and parents may elect Continuation Coverage on behalf of their Children.

In the event that the Continuation Coverage Administrator determines that the individual is not entitled to Continuation Coverage, the Continuation Coverage Administrator will provide to the individual an explanation as to why he or she is not entitled to Continuation Coverage.

Duration of Continuation Coverage

Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under Continuation Coverage will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, Continuation Coverage for Qualified Participants other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, Continuation Coverage for his or her spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, Continuation Coverage generally lasts for only up to a total of 18 months. There are 2 ways in which this 18 month period of Continuation Coverage can be extended.

Disability Extension of Continuation Coverage

If an Employee or anyone in an Employee's family covered under the Plan is determined by the SSA to be disabled and the Employee notifies the Continuation Coverage Administrator as set forth above, the Employee and his or her entire family may be entitled to receive up to an additional 11 months of The Roman Catholic Bishop of Stockton

Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of Continuation Coverage and must last at least until the end of the 18 month period of Continuation Coverage. An extra fee will be charged for this extended Continuation Coverage.

Second Qualifying Event Extension of Continuation Coverage

If an Employee's family experiences another Qualifying Event while receiving 18 months of Continuation Coverage, the spouse and Dependent Children in the family can get up to 18 additional months of Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any Dependent Children receiving Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

Shorter Duration of Continuation Coverage

Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date the Employer ceases to provide a group health plan to any Employee;
2. The date on which coverage ceases by reason of the Qualified Participant's failure to make timely payment of any required contributions or premium;
3. The date that the Qualified Participant first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first); or
4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Participant is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Contribution and/or Premium Requirements

Once Continuation Coverage is elected, the individual must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, Continuation Coverage will be canceled and will not be reinstated.

Additional Information

Additional information about the Plan and Continuation Coverage is available from the Continuation Coverage Administrator, who is:

BASICpacific
Continuation Coverage Administrator
3001 Lava Ridge Ct #160
Roseville, CA 95661
Phone: 800-574-5448
Website: www.basiconline.com

Current Addresses

In order to protect the rights of the Employee's family, the Employee should keep the Continuation Coverage Administrator (who is identified above) informed of any changes in the addresses of family members.

HIPAA PRIVACY

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Participant's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Participant's personal health information. It also describes certain rights the Participant has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling 209-466-0636.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Primary Uses and Disclosures of PHI

1. **Treatment, Payment and Health Care Operations:** The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment,

- Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. **Business Associates:** The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information.
 3. **Other Covered Entities:** The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Not use or disclose genetic information for underwriting purposes.
6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
7. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Required Disclosures of PHI

1. **Disclosures to Participants:** The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his or her personal representative, or treating such person as his or her

personal representative could endanger the Participant.

2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Participant's Rights

The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Participant has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Officer.
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.
6. Amendment: The Participant has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant

with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer Contact Information:
The Roman Catholic Bishop of Stockton
Attn: Cathy Lagomarsino
212 N San Joaquin Street Stockton, CA 95202
Phone: 209-466-0636
Fax: 209-463-5937

HIPAA SECURITY

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

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (“SECURITY RULE”)

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI)**, as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents**, as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
 - i. Privacy Officer.
 - ii. Director of Employee Benefits.
 - iii. Employee Benefits Department employees.
 - iv. Information Technology Department.
 - b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Resolution of Noncompliance

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.