



# The Roman Catholic Diocese of Shreveport

*Your Employee Benefits*



**Provided by:**  
**Christian Brothers Employee Benefit Trust**  
1205 Windham Parkway  
Romeoville, IL 60446-1679  
(800) 807-0400

**SUMMARY OF LIFE BENEFITS  
FOR EMPLOYEES ONLY**

**BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)  
INSURANCE**

**BASIC LIFE**

**INSURANCE\*** . . . . . The amount (not to exceed \$50,000) which is the equivalent of your Annual Compensation multiplied by one and one-half and this result taken to the next higher \$1,000, if not already an exact multiple thereof.

**AD&D PRINCIPAL SUM\*** . . . . . An amount equivalent to your Basic Life Insurance.

\*Your Basic Life and Accidental Death & Dismemberment Insurance will be reduced to a percentage of the amount of insurance benefit shown above, according to your attained age, as shown in the following schedule:

<u>Your Attained Age</u>	<u>% of Benefit</u>
Age 65 but less than 70 . . . . .	67%
Age 70 but less than 75 . . . . .	43%
Age 75 and older . . . . .	33%

Changes in the amount resulting from a change in age are effective on the date of such change in age.

**Annual Compensation** means, on any date, your annual wage then in force as established by your Participating Member (Employer). Annual wage does not include commissions, bonus, or overtime pay.

Changes in the amount of your coverage as the result of a change in your compensation are effective on the date of such change, provided you are then Actively at Work, otherwise on the date you return to Active Work.

Changes in the amount resulting from a change in age are effective on the date of such change in age.

**BASIC LIFE AND AD&D BENEFITS COVER YOU ON OR OFF THE JOB.**

**LIFE BENEFIT BOOKLET**  
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## **INTRODUCTION**

Your benefit plan has been designed to provide financial help for you when a covered loss occurs. The plan is established through a Group Policy issued by Us, Principal Life Insurance Company for the Planholder, the Trustees of the Christian Brothers Employee Benefit Trust.

As a covered Employee of the plan, your rights and benefits are determined by the provisions of the Group Policy. This booklet briefly described those rights and benefits. It outlines what you must do to be covered. It explains how to file claims.

Future of Plan. It is expected that this plan will be continued indefinitely. However, the Planholder does have the right to change or terminate the plan at any time.

Please Read Your Booklet Carefully. We suggest that you start with a review of the terms listed under Definitions at the back of this section.

## **HOW TO BE COVERED**

### **Life and Accidental Death and Dismemberment Insurance**

## **ELIGIBILITY FOR ENROLLMENT**

### When You are Eligible for Coverage

To be eligible for coverage you must be an Employee.

Employee means any person who is employed by a Participating Member (Employer) and regularly scheduled to work for the Participating Member (Employer) for at least 20 hours a week.

Employee will also include:

- a teacher who is teaching at least ½ of a normal work load, as determined by the institution;  
and
- members of religious order and secular priests.

Employee does not include independent contractors, volunteers, etc., whose income from the Participating Member (Employer) is not subject to Federal Withholding for wages or FICA.

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

### **Effective Date of your Coverage**

Before your coverage will become effective, you must request coverage on an enrollment form provided by your Participating Member (Employer). Complete the form giving all the information requested. Sign the form and return it to your Participating Member (Employer) on a timely basis.

Your coverage will then be in force on the date you are eligible, provided proof of good health is not required.

A change in your Scheduled Benefit amount due to a change in your compensation will be effective on the date of the change, provided proof of good health is not required.

However, if you are not Actively at Work on the date your coverage would be effective or on the date of change in your compensation, your coverage will not be in force until the day you return to Active Work.

## **Proof of Good Health**

You will need to file proof of good health to become insured (initially or through future increases in your compensation) for any Life and Accidental Death and Dismemberment Insurance Scheduled Benefit amount in excess of the amount shown in the Group Policy.

The type and form of required proof will be determined by Us and We will pay the reasonable cost of proof required in this instance. Coverage will not be effective until the date the proof of good health has been approved by Us.

## **Individual Incontestability and Misstatement of Age**

All statements made by any individual covered will be representations and not warranties. These statements may not be used to contest the person's coverage unless:

- the coverage has been in force for less than two years during the covered person's lifetime; and
- the statement is in written form signed by the covered person; and
- a copy of the form which contains the statement is given to the covered person or the covered person's beneficiary at the time coverage is contested.

However, the above will not preclude the assertion at any time of defenses based upon the person's not being eligible for coverage under the group plan or upon other provisions of the group plan.

In addition, if an individual's age is misstated, We may, at any time, adjust premiums and benefits to reflect the correct age.

## **WHEN YOUR COVERAGE TERMINATES**

### **Termination of Coverage**

Your coverage will cease on the earliest of:

- the date the Group Plan terminates; or
- the date you cease to belong to a class for which coverage is provided; or
- the date you cease to be a Employee; or
- the date you cease Active Work; or
- the date your Participating Member (Employer) is no longer a participant in the Trust.

If you cease Active Work because of sickness or injury, your plan might provide for limited continuation.

If you cease Active Work because of layoff or leave of absence, coverage may be continued on a limited basis.

In addition, by paying the required contribution, if any, your coverage may be continued under the continuation provisions described on page six.

If you are interested in continuing your coverage beyond the date it would normally terminate, you should consult with your Participating Member (Employer) before your coverage terminates.

## **CONTINUATION OF COVERAGE**

### **Employee (State Required - Illinois)**

If you cease Active Work because you are Disabled, you may continue your Life Insurance until the earlier of:

- the date nine months after your Disability began; or
- the date the Group Plan terminates. However, if the Disability began prior to attainment of age 60 and while you are insured, you may continue your insurance after termination of the Group Plan until the date nine months after the Disability began.

## **DESCRIPTION OF BENEFITS - LIFE INSURANCE**

### **Death Benefit**

If you die while insured for Life Insurance, We will pay your beneficiary the Scheduled Benefit (as shown in the Summary of Benefits listed at the front of this section) in force on the date of your death less any Accelerated Benefit payment and Accumulated Interest Charges as discussed later in this section. If your beneficiary does not survive you, We will pay your estate, spouse, child(ren), parent(s), or other persons as provided in the Group Policy.

Upon your death, the Scheduled Benefit in force on the date of your death less any Accelerated Benefit payment and Accumulated Interest Charges as discussed later in this section will be placed in an interest-bearing draft account. The account balance will be available to your beneficiary at any time, in total or in part, as provided in the Group Policy.

See your Participating Member (Employer) if you would like more information on the Interest Draft Account or on any of the other settlement options that are available to your beneficiary upon your death.

### **Beneficiary**

You should name a beneficiary at the time you enroll for insurance. You may later change your beneficiary by filing a written request with your Participating Member (Employer). See your Participating Member (Employer) for change request forms. A change in your beneficiary will not be in force until your Participating Member (Employer) records the change.

### **Coverage During Disability**

If you cease Active Work for any reason, your insurance will normally terminate. However, if you cease Active Work because you are Disabled, you might qualify to continue your Life Insurance. This continuation is called Coverage During Disability.

To be qualified for Coverage During Disability, you must:

- become Disabled while insured for Life Insurance; and
- become Disabled before the earlier of retirement or age 70; and
- remain Disabled continuously; and
- send proof of Disability to Us within one year of the date Disability starts and as often thereafter as We may require; and

- submit to examinations by a Physician when We require (We will pay for these examinations and will choose the Physician); and
- return, without claim, any individual policy issued under your purchase rights as described below.

If you qualify, Coverage During Disability will be in force on the earlier of:

- the day nine months after the date your Disability began; or
- the date of your death.

Coverage During Disability will cease on the earlier of the date you are age 70 or at the end of the following time period:

<u>Age at Disablement</u>	<u>Period of Continuation</u>
61 or younger .....	To age 65
62 .....	3 ½ years
63 .....	3 years
64 .....	2 ½ years
65 .....	2 years
66 .....	1 ¾ years
67 .....	1 ½ years
68 .....	1 ¼ years
69 .....	1 year

If you die while Coverage During Disability is in force, We will pay your beneficiary the Life Insurance benefit, if any, that would have been paid had you remained insured under the benefit schedule in force on the date your Disability began.

Note that Coverage During Disability will not be in force and NO BENEFIT WILL BE PAID if written proof of Disability is not sent to Us within ONE YEAR of the date Disability starts.

**Accelerated Benefit**

An Accelerated Benefit is an advance (before death) payment of a part of your Life Insurance benefit. To qualify for an Accelerated Benefit, you must:

- be insured for a Life Insurance benefit of at least \$20,000; and
- be Terminally Ill (expected to die within 12 months); and
- send proof of your Terminal Illness to Us.

Proof of Terminal Illness will consist of a statement from your Physician, and any other medical information that We believe is needed to confirm your status.

If you qualify, We will pay you any amount you request; except that:

- only one Accelerated Benefit payment will be made during your lifetime; and
- you must request a payment of at least \$10,000; and
- We will not pay you more than the lower of (1) 50% of your Life Insurance benefit; or (2) \$100,000.

If an Accelerated Benefit is paid, the Life Insurance benefit otherwise payable to your beneficiary upon your death will be reduced by the sum of:

- the Accelerated Benefit payment; plus
- Accumulated Interest Charges.

Accumulated Interest Charges will be the sum of interest charged for each day of the period from the date of your Accelerated Benefit payment to the date of your death. This interest will:

- be calculated by applying a daily rate (equivalent to 8% per year) to the amount of your Accelerated Benefit payment; and
- be limited to a total of not more than 16% of your Accelerated Benefit payment.

During the two-year period following payment of an Accelerated Benefit:

- termination of Active Work because of your Terminal Illness will not result in termination of your Life Insurance; and
- your Life Insurance will be provided without premium charge.

### **Individual Purchase Rights**

You will have the right to buy an individual life insurance policy without submitting proof of your good health:

- If your total Life Insurance terminates because you end Active Work or cease to be in a class eligible for insurance. In these instances, the maximum amount you may buy will be your Life Insurance amount in force on the date of termination, less any individual amount purchased earlier under these rights, and less any Accelerated Benefit and Accumulated Interest Charges as discussed earlier in this section.

- If the Group Policy terminates or is amended to exclude your insurance class after you have been insured for at least five years. In these instances, the maximum amount you may buy will be the smaller of: (1) \$10,000; or (2) your Life Insurance amount in force on the date of termination, less any amount for which you become eligible under any group policy within 31 days.
- If your Coverage During Disability ceases because Disability ends and you do not then become insured under the Group Policy within 31 days. In this instance, the maximum amount you may buy will be the benefit amount in force on the date Disability ends, less any individual amount purchased earlier under these rights, and less any Accelerated Benefit and Accumulated Interest Charges as discussed earlier in this section.

You must apply and pay the first premium for the individual policy within 31 days after the date your Life Insurance or Coverage During Disability ceases.

See your Participating Member (Employer) for the proper forms. Any individual policy issued will be effective on the 32nd day.

The individual policy will be for life insurance only (other than term insurance). No Disability or other benefits will be included. The premium you pay will be at Our normal rate for your age and for the risk class to which you belong on the individual policy's date of issue.

If you die within the 31-day purchase period, your beneficiary will be paid the life insurance amount, if any, you had the right to buy. This payment will be made whether or not you have applied for an individual policy.

## **DESCRIPTION OF BENEFITS - ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE**

### **Benefit Qualification**

To qualify for benefit payment, all of the following must occur:

- You must be injured while insured for Accidental Death and Dismemberment Insurance.
- Your injury must be caused by accident.
- Your injury must be the direct and sole cause of a loss listed in Benefit Payable below.
- Your loss must occur within 90 days of your injury.
- You must satisfy the requirements listed in the Claim Procedures section.

### **Benefits Payable**

If all of the above qualifications are met, We will pay the following percentages of your Scheduled Benefit (or approved amount, if applicable) in force:

- 50% if one hand is severed at or above the wrist; or
- 50% if one foot is severed at or above the ankle; or
- 50% if the sight of one eye is permanently lost; or
- 100% if more than one of the listed losses occurs; or
- 100% if you lose your life.

However, if loss is due to an accident which occurs while riding as a fare-paying passenger on a public conveyance, including aircraft operated by a scheduled air carrier on a regularly scheduled flight, you or your beneficiary will be paid:

- two times your Scheduled Benefit if you lose your life or if you lose two or more of the following in any combination: loss of sight in one eye; loss of a hand; and/or loss of a foot; or
- your Scheduled Benefit if you lose any one of the following: lost of sight in one eye; loss of a hand; or loss of a foot.

Total payment for all losses that result from the same accident will not exceed 100% of your Scheduled Benefit. Payment for loss of life will be to the beneficiary you named for Life Insurance. Payment for all other losses will be to you.

## **Limitations**

Payment will not be made for any loss to which a contributing cause is:

- willful self-injury or self-destruction, while sane or insane; or
- disease or the treatment of disease; or
- voluntary participation in a riot, assault, felony, or insurrection; or
- participation in flying, ballooning, parachuting, or other aeronautic activity, except as a passenger on a commercial aircraft; or
- duty as a member of a military organization; or
- war or act of war; or
- the use of any drug, narcotic, or hallucinogen not prescribed for you by a licensed Physician.

## **CLAIM PROCEDURES**

### **Claim Forms**

Your Participating Member (Employer) will provide forms to assist you in filing claims.

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

Federal law permits up to 90 days for processing claims and up to 60 days for reviewing denied claims. Both time limits may be extended if unusual factors exist.

In actual practice, most claims will be processed and paid within a few days after We receive completed proof of loss. Further, if a claim cannot be paid, We will promptly explain why.

If you disagree with a claim denial, a review may be requested. In order for Us to review a denied claim, your Participating Member (Employer) must receive a written request from you within 120 days of receipt of notice of the denial. All added facts should be given to your Participating Member (Employer) within one year of receipt of notice of the denial. The Participating Member (Employer) will send this information to Us. We will then conduct the review. You will be advised of the final decision and the reasons.

### **Prompt Filing**

Completed claim forms and other information needed to prove loss should be filed promptly. Proof of loss should be sent to Us within 90 days after the date of loss. Proof of loss sent later will be accepted only if there is reasonable cause for the delay.

### **Medical Examinations**

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

### **Legal Action**

Legal action for a claim may not be started earlier than 60 days after proof of loss is filed. Further, no legal action may be started later than three years after proof is required to be filed.

### **Time Limits**

All time limits listed in this section will be extended to meet any minimums required by law.

## DEFINITIONS

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

**Active Work and Actively at Work** mean the active performance of all of a Employee's normal job duties at the Participating Member's (Employer's) usual place or places of business.

**Disability; Disabled** mean your inability, because of sickness or injury, to work at any job that reasonably fits your background and training.

**Employee** means any person who is employed by a Participating Member (Employer) and regularly scheduled to work for the Participating Employer for at least 20 hours a week.

Employee will also include:

- a teacher who is teaching at least ½ of a normal work load, as determined by the institution; and
- members of religious order and secular priests.

Employee does not include independent contractors, volunteers, etc., whose income from the Participating Member (Employer) is not subject to Federal Withholding for wages or FICA.

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

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

**Physician** means a licensed Doctor of Medicine or Osteopathy.

**Planholder** means the Trustees of the Christian Brothers Employee Benefit Trust and shall include any affiliate or subsidiary of the Planholder participating in this plan.

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

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

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

**Trustee(s)** means the entity elected by the Members (Employers) and is responsible for the administration of the Trust and Plan.

**We, Us, and Our** mean Principal Life Insurance Company, Des Moines, Iowa.

## **PLAN INFORMATION**

### **Plan name:**

The Christian Brothers Employee Benefit Trust, Life and Accidental Death and Dismemberment Insurance insured by Principal Life Insurance Company.

### **Plan sponsor:**

Trustees of Christian Brothers Employee Benefit Trust  
c/o Christian Brothers Services  
1205 Windham Parkway  
Romeoville, IL 60446-1679

### **Plan year:**

January 1st thru December 31st

### **Plan Administrator:**

Christian Brothers Services (appointed by the Trustees)  
1205 Windham Parkway  
Romeoville, IL 60446-1679

EIN No. 36-3884439

For information on conversion of Basic Life Insurance consult the Plan Administrator.

### **Plan costs:**

Basic Life and AD&D are paid by the Member (Employer).

### **Agent for service or legal process:**

Managing Director, Employee Benefit Services,  
the Christian Brothers Employee Benefit Trust  
1205 Windham Parkway  
Romeoville, IL 60446-1679

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

### **Plan benefits provided by:**

Principal Life Insurance Company, Des Moines, Iowa.

**Plan eligibility and benefits:**

See the Summary of Benefits at the front of this section of the booklet for the description of benefits. See the table of contents in this section of the booklet to locate the eligibility requirements.

**How to file a claim:**

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

**Plan Trustees:**

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

## **ILLINOIS NOTICE**

This is to advise you that if you have any complaints about your insurance you may contact the following:

Principal Life Insurance Company  
Attention: Deb West, Counsel  
711 High Street  
Des Moines, Iowa 50392-0220  
Telephone: 1-800-325-2532, Extension 70962

or

Illinois Department of Insurance  
Consumer Division or  
Public Services Section  
320 West Washington Street  
Springfield, Illinois 62767

Please identify all correspondence with the group account number and your full name and address. Please be as specific as possible about the nature of your complaint. Include all relevant information so that prompt action can be taken to resolve your complaint satisfactorily.

## **SUMMARY OF LTD BENEFITS FOR EMPLOYEES ONLY**

### **LONG TERM DISABILITY BENEFITS**

#### **BENEFIT ELIMINATION PERIOD**

“Benefit Elimination Period” means a period of three (3) consecutive months of your Total Disability for which no benefit is payable. The Benefit Elimination Period begins on the first day of Total Disability.

Note: If your Total Disability stops during the Benefit Elimination Period for any 14 days (or less) and immediately resumes, then the Total Disability will be treated as continuous. Only days you are Totally Disabled can be applied toward the Benefit Elimination Period.

#### **BENEFIT PERIOD**

The Benefit Period begins after the satisfaction of the Benefit Elimination Period and is subject to the Claim Procedures section (pages 10 & 11).

#### **MAXIMUM BENEFIT PERIOD**

The Maximum Benefit Period is to age 65 or the date you recover, whichever is sooner. The Benefit Period may continue beyond age 65 for a limited period for a Total Disability occurring on or after age 62 (as described on page 5).

#### **BASIC MONTHLY COMPENSATION**

Basic Monthly Compensation is your basic monthly wage in effect immediately prior to the date Total Disability begins, as established by your Member (Employer). Basic wage does not include commissions, bonus or overtime pay. The maximum Basic Monthly Compensation considered is \$8,333.

#### **BENEFITS PAYABLE - MONTHLY BENEFIT**

60% of your Basic Monthly Compensation to a maximum monthly benefit of \$5,000. Benefits may increase to 70% of your Basic Monthly Compensation when combined with Other Income Benefits. Monthly Benefits are paid at the end of the month. Benefits for partial months will be based on the number of Totally Disabled days lapsed divided by 30.

#### **MINIMUM BENEFIT**

\$100 or 10% of your Covered Monthly Compensation, whichever is greater.

#### **SURVIVOR DEATH BENEFITS**

Three (3) additional months of Disability Income are payable to your eligible survivors if you die during a Benefit Period.

**LTD BENEFIT BOOKLET**  
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# **INTRODUCTION**

## **Plan Benefits**

Plan Benefits are governed by the applicable benefit description booklet.

## **Plan Interpretation**

This Benefit Description booklet has been prepared with as much information as is reasonable to help you understand your benefits.

However, some terms in the Plan may require interpretation as they apply to any specific situation.

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

## DEFINITIONS

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

**Active Work and Actively at Work** means the active performance of all of an Employee's normal occupation duties at the Member's (Employer's) usual place or places of business. The Employee must also meet the minimum requirement of hours as defined under the definition of Employee.

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

**Basic Monthly Compensation** means your basic monthly wage in effect immediately prior to the date Total Disability begins, as established by your Member (Employer). Basic wage does not include commissions, bonus or overtime pay.

**Benefit Elimination Period** means a period of three (3) consecutive months of continuous Total Disability, while covered, before any benefits are payable.

**Benefit Period** means after a Benefit Elimination Period, a period of continuous Total Disability for which you are eligible for Benefit Payments.

**Dependent** means your spouse and/or children if they qualify for benefits under the Federal Social Security Act as a result of your disability.

**Employee** means an employee of a Participating Member (Employer) whose work week is scheduled for at least 20 hours in a normal work week:

- For a teacher, employee means a teacher who is teaching at least ½ of a normal work load, as determined by the institution.
- Employee may include members of religious orders and secular priests.
- Employee does not include independent contractors, volunteers, etc., whose income from the Member (Employer) is not subject to Federal Withholding for wages or FICA.

**Hospital** or Institution means facilities licensed to provide care or treatment for the condition causing the Disability.

**Illness** means a bodily injury, bodily sickness, pregnancy or mental Illness.

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

- is operated under the auspices of the Roman Catholic Church, in good standing thereof, and is currently listed, or approved for listing in The Official Catholic Directory, published by P.J. Kenedy & Sons; and

- is exempt from taxation under section 501 (c)(3) of the Internal Revenue Code of 1986, as amended; and
- is organized as a not-for-profit corporation, if the organization is a corporation.

**Physician** means a licensed Doctor of Medicine or Osteopathy.

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

**Rehabilitative Employment** means work in any gainful occupation for which your training, education or experience will reasonably allow. The work must be approved by a Physician or a licensed rehabilitation specialist approved by Us. Rehabilitative Employment includes work performed while Disabled, but does not include performing all the material duties of your regular occupation on a full-time basis.

**Required Contribution/Contributions** means the amount of monies required to make coverage effective. The amount is decided by Us periodically.

**Retirement Plan** means a defined contribution or defined benefit plan. These are plans which provide retirement benefits to Employees and are not funded entirely by the Employee's contributions. A Retirement Plan includes but is not limited to any plan which is part of any federal, state, county, municipal or association retirement system.

**Retirement Payment** when used with the term Retirement Plan means money which:

- is payable under a Retirement Plan, either in a lump sum or in the form of periodic payments;
- does not represent contributions made by an Employee and is payable upon:
  - a. early or normal retirement; or
  - b. disability if the payment reduces the amount of money which would have been paid at the normal retirement age under the plan if the disability had not occurred.

**Total Disability** means your inability, because of sickness or injury, to work:

- for the first 27 months of disability, at your regular occupation; and
- following the first 27 months, at any occupation that reasonably fits your training, education or experience.

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

**Trustee(s)** means the entity elected by the Members (Employers) and is responsible for the administration of the Trust and Plan.

**We, Us, and Our** mean(s) the Trustee or Administrator for specific duties which have been delegated to the Administrator by the Trustee.

## **ELIGIBILITY FOR ENROLLMENT**

### **When You Are Eligible for Coverage**

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

### **How You Enroll for Coverage**

To enroll for coverage, obtain an enrollment form from your Member (Employer).

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

You are covered the first day you are eligible. All effective dates of coverage are subject to the provisions described under, "Delay of Effective Date," section below.

### **Delay of Effective Date**

If you are not Actively at Work on the date you become eligible for coverage, your coverage will be delayed until you satisfy the Active Work Requirement. \*

\* A requirement that you be Actively at Work as an Employee at the business establishment of the Member (Employer) or at other locations to which the Member's (Employer's) business requires you to travel.

### **Changes in Coverage**

Subject to the Delay of Effective Date, changes in coverage take place immediately.

### **Termination of Coverage**

Coverage terminates when:

- your employment terminates; or
- you no longer qualify as an Employee; or
- coverage terminates on the class of employees to which you belong; or
- you discontinue required contributions; or
- The Plan terminates.

## **BENEFITS**

This plan is designed to help you financially if a prolonged and serious disability, which commences while you are covered, prevents you from earning Basic Monthly Compensation for an extended period of time.

### **When Payments Begin - The Maximum Benefit Period**

To become eligible for benefits you must be continuously and Totally Disabled due to accident or Illness during a Benefit Elimination Period.

<b>Age at Disablement</b>	<b>Maximum Benefit Period</b>
61 or younger	To age 65
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

If you return to Active Work immediately, your contributions are resumed.

### **When Your Benefit Period Ends**

- The date you die; or
- the date your Total Disability ends; or
- the date you reach the end of the Maximum Benefit Period; or
- the date you fail to provide any required proof of Total Disability; or
- the date you fail to submit to any physical examination required by Us; or
- the date you fail to report any "Other Income Benefits."

### **Total Disability Defined**

You will be considered Totally Disabled if during the first 27 months of disability, you are continuously and completely unable to engage in your regular occupation or employment. Thereafter, you will be considered Totally Disabled if you are completely unable to engage in any gainful occupation or employment, for wage and/or profit for which you are qualified, based on your education, training, and experience.

## **Monthly Disability Benefits Payable**

Your Monthly Benefit amounts to 60% of your Basic Monthly Compensation, not to exceed \$5,000. In all instances, your Monthly Benefit, in combination with Other Income Benefits, is subject to 70% of Basic Monthly Compensation. In no event will your Monthly Benefit be reduced to less than \$100 or 10% of your Basic Monthly Compensation, whichever is greater.

## **Integration With Other Income Benefits**

Your Monthly Benefit, in combination with Other Income Benefits may not exceed 70% of your Basic Monthly Compensation.

The following will be considered as Other Income Benefits, and subject to the Overriding Limit:

1. The amount you receive or are entitled to receive under:
  - a workers' compensation law; or
  - an occupational disease law; or
  - any other act or law with similar intent.
2. The amount that you receive or are entitled to receive as disability income payments under any:
  - State compulsory benefit act or law;
  - automobile liability insurance policy;
  - other group insurance plan.
3. The amount that you, your spouse and your children receive or are entitled to receive as disability payments based on your earning records because of your disability under:
  - the United States Social Security Act
  - the Canada Pension Plan; or
  - the Quebec Pension Plan; or
  - any similar plan or act.
4. The amount that you receive as retirement payments, or the amount your spouse and your children receive as retirement payments based on your earning record:
  - the United States Social Security Act
  - the Canada Pension Plan; or
  - the Quebec Pension Plan; or
  - any government or statutory program.
5. Any disability payments you receive from an employer-sponsored plan, employee benefit organization plan to which an employer contributes, or union benefit plan.
6. The amount that you:
  - receive as disability payments under your Member's (Employer's) retirement plan;
  - or
  - receive as retirement payments under your Member's (Employer's) retirement plan.

7. The amount that you receive from a third party (after submitting attorney's fees) by judgement, settlement or otherwise.
8. Any salary continuation, vacation pay or sick pay from any employer.

The Administrator may estimate the Social Security award you may receive in calculating the amount of your Monthly Benefit.

Regardless of how the retirement payments from the retirement plan are distributed, We will consider your and your Member's (Employer's) contributions to be distributed simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible Retirement Plan. We will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

With the exception of retirement payments, We will only subtract deductible sources of income which are payable as a result of the same disability.

We will not reduce your benefit payments by your Social Security retirement income if your disability began after retirement and you were already receiving Social Security retirement payments.

After the initial deduction for the benefits under the United States Social Security Act, your monthly benefit will not be further reduced due to any cost of living increase payable under this Act.

Other Income Benefit does not include:

- retirement payments due to Employee contributions to a 401 (K) or a 403 (B) plans;
- thrift plans;
- tax sheltered annuities (TSA);
- stock ownership plans;
- credit disability insurance;
- non-qualified plans of deferred compensation plans;
- military pension and disability income plans;
- franchise disability income plans;
- individual disability income plan;
- a retirement plan from another Employer;
- individual retirement accounts (IRA).

## **Lump Sum Payments**

Other Income Benefits which are paid in a lump sum will be prorated on a monthly basis over the time period for which the sum is given. If no time period is stated, the sum will be perforated on a monthly basis over the Employee's expected lifetime, as determined by Us.

## **Survivor Benefits**

If a Totally Disabled Employee dies during the Benefit Period, three (3) months of benefits will be paid to the surviving spouse, if they had been married at least one year. If there is no surviving spouse, benefits will be paid in equal shares to the Employee's unmarried dependent children under the age of 21. No Survivor Death Benefits will be payable for any month in which the Employee is not survived by one of the persons described or if the benefit would not have been payable to the Employee had he lived and remained disabled.

## **Rehabilitation Benefits**

If a Totally Disabled Employee engages in a program of Rehabilitative Employment approved by Us, his or her Monthly Benefit may be continued during such employment. Earnings and wages received from Rehabilitative Employment are considered Other Income Benefits. The Monthly Benefit is increased to 80% of Basic Monthly Compensation during such period of approved Rehabilitative Employment.

"Rehabilitative Employment" means work in any gainful occupation for which your training, education or experience will reasonably allow. The work must be approved by a Physician or a licensed rehabilitation specialist approved by Us. Rehabilitative Employment includes work performed while Disabled, but does not include performing all the material duties of your regular occupation on a full-time basis.

## **Recurrent Disability**

If you return to Active Work for less than six (6) months, a recurrent Total Disability for the same or related cause will be part of the same Total Disability. A new Benefit Elimination Period is not required. Our liability for the entire period will be subject to the terms of the policy for the original period of Total Disability.

If after a period of Total Disability for which benefits are payable, you return to Active Work for at least six (6) consecutive months, any recurrent Total Disability from the same or related cause will be part of a new period of Total Disability. A new Benefit Elimination Period must be completed before any further Monthly Benefits are payable.

If you become eligible for insurance coverage under any other group long term disability insurance plan, then this recurrent disability section will not apply to you.

## **Limitations**

Benefits are not payable for disabilities due to:

- intentionally self-inflicted injuries;
- abortion;
- in consequence or having participated in a felony;
- war or any act of war, declared or undeclared.

## **Pre-Existing Condition Limitation**

Benefits are not payable for a disability for an Illness for which a covered Person:

- incurred charges;
- received medical treatment;
- consulted a Physician; or
- took prescription drugs

within three (3) months before coverage began under this plan, unless the Benefit Elimination Period commences after the earliest of the following to occur;

- a three (3) consecutive month period where the Employee has not:
  - incurred charges;
  - received medical treatment;
  - consulted a Physician; or
  - taken prescription drugs;for such condition, or any complication therefrom; or
- the Covered Employee has had 12 consecutive months of continuous coverage.

## **Limited Payment for Mental or Nervous Disorder, Chemical Dependency or Alcoholism**

Benefits for disabilities caused directly or indirectly, partly or wholly by mental or nervous disorders, alcoholism or chemical dependency shall be limited to a payment of 24 months during a covered person's lifetime while not confined to a Hospital or Institution.

## **Extension of Benefits**

1. Should you cease Active Work due to leave of absence, layoff or no longer satisfy the definition of Employee, your coverage will be continued upon payment of requested contributions to the end of the month.
2. If you cease Active Work because of Total Disability, your coverage will be continued upon payment of required contributions to the end of the Benefit Elimination Period. Coverage will be continued thereafter on a Waiver of Contributions basis during any period for which you are entitled to receive benefits under the Plan for the Total Disability.
3. It should be noted that only an Employee who was on Waiver of Contributions during his or her Benefit Period and who returns to work immediately upon recovery remains covered. All others must meet the Plan requirements applicable to new Employees in order to become covered again.

# **CLAIM PROCEDURES**

## **Claim Forms**

Your Member (Employer) will request forms from Us to assist you in filing claims.

## **Proof of Loss**

You must submit the following documents signed by you:

1. A completed application signed by you.
2. A completed statement signed by the Member (Employer).
3. A completed statement signed by your attending Physician.
4. Your written authorization for Us to obtain the records and information needed to determine your eligibility for Long Term Disability Benefits.
5. Completion of all other documents in the initial filing packet.

Proof of continuous Disability and regular attendance of a Physician must be given to Us within 30 days upon request.

All expenses incurred for submission of Proof of Loss above will be the responsibility of the claimant.

## **Prompt Filing**

Completed claim forms and other information needed to prove loss should be filed promptly. Written notice of Total Disability should be sent to Us within 60 days from the date of loss. Written proof that Total Disability exists and has been continuous must be sent to Us within four (4) months after you complete your Benefit Elimination Period. Proof of loss sent later will be accepted only if there is a reasonable cause for the delay. In no event will a Benefit Period begin 12 months prior to the date the Administrator receives Proof of Loss.

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

1. We will process your claim as quickly as possible after We have received all of the required information.
2. If your claim has been denied, or if you have not heard anything within 90 days after you have sent it in, you can appeal in writing and have your claim reviewed. You have 60 days from the time you are notified to appeal the denial.
3. Besides having the right to appeal, you or your authorized representative can examine any plan documents related to your claim. You can also submit, in writing, reasons why you think the claim should not be denied.
4. Those reviewing your claim have to act within 60 days of receiving it. However, in special cases, they may be allowed up to 180 days. The final decision will be sent to you in writing, together with an explanation of how the decision was made.

5. The final decision as to whether a claim is payable to you is made by the Trustee in matters dealing with long term disability benefits.

### **Physical Examination**

We may request the claimant be examined by a Physician. We will pay for these examinations and will choose the Physician to perform them.

**Note: All expenses incurred for submission of Proof of Loss will be the responsibility of the claimant.**

### **Determination of Other Income Benefits**

If you filed a claim for Long Term Disability benefits, your Other Income Benefits will be determined this way:

1. You must, when requested, report all such income to Us. Your report must include proof that you have applied for all income for which you are eligible and proof of rejection if any application is declined.
2. If any income is payable to you in a lump sum, We will convert and apply that income on a monthly equivalent basis.
3. You must apply for Social Security Benefits for yourself, your spouse and other Dependents. Until exact amounts are known, We will estimate the Social Security benefits for which you and your Dependents are eligible and will include that estimate in your Other Income Benefits.

### **Excess Disability Payments**

If excess benefits are paid because your Other Income Benefits are understated, we will have the option to:

- reduce your future benefits payable by the full amount of the excess payment; or
- recover the excess payment directly from you.

## **PLAN INFORMATION**

### **Plan name:**

Christian Brothers Employee Benefit Trust

### **Plan sponsor:**

Trustees of Christian Brothers Employee Benefit Trust  
c/o Christian Brothers Services  
1205 Windham Parkway  
Romeoville, IL 60446-1679

### **Plan year:**

January 1st thru December 31st

### **Plan Administrator:**

Christian Brothers Services (appointed by the Trustees)  
1205 Windham Parkway  
Romeoville, IL 60446-1679

EIN No. 36-3884439

### **Plan costs:**

Long Term Disability Benefits paid by the Member (Employer)

### **Agents for service or legal process:**

Managing Director, Employee Benefit Services,  
the Christian Brothers Employee Benefit Trust  
1205 Windham Parkway  
Romeoville, IL 60446-1679

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

### **Plan benefits provided by:**

The Christian Brothers Employee Benefit Trust

**Plan eligibility and benefits:**

See the Summary of Benefits at the front of this section of the booklet for the description of benefits. See the Table of Contents in this section of the booklet to locate the eligibility requirements.

**How to file a claim:**

See the Table of Contents in this section of the booklet to locate the "Claims Procedures."

**Plan Trustees:**

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

## **IMPORTANT NUMBERS**

### **BENEFIT ADVICE**

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

**1-800-807-0400**

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

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### **PREFERRED PROVIDER ORGANIZATION (PPO) & COST CONTAINMENT ADMINISTRATOR**

Your Member (Employer) has agreed to the following PPO organization(s).

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Name of PPO: **American LIFECARE**

Nationwide Provider Verification Number: **1-800-749-2298**

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

Cost Containment Administrator: **Health Information Line**

Authorization Number: **1-800-533-5044**

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When traveling or attending school out of your PPO area,  
call **Private Healthcare Systems** at **800-678-7427**  
for participating providers.

Cost Containment Administrator: **Health Information Line**

Authorization Number: **1-800-533-5044**

**MEDICAL SUMMARY OF BENEFITS  
FOR ALL ENROLLED EMPLOYEES  
AND DEPENDENTS**

**PREFERRED PROVIDER ORGANIZATION (PPO)**

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

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

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

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

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

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

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

**COMPREHENSIVE MEDICAL BENEFITS  
(Subject to Cost Containment Requirements)**

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

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

**MAXIMUM MEDICAL PAYMENT LIMITS**

Following are various Maximum Medical Payment Limits for a Covered Person:

Comprehensive Lifetime Medical Benefit Maximum . . . . . \$ 3,000,000

Transplant Lifetime Benefit Maximum . . . . . Refer to Organ and Tissue  
Transplant Benefits Section

Note: See Special Benefit Provisions - Limited section for additional limitations.

**PREVENTIVE CARE BENEFIT - PPO PROVIDERS ONLY**

Covered Charges will be paid at 100% up to \$500 per calendar year for each Covered Person. Benefits are payable only for the following listed services which are performed as part of an annual routine physical and only until the sum of benefits paid for one or more of the listed services reaches the \$500 maximum. When the maximum benefit has been paid, normal Plan benefits will apply. This 100% benefit will apply to amounts billed for services outside your physician’s office and will include professional reading of lab or x-rays when the test is performed by a PPO provider.

Annually- Adult: CBC & Chemistry or General Health Panel  
Urinalysis  
Pap Test - thin prep or regular (Female)

Annually - Age 40+: Lipid Panel (Complete Cholesterol Screening)  
Mammogram (Female)

Annually - Age 50+: Hemoccult  
PSA (Male)

Age 50+: Colonoscopy, one every 3 years  
Bone Density Study, one every 3 years

**MATERNITY BENEFIT**

Normal Plan benefits will apply for charges related to pregnancy. Maternity benefits will include three routine obstetrical ultrasounds. Any additional ultrasounds will be covered if Medically Necessary Care is substantiated.

**SPECIAL BENEFITS PROVISIONS - LIMITED**

**(As explained in the Description of Benefits, Comprehensive Medical Coverage section of this booklet - refer to the table of contents following this Summary of Benefits)**

- I. Home Health Care Benefits
- II. Hospice Care Benefits
- III. Mental or Nervous Disorder, Chemical Dependency and Alcoholism Benefits.
- IV. Other Covered State Licensed Practitioners Benefits
- V. Skilled Nursing Facility Confinement Benefits
- VI. Wellness Benefits
- VII. Orthotic Benefits
- VIII. Physical and Occupational Therapy Benefits
- IX. Organ and Tissue Transplant Benefits

## COMPREHENSIVE MEDICAL

### Medical Care Categories of Covered Charges

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

### Benefits Payable

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

Service	Preferred Providers	Other Than Preferred
<u>Category A</u>		
Inpatient Hospital Services		
Rate of Payment . . . . .	90%	70%
Deductible Required ** . . . . .	\$1,000	\$1,000
Outpatient Hospital Services		
Rate of Payment . . . . .	90%	70%
Deductible Required ** . . . . .	\$1,000	\$1,000
Emergency Hospital Services		
Rate of Payment . . . . .	90%	70%
Deductible Required ** . . . . .	\$1000	\$1,000
<u>Category B</u>		
Physician Hospital Services (including surgery and Physician Visits)		
Rate of Payment . . . . .	90%	70%
Deductible Required ** . . . . .	\$1,000	\$1,000
Other Medical Providers		
Rate of Payment . . . . .	90%	70%
Deductible Required ** . . . . .	\$1,000	\$1,000

<b>Service</b>	<b>Preferred Providers</b>	<b>Other Than Preferred</b>
<u>Category C</u>		
Services at home or at a Physician's office or clinic		
Rate of Payment .....	100% of first \$300 90% thereafter	70%
Co-Pay Required * .....	\$25 per visit	---
Deductible Required ** .....	.....	\$1,000

Category D

Other Medical Services

Rate of Payment .....	80%	80%
Deductible Required ** .....	\$1,000	\$1,000

**Medical Emergency**

If you or one of your Dependents require treatment for a Medical Emergency and cannot reasonably reach a Preferred Provider, the hospital charges and the emergency room physician charges for such treatment received will be paid as if treatment had been provided by a Preferred Provider.

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

**Mental or Nervous Disorder, Chemical Dependency and Alcoholism (Applicable to medical care received from Preferred Providers or from Other Than Preferred Providers)**

Benefits below are specific for conditions of Mental or Nervous Disorder, Chemical Dependency and Alcoholism:

<b>Service</b>	<b>Preferred Providers</b>	<b>Other Than Preferred</b>
<b>Inpatient Hospital Service</b>		
(Benefits will be payable the same as any other sickness)		
Hospital Charges . . . . .	90% after \$1,000 deductible **	70% after \$1,000 deductible **
Other Medical Providers . . . . .	90% after \$1,000 deductible **	70% after \$1,000 deductible **
Maximum Benefit Payable . . . . .	30 days in a Covered Person's lifetime	
<b>Partial Hospitalization or Day Treatment Program</b>		
(Benefits will be payable the same as any other sickness)		
Maximum Benefit Payable . . . . .	90% after \$1,000 deductible **	70% after \$1,000 deductible **
	30 days per Covered Person per Calendar Year 60 days in a Covered Person's lifetime	
<b>Outpatient Services (Visits)</b>	80% after \$1,000 deductible **	80% after \$1,000 deductible **
Maximum Benefit Payable . . . . .	40 Visits per Covered Person per Calendar Year	
Benefits will be payable as indicated for Covered Charges for all covered providers. The percent you pay will not apply toward the Out-of-Pocket Expense Maximum.		
<b>Other Outpatient Services (i.e., Lab and Psych Testing)</b> . . . . .	90% after \$1,000 deductible **	70% after \$1,000 deductible **
(Benefits will be payable the same as any other sickness)		

**SEE SPECIAL BENEFITS PROVISIONS - LIMITED, SECTION (III.) FOR A MORE DETAILED DESCRIPTION OF THE MENTAL OR NERVOUS DISORDER, CHEMICAL DEPENDENCY AND ALCOHOLISM BENEFITS.**

**\*Co-Pay Requirement Amount(s)**

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

**\*\*Deductible Requirement Amount(s)**

- You pay a single \$1,000 per person deductible each Calendar Year (or \$3,000 per family, but not counting more than \$1,000 for any one person). After you satisfy the deductible, We will pay Covered Charges at the rate of payment shown in Benefits Payable above.

<b>Out-Of-Pocket Expense Maximum per Calendar Year</b>	<b>Preferred Providers</b>	<b>Other Than Preferred</b>
Per Person .....	\$ 2,000	\$ 4,000
Per Family .....	\$ 4,000	\$ 8,000

- If the amount you pay for Covered Charges in any one Calendar Year reaches the Out-of-Pocket Expense Maximum shown above, We will pay 100% of additional Covered Charges (except as described above).
- The percent you pay in excess of the Co-Pay amount will be counted toward satisfaction of the Out-of-Pocket Expense Maximum shown, but will not be counted toward satisfaction of the Calendar Year deductible.
- The amounts that DO NOT apply toward your Out-of-Pocket Expense Maximum are:
  - Any Co-Pay amount required; and
  - the percent you pay under “Outpatient Services (Visits)”, for the treatment of Mental or Nervous Disorder, Chemical Dependency and Alcoholism; and
  - the percent you pay under, “Other Covered State Licensed Practitioners Benefits”; and
  - penalties incurred for failure to comply with any Cost Containment Requirements; and
  - Co-Pays required from you under the Prescription Drug Benefit.

## **Hospital Benefit Reduction**

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

- a Hospital Preadmission Authorization is requested by you, or a family member, or a Physician and approved by the Cost Containment Administrator. In addition, for confinement beyond the initial period, the Cost Containment Administrator approves any extension.

*(If a Hospital Preadmission Authorization is not requested in a timely manner as specified above, the 25% reduction in benefits payable will be applied, but only to the charges incurred up to the date a Hospital Preadmission Authorization is obtained. Benefits will be payable only for that part of the Hospital Confinement Charges that We determine to be Medically Necessary Care.)*

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

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

**Your medical identification card gives you a telephone number to call your Cost Containment Administrator for Hospital reviews. You must follow all of the Cost Containment Requirements discussed later in this booklet or your benefits will be reduced as described above.**

NOTE: See the Claim Procedures Section for important information on filing your medical claims.

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## YOUR ROLE IN CONTROLLING HEALTH CARE COSTS

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

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

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

Make Sure You Need Surgery. Follow the rules of the second opinion program. If you need surgery, ask about same day surgery. Many procedures can be performed safely without a Hospital stay. You may have these surgeries as an outpatient or at a place other than a Hospital and go home the same day.

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

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

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

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

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

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

## **INTRODUCTION**

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

## **PLAN BENEFITS**

Plan Benefits are governed by the applicable benefit description booklet.

## **PLAN INTERPRETATION**

This Benefit Description booklet has been prepared with as much information as is reasonable to help you understand your benefits.

However, some terms in the Plan may require interpretation as they apply to any specific situation.

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

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

## **CONFORMITY WITH STATE MANDATES - ONLY IF MANDATES ARE APPLICABLE TO CHURCH PLANS**

The Christian Brothers Employee Benefit Trust is a “church plan” as designated by the Internal Revenue Service and Department of Labor. There may be instances where a state mandated benefit applies to the Trust. In those instances, the Christian Brothers Employee Benefit Trust will conform to the state mandate, unless the mandated benefit would conflict with the doctrine or tenets of the Roman Catholic Church.

## **HOW TO BE COVERED**

### **ELIGIBILITY FOR ENROLLMENT**

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

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

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

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

#### **Newborns - 31-Day Coverage**

Under this Plan, your newborn child will be automatically covered until the child attains 31 days of age.

If you do not enroll this child for Dependent coverage before the 31 days end, the "Late Enrollment" provision will apply.

#### **How You Enroll for Coverage**

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

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

##### **Noncontributory Coverage:**

- If no contributions are required from you for the coverage, you are covered the first day you are eligible.
- If no contributions are required from you for Dependent coverage, your Dependents will be covered on the first day you are eligible for Dependent coverage.
- All effective dates of coverage are subject to the provisions described under, "Delay of Effective Date," section below.

### **Contributory Coverage:**

- If contributions are required from you for the coverage, you are covered on the date you make proper enrollment. If you delay your enrollment more than 31 days beyond the date you were first eligible for coverage, your coverage will be subject to "Late Enrollment," as described below.
- If contributions are required from you for Dependent coverage, you are covered for Dependent coverage on the date you make proper enrollment for such coverage. If you delay your enrollment more than 31 days beyond the date you were first eligible for Dependent coverage, your coverage will be subject to "Late Enrollment," as described below.
- All effective dates of coverage are subject to the provisions described under, "Delay of Effective Date," section below.

### **Delay of Effective Date**

If your coverage is to become effective on your first day of work and you do not satisfy the Active Work requirement, your coverage will be delayed until you satisfy that requirement. The Active Work requirement means the active performance of all of your normal job duties at the Member's (Employer's) usual place or places of business.

### **Late Enrollment**

If enrollment is not made within 31 days of the eligibility date and you wish to enroll at a later date, you and/or your dependent(s) will be considered Late Enrollees. For Late Enrollees, coverage will be effective the first of the month following a six month deferral period from the date the enrollment form is received by Us. Coverage for Late Enrollees will be subject to the Pre-Existing Conditions Limitation.

### **Special Enrollment**

If you or your Dependent(s) are covered by a group plan or plans provided by your Dependent's employer, and such coverage is lost involuntarily, this Plan will accept you and your Dependent(s) under conditions provided by the Plan Administrator.

The Pre-Existing Conditions Limitation will apply under this provision.

It is important that you contact your Employer immediately when such loss of coverage is imminent.

## **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

The Christian Brothers Employee Benefit Trust is subject to HIPAA. HIPAA addresses certain aspects of eligibility, enrollment and the Pre-Existing Conditions Limitation such as:

- Late Enrollment; and
- Special Enrollment; and
- coverage for pregnancy, newborn children & adopted children; and
- time limitations under the Pre-Existing Conditions Limitation.

This plan will comply with HIPAA. For details on this law, please contact your Plan Administrator.

## **ELIGIBLE DEPENDENTS**

For Comprehensive Medical Expense Benefits, Dependent means:

- your spouse, if not in the Armed Forces and not covered as an Employee; and
- your unmarried natural or legally adopted child less than 19 years of age, if not in the Armed Forces and not eligible as an Employee; and
- your unmarried natural or legally adopted child age 19 years but less than 24 years, if not in the Armed Forces and not eligible as an Employee provided:
  - the child is claimed as an exemption, as defined by the I.R.S. Code of the U.S., on your Federal income tax return; or
  - the child is a full-time student at an accredited school; and
- your unmarried stepchild or any child for whom you have legal guardianship, living with you, if they meet all requirements above and We approve in writing.

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

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

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

### **Change in Family Status**

Once you are in the Plan, it is necessary that you promptly enroll your eligible Dependent(s). Also, please notify your Member (Employer) when you no longer have any eligible Dependents. If you do not enroll your Dependent(s) within 31 days after the Dependent(s) becomes eligible, your Dependent's coverage will be subject to the "Late Enrollment" provision.

If you have one or more covered children, you must report the names and dates of birth of any additional children. If only children are covered and a spouse becomes eligible, a report is also required. Forms are available for reporting changes in family status.

## **WHEN YOUR COVERAGE TERMINATES**

### **Termination of Coverage**

Coverage for you and your Dependents terminates when:

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

Coverage for a Dependent terminates when:

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

### **Continuation Privilege**

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

#### **Employee and Dependent Continuation Privilege**

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

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

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

You should contact your Member (Employer) immediately to obtain the necessary forms required for continuation.

## **Retiree Medical Continuation Privilege**

If you retire at age 55 or older with at least five consecutive years of Medical coverage under the Plan prior to retirement and are receiving a Social Security retirement benefit or a retirement benefit from your Member's (Employer's) retirement plan, you may be eligible to continue your Medical coverage, and your eligible Covered Dependents Medical coverage, by paying the required contribution.

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

You should contact your Member (Employer) immediately to obtain the necessary forms for continuation.

Note: Retirees who are eligible for Medicare must have both Medicare A and B coverage. If Medicare could be in effect for a retiree, the Plan only provides benefits under the Integration with Medicare provision discussed later in this booklet.

## **DESCRIPTION OF BENEFITS**

### **COMPREHENSIVE MEDICAL COVERAGE**

Comprehensive Medical Expense Benefits are designed to help pay expenses for Medically Necessary Care and services which you would otherwise have to pay in full.

#### **Maximum Medical Payment Limits**

Following are various Maximum Medical Payment Limits for a Covered Person:

Comprehensive Lifetime Medical Benefit Maximum .....	\$3,000,000
Transplant Lifetime Benefit Maximum .....	Refer to Organ and Tissue Transplant Benefits Section

Note: See Special Benefit Provisions - Limited section for additional limitations.

#### **Comprehensive Medical Payment Qualification**

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

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

#### **Medical Benefits Payable**

Benefits payable are for Medically Necessary Care, described in this section, and are subject to:

- Cost Containment Requirements, as detailed; and
- all listed limitations; and
- the terms and conditions of:
  - Coordination with Other Benefits; and
  - Reimbursement/Subrogation.

## **Medical Payment Conditions**

Your Comprehensive Medical Benefits Plan covers the Prevailing Charges for medical care and services which are Medically Necessary Care for treatment of an illness or injury. Reimbursement for Covered Charges is based on charges:

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

## **Covered Charges**

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

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

Covered Charges are based on four Categories of medical care services as described below.

**Category A** includes:

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

**Category B** includes:

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

**Category C** includes:

- charges for services furnished at a Physician's clinic or office or at your home. Such services include charges from the Physician's clinic or office for dressings, supplies, equipment, injections, anesthesia, blood, blood plasma, x-ray and laboratory examinations, x-ray, radium, and radioactive isotope therapy, routine physical examinations (except as limited under Special Benefit Provisions - Limited, Section (III.) Mental or Nervous Disorder, Chemical Dependency and Alcoholism Benefits);
- charges for services at a Physician's clinic or office for genetic testing if the testing meets the Plan's criteria and is pre-approved by Us;
- charges for services at a Physician's clinic or office for an initial visit for the restoration of fertility or the promotion of conception. Covered charges will include initial lab tests, hysterosalpingogram, hysteroscopy, pelvic ultrasound, and transvaginal ultrasound. Covered charges may also include corrective surgery if documentation is provided verifying abnormal or non-functioning body processes;
- charges for the services of a Registered Nurse, but only when such services are provided by:
  - an advanced practice Registered Nurse in lieu of a Physician; i.e., Certified Nurse Anesthetist, Certified Nurse Midwife, Certified Registered Nurse Practitioner (except as limited under Special Benefit Provisions - Limited, Section (III.) Mental or Nervous Disorder, Chemical Dependency and Alcoholism Benefits);
- Dental Services to repair damage to the jaw and sound natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and the Dental Services are completed within twelve months after the accident, and not covered by your dental plan;
- charges for the services of a Health Care Extender. Health Care Extender means a member of a covered provider's staff or allied health practitioner. Medical services must be billed by and delivered under the Direction and Supervision of a provider covered by the Plan.

**Category D** includes:

- charges for services by an Other Covered State Licensed Practitioner as limited under Special Benefit Provisions - Limited, Section (IV) Other Covered State Licensed Practitioners Benefits;
- Federal Legend drugs and medicines requiring a Physician's prescription that are not eligible under the Prescription Drug Coverage for Retail Network Pharmacy and Home Delivery Pharmacy;
- charges for transportation by ambulance provided by a Hospital or licensed service to a local Hospital (or to the nearest Hospital equipped to furnish needed treatment not available in a local Hospital);
- surgical dressings, casts, splints, braces, crutches, artificial limbs, and artificial eyes;
- charges for rental or purchase of Durable Medical Equipment (DME). The maximum charges eligible for consideration for rental of DME will be limited to the purchase price. When We determine whether to purchase or rent the equipment, We will consider the type of equipment requested, and the condition and length of time for which it will be used. Eligible equipment is a walker, wheelchair, hospital-type bed, CPAP machine, nebulizer, or artificial respirator. Other DME may be eligible after Our review, but We must pre-approve the requested equipment;
- oxygen (including rental of equipment for its administration);
- convalescent care in a Skilled Nursing Facility only as described under Special Benefit Provisions - Limited, Section (V.) Skilled Nursing Facility Confinement Benefits;
- Hospice Care only as described under Special Benefit Provisions - Limited, Section (II.) Hospice Care Benefits;
- Home Health Care only as described under Special Benefit Provisions - Limited, Section (I.) Home Health Care Benefits;
- the services of a Registered Nurse, but only when such services are provided during confinement in a Skilled Nursing Facility or when such services are provided as part of Home Health Care or Hospice Care (all described under Special Benefit Provisions - Limited);
- the services of a licensed physiotherapist, but only when such services are provided during confinement in a Skilled Nursing Facility as described under Special Benefit Provisions - Limited, Section (V.) Skilled Nursing Facility Confinement Benefits.

## Miscellaneous

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

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

Covered Charges for laboratory services at LabOne: The Plan will pay 100% of all covered laboratory charges when such services are performed at a **LabOne** facility or when laboratory tests taken at your doctor's office are submitted to **LabOne** for examination.

## Prevailing Charges for Multiple Surgical Procedures

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

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

## **SPECIAL BENEFIT PROVISIONS - LIMITED**

In order to give you and your Dependent(s) a balanced Comprehensive Medical Plan, certain benefit provisions have been added. These special benefit provisions modify payments to providers and are as follows:

- (I) Home Health Care Benefits
- (II) Hospice Care Benefits
- (III) Mental or Nervous Disorder, Chemical Dependency and Alcoholism Benefits
- (IV) Other Covered State Licensed Practitioners Benefits
- (V) Skilled Nursing Facility Confinement Benefits
- (VI) Wellness Benefits
- (VII) Orthotic Benefits
- (VIII) Physical and Occupational Therapy Benefits
- (IX) Organ and Tissue Transplant Benefits

Covered Charges exceeding Prevailing Charges are not eligible for payment.

**I. Home Health Care Benefits**

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

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

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

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

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

Maximum Home Health Care Visits . . . . . 100 visits per Calendar Year

## II. Hospice Care Benefits

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

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

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

All terms are defined under "Definitions."

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

- exceed \$60 for any one day of Hospice Care; or
- exceed \$4,000 for any one Hospice Care Episode; or
- exceed six months for all Hospice benefits due to the same or a related injury or sickness; or
- are for Hospice Care Services not approved by the attending Physician and Us; or
- are for transportation services; or
- are for custodial care (services or supplies provided to assist a person in daily living--e.g., meals and personal grooming); or
- are for Hospice Care Services provided at a time other than during a Hospice Care Episode.

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

Maximum Covered Charge Per Day . . . . . \$60.00 per day

Maximum Covered Charge Per Hospice Care Episode . . . . . \$4,000.00 per Episode

### **III. Mental Or Nervous Disorder, Chemical Dependency And Alcoholism Benefits**

#### **Inpatient Hospital Services**

If you are confined in a Hospital (or an institution as defined under Hospital) for 15 or more consecutive hours due to a Mental or Nervous Disorder, Chemical Dependency or Alcoholism, benefits will be payable for charges by the Hospital for room, board, and other usual services, and for Physician Visits provided during such confinement.

Benefits will be payable the same as any other sickness for not more than 30 days of confinement in a Covered Person's lifetime.

Benefits will be payable for Physician Visits when provided while the person is Hospital confined, only if the Visits occur during the period for which these inpatient Hospital benefits are payable.

Benefits will be payable the same as any other sickness.

Lifetime Maximum Benefit Payable . . . . . 30 days in a Covered Person's lifetime

#### **Partial Hospitalization/Day Treatment Program**

If you are participating in a Partial Hospitalization or Day Treatment Program due to a Mental or Nervous Disorder, Chemical Dependency or Alcoholism, benefits will be payable for program charges and Physician Visits provided during the Program.

Benefits will be payable the same as any other sickness for not more than 30 days per Covered Person per Calendar Year or 60 days in a Covered Person's lifetime.

Benefits will be payable for Physician Visits when provided while the Covered Person is in the Program.

"Partial Hospitalization or Day Treatment Program" means a structured Program approved by Us, under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health, Alcohol, or Drug Abuse Treatment Services in a Partial Hospitalization or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.

"Partial Hospitalization or Day Treatment Facility" means a Hospital (or an institution as defined under Hospital) that is licensed by the proper authority of the state in which it is located to provide a Partial Hospitalization or Day Treatment Program.

Benefits will be payable the same as any other sickness.

Maximum Benefit Payable . . . . . 30 days per Covered Person per Calendar Year

Lifetime Maximum Benefit Payable . . . . . 60 days in a Covered Person's lifetime

**Outpatient Services (Visits)**

If you receive treatment on an outpatient basis due to a Mental or Nervous Disorder, Chemical Dependency or Alcoholism, benefits will be payable for Covered Charges incurred for such treatment.

"Outpatient Services (Visits)" means Treatment or Services by a Physician or Other State Licensed Practitioner which are provided other than when confined in a Hospital for 15 or more consecutive hours or covered under a Partial Hospitalization or Day Treatment Program. If a Hospital stay or Partial Hospitalization or Day Treatment Program is not covered, charges by the Physician or Other State Licensed Practitioner may be eligible as Outpatient Services (Visits).

Benefits will be payable for not more than 40 Visits per Covered Person per Calendar Year.

See your Summary of Benefits for the percentage payable by the Plan for Covered Charges. The percent you pay will not apply toward the Calendar Year Deductible and Out-of-Pocket Expense Maximum.

Maximum Benefit Payable . . . . . 40 Visits per Covered Person per Calendar Year

**Other Outpatient Services (i.e. Lab and Psych Testing)**

If you receive treatment on an outpatient basis other than described under Outpatient Services (Visits) due to a Mental or Nervous Disorder, Chemical Dependency or Alcoholism, benefits will be payable for Covered Charges incurred for such treatment.

Benefits will be payable the same as any other sickness.

**No benefits will be payable for any charges incurred in excess of the limits and maximums described above for all charges due to Mental Nervous Disorder, Chemical Dependency and Alcoholism Benefits.**

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

Comprehensive Medical Covered Charges will include charges by Other Covered State Licensed Practitioners who are not specifically mentioned as covered elsewhere under this medical plan.

Note: All charges for acupressure and acupuncture services are eligible under this benefit only. No acupressure or acupuncture services are covered for the treatment of mental or nervous disorders, chemical dependency, and alcoholism.

This limited benefit will include charges from a state licensed dietician to assist a Covered Person in their nutritional needs for the treatment of a covered illness if such treatment is Medically Necessary Care and ordered by a Physician.

Benefits are limited to:

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

The percent you pay will not apply toward the Calendar Year Deductible and Out-of-Pocket Expense Maximum.

Maximum Benefit Payable . . . . . \$2,000.00 per Calendar Year

**V. Skilled Nursing Facility Confinement Benefits**

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

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

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

Maximum Skilled Nursing Facility Days . . . . . 120 Days per Related Sickness

**VI. Wellness Benefit**

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

**VII. Orthotic Benefit**

Benefits are limited to a maximum payment of \$500 in a Covered Person’s lifetime.

Comprehensive Medical Covered Charges will include charges for Medically Necessary Care for:

- all services, including testing and casting, related to the purchase of orthotics. This benefit will apply only when the orthotics are prescribed for specific diagnosed medical conditions, such as, but not limited to: bone spurs, heel spurs or plantar fasciitis.

Maximum Benefit Payable . . . . . \$500.00 per Covered Person’s Lifetime

**VIII. Physical and Occupational Therapy Benefits**

Comprehensive Medical Covered Charges will include charges for Medically Necessary Care for physical and/or occupational therapy for services rendered by a Physician, licensed Physical Therapist, or licensed Occupational Therapist. Benefits payable for Treatment or Service performed other than while Hospital inpatient confined, by use of: exercise; application of cold, heat, or electricity; traction; diathermy; ultrasound; or water will be limited to a maximum benefit of \$6,000 each calendar year for each Covered Person. Charges incurred for each Physician Visit at the Physician’s office or clinic when physical therapy is performed will be applied toward the calendar year maximum benefit, unless other non-physical therapy services are provided during the office or clinic visit. If other non-physical therapy services are provided during the office or clinic visit, charges incurred for the Physician Visit will not apply toward the calendar year maximum benefit.

Maximum Benefit Payable . . . . . \$6,000.00 per Calender Year

## **IX. ORGAN AND TISSUE TRANSPLANT BENEFITS**

### **Payment Conditions - Transplant Services**

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

### **Covered Transplants**

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

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

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

### **Covered Charges**

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

### **Benefits Payable; Within the Transplant Network**

For Transplant Services provided by a Transplant Network Provider, benefits payable for Treatment or Service received each calendar year will be paid at the PPO level of benefits.

Covered charges will also include charges incurred by the organ donor for a Covered Transplant if the charges are not covered by any other medical expense coverage.

Travel / Lodging Benefit: If transplant related services are provided by a Transplant Network Provider, travel and lodging expenses for the patient and the patient's Immediate Family will be covered if the treating facility is greater than 150 miles one way from the patient's home (excluding travel and lodging provided by a family member or friend). This would include ambulance expenses that would otherwise be excluded under the Comprehensive Medical ambulance benefit if such expenses are incurred solely to meet timing requirements imposed by the transplant. Benefits payable cannot be used to satisfy any Deductible or Co-Pay amount under the ambulance benefit in the normal provisions of the Comprehensive Medical section.

Travel and lodging benefits will be payable at 100% without application of any Deductible Amount, up to a lifetime maximum benefit of \$5,000 for each approved transplant. All travel and lodging benefits must be approved in advance by Us.

**Benefits Payable; Outside the Transplant Network**

For Transplant Services provided by any covered provider other than a Transplant Network Provider, benefits will be payable on the same basis as for any other sickness up to the following maximum benefits for each surgery listed below, and up to a lifetime maximum benefit of \$150,000 for each Covered Person.

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

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

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

The cost of organ or tissue procurement from a living person (living donor) is not covered.

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

**Limitations: Applicable Within and Outside the Transplant Network**

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

For each transplant episode, Covered Charges will include:

- a. Transplant evaluations from no more than two transplant providers; and
- b. No more than one listing with United Network of Organ Sharing (UNOS).

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

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

Comprehensive medical benefits will not be paid for confinement, treatment, service or materials for:

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

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

## **DEDUCTIBLE REQUIREMENT**

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

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

### **Family Limit**

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

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

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

The following are not eligible toward your Out-of-Pocket Expense Maximum:

- The amounts that DO NOT apply toward your Out-of-Pocket Expense Maximum are:
  - Any Co-Pay requirement if applicable; and
  - The percent you pay under "Outpatient Services (Visits)" for the treatment of Mental or Nervous Disorder, Chemical Dependency, or Alcoholism; and
  - The percent you pay under "Other Covered State Licensed Practitioners"; and
  - Penalties incurred for failure to comply with any Cost Containment Requirements; and
  - Co-Pays required from you under the Prescription Drug Benefit.

## LIMITATIONS OF COMPREHENSIVE MEDICAL BENEFITS

Comprehensive Medical benefits will not be paid for:

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

- q. Treatment or Service for Mental or Nervous Disorders, Chemical Dependency, and Alcoholism, except as provided under Special Benefit Provisions - Limited, Section (III.); or
- r. behavior modification or group therapy (except as limited under Special Benefit Provisions - Limited, Section (III.) Mental or Nervous Disorder, Chemical Dependency and Alcoholism Benefits); or
- s. Treatment or Service for marital counseling or social counseling; or
- t. Treatment or Service for smoking cessation or nicotine addiction, gambling addiction, or stress management; or
- u. Treatment or Service for educational or instructional purposes (except as described under Covered Charges); or
- v. Treatment or Service for educational, training, or developmental problems, learning disorders; or
- w. Dental Services (except as described under Covered Charges); or
- x. Treatment or Service for any form of temporomandibular joint disorder (malfunction, degeneration, or disease related to the joint that connects the jaw to the skull), including but not limited to braces, splints, appliances, or surgery of any type; or
- y. drugs and medicines eligible under the Prescription Drug Coverage for Retail Network Pharmacy and Home Delivery Pharmacy, except as listed under Covered Charges; or
- z. Treatment or Service for DESI (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness); or
- aa. charges for non-prescription drugs; non-prescription vitamins and minerals; or
- ab. charges for nutritional supplements, special diets, special formula; or
- ac. charges for eye examinations for correction of vision or fitting of glasses, vision materials (frames or lenses); or
- ad. Treatment or Service for Kerato-Refractive Eye Surgery (surgery to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including but not limited to radial keratotomy and keratomileusis surgery); or
- ae. acupuncture or acupressure treatment (except as limited under Special Benefit Provisions - Limited, Section (IV.) Other Covered State Licensed Practitioners Benefits); or
- af. Treatment or Service for Cosmetic Surgery (except when the surgery results from an accidental injury and is performed within 18 months of that injury); or

- ag. Treatment or Service for:
- human-to-human organ or bone marrow transplants, except as provided under Special Benefits Provisions- Limited, Section (IX.); or
  - animal-to-human organ or tissue transplants; or
  - implantation within the human body of artificial or mechanical devices designed to replace human organs; or
- ah. Treatment or Service for unattended home sleep studies; or
- ai. any nursing services (except as described under Covered Charges); or
- aj. Treatment or Service for custodial care; or
- ak. Treatment or Service for maintenance therapy or supportive care or when maximum therapeutic benefit (no further objective improvement) has been attained; or
- al. charges for sports, employment or immigration physicals; or
- am. charges for transportation or ambulance services except as described under Covered Charges; or
- an. Durable Medical Equipment used for:
- personal hygiene, comfort, or convenience, whether or not recommended by a Physician, including, but not limited to, air conditioners, humidifiers, diapers, underpads, bed tables, tub bench, shower chair, hooyer lift, gait belts, bedpans, physical fitness equipment, stair glides, elevators, or lift; or
  - “barrier free” home modifications, whether or not recommended by a Physician, including, but not limited to, ramps, grab bars, or railings; or
  - non-implantable communication-assist devices, including, but not limited to, communications boards, and computers; or
- ao. charges for comfort or convenience services and supplies; or
- ap. charges for prone standers, Amigo-type carts, motorized scooters, etc.; or
- aq. charges for heating pads, heating and cooling units, ice bags or cold therapy units; or
- ar. charges for devices used specifically as safety items or to affect performance in sport-related activities; or
- as. charges for hearing aids and related charges; or
- at. charges for wigs or hair prostheses; or
- au. delivery charges or taxes; or

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

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

## **PRE-EXISTING CONDITIONS LIMITATION**

### **PRE-EXISTING CONDITION DEFINED**

Pre-Existing Condition means an illness for which a Covered Person:

- incurred charges;
- received medical treatment;
- consulted a physician; or
- took prescription drugs

within three months before the Covered Person's Enrollment Date.

### **PRE-EXISTING CONDITIONS LIMITATION**

Benefits will be limited to \$3,000 per Covered Person for a Pre-Existing Condition until the earlier of (a) or (b):

a) The Covered Person has not:

- incurred charges;
- received medical treatment;
- consulted a physician; or
- taken prescription drugs

for such condition, or any complication therefrom, for 90 consecutive days from the Covered Person's Enrollment Date; or

b) 12 consecutive months from the Covered Person's Enrollment Date.

### **Enrollment Date**

Enrollment Date means, the earlier of the first day coverage begins or, if your Member (Employer) requires a waiting period before coverage begins, the first day of the waiting period.

The Enrollment Date for Late Enrollees is the date coverage begins.

This Plan will comply with HIPAA. For details on this law, please contact your Plan Administrator.

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

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

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

## **COORDINATION WITH OTHER BENEFITS**

### **MEDICAL EXPENSE COVERAGE**

#### **Intent**

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

#### **Definitions**

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

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

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

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

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

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

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

## Effect on Benefits

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

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

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

## Order of Benefit Determination

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

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

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

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

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the

benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first.

Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules for Dependent children of parents who are not separated or divorced.

- Active/Inactive Employee. The benefits of a Plan which covers a person as an Employee who is neither laid off nor retired, or as that Employee's Dependent, are determined before the benefits of a Plan which covers that person as a laid-off or retired Employee or as that Employee's Dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.
- Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an Employee, Member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.
- Automatic Coverage for a Newborn Child. When This Plan and another Plan both provide benefits, the benefits of the other Plan will be determined before the benefits payable under the Automatic Coverage for a Newborn Child provision of This Plan.
- Continuation/Extension of Benefits. When This Plan and another Plan both provide benefits, the benefits of the plan covering the person as an employee, member or subscriber, or as that person's dependent, will be determined before the benefits payable under This Plan's Extension of Benefits.

## **Medicare Rules**

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

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

## **Medicare Exception**

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

Federal law will usually apply in such instances if:

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

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

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

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

It works this way:

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

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

## **Coordination with HMOs**

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

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

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

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

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

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

## **Secondary Only Coverage under This Plan under the Automatic Coverage for a Newborn Child provision**

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

## **Exchange of Information**

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

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

## **Facility of Payment**

We may reimburse any other plan if:

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

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

## **Right of Recovery**

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

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

## **Transfer of Rights (Applicable in California)**

### **Applicability**

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

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

### **Transfer of Rights**

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

### **Covered Person Obligations**

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

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

## **REIMBURSEMENT/SUBROGATION**

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

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

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

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

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

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

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

## **COST CONTAINMENT REQUIREMENTS**

The benefits for Hospital Confinement Charges will be reduced 25% unless cost containment procedures are followed. (This 25% penalty will not exceed a Penalty Maximum of \$2,000 per Calendar Year for any one person.)

### **Hospital Preadmission Authorization**

When Hospital confinement is necessary, you will need to follow the procedures below (in order to qualify for payment of Hospital Confinement Charges at the standard rate for your plan). The procedures differ depending on the type of Hospital admission:

- FOR OTHER THAN A MEDICAL EMERGENCY

Before you enter the Hospital, you, or a family member, or your Physician must call the toll-free number of the Cost Containment Administrator (provided on your ID card), and provide the information requested.

- FOR A MEDICAL EMERGENCY

You, a family member, or your Physician must call the toll-free number of the Cost Containment Administrator and provide the information requested within two working days after you enter the Hospital, or as soon as reasonably possible.

- TO EXTEND HOSPITALIZATION

The Cost Containment Administrator will contact the Hospital on or before the anticipated date of discharge. If a longer hospitalization is anticipated, the attending Physician will be called to review a continued length of stay.

- MATERNITY DELIVERY

For most births, there is no need to call the Cost Containment Administrator. The mother and child automatically receive a two-day Hospital stay approval for a normal birth or a four-day Hospital stay approval for a cesarean section birth.

However, you must call to have the stay reviewed if:

- Complications require a Hospital stay over two days for mother and/or child for a normal birth or over four-days for a cesarean section birth.
- The mother becomes hospitalized during the pregnancy for any reason other than delivery.

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

## **Precertification of Surgery Procedures**

When you are advised that surgery may be necessary, you will need to follow the procedures below.

You, a family member, or your Physician must call the toll-free number of the Cost Containment Administrator (provided on your ID card) on any working day and provide the information requested. The call will be directed to a medical professional who will review the need for surgery with your Physician. The Cost Containment Administrator will then tell you whether a second opinion is recommended. You may elect to obtain a second opinion for any surgical procedure.

### **Steps to follow when obtaining a Second Surgical Opinion:**

- A special Second Surgical Opinion claim form is not required.
- You may call the Cost Containment Administrator or your Physician for the names of two or three second opinion Physicians--unless you already know of a qualified specialist who can provide the second opinion. The Physician who provides the second opinion should not be affiliated with any Physician who has already recommended surgery or who may be involved in performing the surgery.
- You and your Physician should decide what is the next step. If you want a third opinion, you may use the toll-free number for assistance.

You are free to follow the advice of any Physician.

Remember, if you have questions regarding any aspect of the second opinion process, just call the Cost Containment Administrator and ask for second opinion information. You will be connected with a medical professional who will help you.

## **CLAIM PROCEDURES**

### **Prompt Filing**

Completed claims, and other information needed to prove loss, should be filed with Us within 90 days after the date of loss. Proof of loss sent later will be accepted only if there is reasonable cause for the delay.

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

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

We will process your claim as quickly as possible after We have received all the required information.

If your claim has been denied, or if you have not heard from Us within 90 days after you have sent it in, you can appeal in writing and have your claim reviewed. You have at least 60 days to appeal from the time you are notified of the denial or at least 60 days from the end of the processing period, if you've heard nothing by that time.

Besides having the right to appeal, you or your authorized representative can examine any plan documents related to your claim. You can also submit, in writing, reasons why you think the claim should not be denied.

Those reviewing your claim have to act within 60 days of receiving it. However, in special cases, they may be allowed up to 180 days. The decision will be sent to you in writing, together with an explanation of how the decision was made.

The final decision as to whether a claim is payable to you is made by the Trustees in matters dealing with long term disability and medical/dental/vision benefits.

### **Physical Examinations**

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

## **Release of Medical Information**

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

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

We will keep such information confidential whenever possible but, under certain circumstances, it may be disclosed without specific authorization.

## DEFINITIONS

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

**Active Work and Actively at Work** means the active performance of all of your normal job duties at the Member's (Employer's) usual place or places of business.

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

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

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

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

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

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

**Covered Charges** will be treatment or services:

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

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

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

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

**Dependent** means:

- your spouse, if not in the Armed Forces, and not covered as an Employee; and
- your unmarried natural or legally adopted child less than 19 years of age, if not in the Armed Forces and not eligible as an Employee; and
- your unmarried natural or legally adopted child, age 19 years but less than 24 years, if not in the Armed Forces and not eligible as an Employee, provided:
  - the child is claimed as an exemption, as defined by the I.R.S. Code of the U.S., on your Federal income tax return; or
  - the child is a full-time student at an accredited school, and
- your unmarried stepchild or any child for whom you have legal guardianship, living with you, if they meet all the requirements above and We approve in writing.

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

**Durable Medical Equipment** means equipment that:

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

**Employee** means an employee of a Participating Member (Employer) whose work week is scheduled for at least 20 hours in a normal work week. Also:

- For a teacher, Employee means a teacher who is teaching at least ½ of a normal work load, as determined by the institution.
- Employee may include members of religious orders and secular priests.
- Employee does not include independent contractors, volunteers, etc., whose income from the Member (Employer) is not subject to Federal Withholding for wages or FICA.

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

**Experimental or Investigational Measures** means any confinement, treatment, service, substance, or device, regardless of any therapeutic value, not Generally Accepted by specialists in that particular field of medicine.

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

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

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

Direction and Supervision means:

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

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

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

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

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

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

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

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

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

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

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

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

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

**Hospital** means an institution that is:

- operated according to the laws pertaining to hospitals; and
- primarily and continuously engaged in providing inpatient care and treatment through medical, diagnostic, and major surgical facilities, either on its premises or in facilities available to the hospital on a prearranged basis, under the supervision of a staff of doctors and with a 24-hour nursing service; and
- licensed as a hospital by the proper authority of the state in which it is located (if licensing is required by that state); and
- under "Special Benefit Provisions - Limited", Section (III.) only, a licensed institution, other than a Hospital, with 24-hour nursing service, and under the supervision of a physician, whose primary purpose is the treatment of Mental or Nervous Disorder, Chemical Dependency, and Alcoholism;

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

**Hospital Confinement Authorization** means approval by the Cost Containment Administrator of a Physician's plan for:

- a proposed Hospital admission (for other than a Medical Emergency); or
- a Hospital admission for a Medical Emergency.

The report must be made by telephone to the Cost Containment Administrator. It must include:

- the reason for the Hospital admission and confinement; and
- the significant symptoms, physical findings, and treatment plan; and
- the procedures performed or to be performed during the Hospital confinement; and
- the estimated length of Hospital confinement.

It must be provided to the Cost Containment Administrator:

- at least one week prior to a proposed Hospital admission (for other than a Medical Emergency); or
- within two working days following a Hospital admission for a Medical Emergency, or as soon as reasonably possible.

In addition, a Hospital Confinement Authorization may be extended if additional Hospital confinement is necessary. The Cost Containment Administrator will assume the responsibility of initiating a review for extension. However, an additional Physician's report must be furnished to and approved by the Claim Administrator. The report must include:

- the reasons for requesting additional Hospital confinement; and
- the procedures to be performed during the confinement; and
- the estimated length of the additional Hospital confinement.

It must be provided to the Cost Containment Administrator prior to the expiration of the Hospital Confinement Authorization currently in force.

**Hospital Confinement Charges** means Covered Charges by a Hospital for room, board, and other usual services and by a Physician for pathology, radiology, or the administration of anesthesia while a person is confined in a Hospital. The charges must be incurred while the person is confined for a period of at least 15 consecutive hours (for any cause).

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

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

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

**Medically Necessary Care** means any confinement, treatment, or service that is prescribed by a Physician and considered by Us to be necessary and appropriate to treat an illness or injury and not in conflict with Generally Accepted medical standards.

**Medically Necessary Care (Applicable to Wellness Benefit (VI))** means any confinement, treatment, or service that is prescribed by a Physician and considered by Us to be necessary and appropriate and not in conflict with Generally Accepted medical standards.

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

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

**Other Covered State Licensed Practitioner** means a practitioner who:

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

**Partial Hospitalization or Day Treatment Program** means a structured Program approved by Us, under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health, Alcohol, or Drug Abuse Treatment Services in a Partial Hospitalization or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.

**Partial Hospitalization or Day Treatment Facility** means a Hospital (or an institution as defined under Hospital) that is licensed by the proper authority of the state in which it is located to provide a Partial Hospitalization or Day Treatment Program.

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

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

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

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

**Physician** means:

- a licensed Doctor of Medicine or Osteopathy; or
- a licensed Doctor of Podiatric medicine.

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

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

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

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

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

- the Hospital's most frequent semiprivate room rate, if the Hospital has semiprivate rooms; or
- 90% of the Hospital's most frequent private room rate, if the Hospital has no semiprivate rooms.

**Psychologist** means a person who is licensed or certified by the State in which he or she practices to provide treatment for Mental or Nervous Disorders, Chemical Dependency, or Alcoholism.

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

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

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

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

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

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

**Transplant Network Provider** means the Transplant Facilities and other providers participating in the United Resource Network's Transplant and Pediatric Transplant Network.

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

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

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

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

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

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

## **PLAN INFORMATION**

### **Plan name:**

Christian Brothers Employee Benefit Trust

### **Plan sponsor:**

Trustees of Christian Brothers Employee Benefit Trust  
c/o Christian Brothers Services  
1205 Windham Parkway  
Romeoville, IL 60446-1679

### **Plan year:**

January 1st thru December 31st

### **Plan Administrator:**

Christian Brothers Services (appointed by the Trustees)  
1205 Windham Parkway  
Romeoville, IL 60446-1679

EIN No. 36-3884439

### **Plan costs:**

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

### **Agent for service or legal process:**

Managing Director, Employee Benefit Services,  
the Christian Brothers Employee Benefit Trust  
1205 Windham Parkway  
Romeoville, IL 60446-1679

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

### **Plan benefits provided by:**

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

**Plan eligibility and benefits:**

See the Summary of Benefits and table of contents in this section of the booklet to locate description of medical benefits and eligibility requirements.

**How to file a claim:**

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

**Plan Trustees:**

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

## **PRESCRIPTION DRUG BENEFITS MANAGER**

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

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

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

**PRESCRIPTION SUMMARY OF BENEFITS  
FOR ALL ENROLLED EMPLOYEES  
AND DEPENDENTS**

**PRESCRIPTION DRUG COVERAGE**

**RETAIL NETWORK PHARMACY (Up to 30-Day Supply)**

For prescription drugs obtained at a Retail Network Pharmacy, benefits payable will be 100% of Covered Charges in excess of the copayment described below.

**Copayment**

The prescription drug copayment for prescription drugs obtained at a Retail Network Pharmacy will be the first:

- \$10 of Generic Prescription Drug Charges for each prescription and each refill; or
- \$20 of all Preferred Brand-Name Prescription Drug Charges for each prescription and each refill (as explained in the description of your “formulary” below); or
- \$40 of all Non-Preferred Brand-Name Prescription Drug Charges for each prescription and each refill.

When a Physician allows a generic substitution and you choose the Brand-Name prescription, you will be responsible for the additional difference in the copayment (\$10 or \$30) plus the difference in cost between the brand name prescription and its generic equivalent.

Prescription drugs obtained at a non-network pharmacy will be reimbursed at 80% of the Retail Network Pharmacy price, less the copayment above.

**HOME DELIVERY PHARMACY (Up to 90-Day Supply)**

Home Delivery Pharmacy prescription drug benefits payable will be 100% of Covered Charges in excess of the copayment described below.

**Copayment**

The Home Delivery Pharmacy prescription drug copayment will be the first:

- \$20 of Generic Prescription Drug Charges for each prescription and each refill; or
- \$40 of all Preferred Brand-Name Prescription Drug Charges for each prescription and each refill (as explained in the description of your “formulary” below); or
- \$80 of all Non-Preferred Brand-Name Prescription Drug Charges for each prescription and each refill.

## **YOUR PREFERRED PRESCRIPTIONS ® FORMULARY**

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

**PRESCRIPTION DRUG BOOKLET**  
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## **INTRODUCTION**

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

## **PLAN BENEFITS**

Plan Benefits are governed by the applicable benefit description booklet.

## **PLAN INTERPRETATION**

This Benefit Description booklet has been prepared with as much information as is reasonable to help you understand your benefits.

However, some terms in the Plan may require interpretation as they apply to any specific situation.

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

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

## **CONFORMITY WITH STATE MANDATES - ONLY IF MANDATES ARE APPLICABLE TO CHURCH PLANS.**

The Christian Brothers Employee Benefit Trust is a “church plan” as designated by the Internal Revenue Service and Department of Labor. There may be instances where a state mandated benefit applies to the Trust. In those instances, the Christian Brothers Employee Benefit Trust will conform to the state mandate, unless the mandated benefit would conflict with the doctrine or tenets of the Roman Catholic Church.

## **HOW TO BE COVERED**

### **ELIGIBILITY FOR ENROLLMENT**

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

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

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

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

#### **How You Enroll for Coverage**

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

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

##### **Noncontributory Coverage:**

- If no contributions are required from you for the coverage, you are covered the first day you are eligible.
- If no contributions are required from you for Dependent coverage, your Dependents will be covered on the first day you are eligible for Dependent coverage.
- All effective dates of coverage are subject to the provisions described under, "Delay of Effective Date," section below.

##### **Contributory Coverage:**

- If contributions are required from you for the coverage, you are covered on the date you make proper enrollment. If you delay your enrollment more than 31 days beyond the date you were first eligible for coverage, your coverage will be subject to, "Late Enrollment," as described below.

- If contributions are required from you for Dependent coverage, you are covered for Dependent coverage on the date you make proper enrollment for such coverage. If you delay your enrollment more than 31 days beyond the date you were first eligible for Dependent coverage, your coverage will be subject to, "Late Enrollment," as described below.
- All effective dates of coverage are subject to the provisions described under, "Delay of Effective Date," section below.

### **Delay of Effective Date**

If your coverage is to become effective on your first day of work and you do not satisfy the Active Work requirement, your coverage will be delayed until you satisfy that requirement. The Active Work requirement means the active performance of all of your normal job duties at the Member's (Employer's) usual place or places of business.

### **Late Enrollment**

If enrollment is not made within 31 days of the eligibility date, you and/or your dependent(s) will be considered Late Enrollees. For Late Enrollees, coverage will be effective the first of the month following a six month deferral period from the date enrollment is received by Us. Coverage for Late Enrollees will be subject to the Pre-Existing Conditions Limitation for a period of up to 12 months.

### **Special Enrollment**

If you or your Dependent(s) are covered by a group plan or plans provided by your Dependent's employer, and such coverage is lost involuntarily, this Plan will accept you and your Dependent(s) under conditions provided by the Plan Administrator.

The Pre-Existing Conditions Limitation may apply under this provision.

It is important that you contact your Employer immediately when such loss of coverage is imminent.

### **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

The Christian Brothers Employee Benefit Trust is subject to HIPAA. HIPAA addresses certain aspects of eligibility, enrollment and the Pre-Existing Conditions Limitation such as:

- Late Enrollment; and
- Special Enrollment; and
- coverage for pregnancy, newborn children and adopted children; and
- time limitation under the Pre-Existing Conditions Limitation.

This plan will comply with HIPAA. For details on this law, please contact your Employer.

## **ELIGIBLE DEPENDENTS**

For Prescription Drug Benefits, Dependent means:

- your spouse, if not in the Armed Forces and not eligible as an Employee; and
- your unmarried natural or legally adopted child less than 19 years of age, if not in the Armed Forces and not eligible as an Employee; and
- your unmarried natural or legally adopted child, age 19 years but less than 24 years, if not in the Armed Forces and not eligible as an Employee provided:
  - the child is claimed as an exemption, as defined by the I.R.S. Code of the U.S., on your Federal income tax return; or
  - the child is a full-time student at an accredited school; and
- your unmarried stepchild or any child for whom you have legal guardianship, living with you, if they meet all requirements above and we approve in writing.

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

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

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

### **Change in Family Status**

Once you are in the Plan, it is necessary that you promptly enroll your eligible Dependents. Also, please notify your Member (Employer) when you no longer have any eligible Dependents. If you do not enroll your Dependent within 31 days after the Dependent becomes eligible, your Dependent's coverage will be subject to the "Late Enrollment" provision.

If you have one or more covered children, you must report the names and dates of birth of any additional children. If only children are covered and a spouse becomes eligible, a report is also required. Forms are available for reporting changes in family status.

## **WHEN YOUR COVERAGE TERMINATES**

### **Termination of Coverage**

Coverage for you and your Dependents terminates when:

- your employment terminates; or
- you no longer qualify as an Employee; or
- coverage terminates on the class of employees to which you belong; or
- you discontinue required contributions; or
- your Comprehensive Lifetime Medical Benefits Maximum has been reached; or
- you cease Active Work; or
- your Member (Employer) no longer is a participant in the Trust; or
- the Plan terminates.

Coverage for a Dependent terminates when:

- your Dependent is no longer eligible for coverage; or
- your Dependent's coverage under the Plan terminates; or
- your coverage as an Employee terminates; or
- your Dependent's Comprehensive Lifetime Medical Benefits Maximum has been reached;  
or
- the Plan terminates.

### **Continuation Privilege**

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

#### **Employee and Dependent Continuation Privilege**

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

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

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

You should contact your Member (Employer) immediately to obtain the necessary forms required for continuation.

## **Retiree Prescription Drug Continuation Privilege**

If you retire at age 55 or older with at least five consecutive years of Medical coverage under the Plan prior to retirement and are receiving a Social Security retirement benefit or a retirement benefit from your Member's (Employer's) retirement plan, you may be eligible to continue your Prescription Drug coverage, and your eligible Covered Dependents Prescription Drug coverage, by paying the required contribution.

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

You should contact your Member (Employer) immediately to obtain the necessary forms for continuation.

Note: Retirees who are eligible for Medicare must have both Medicare A and B coverage. If Medicare could be in effect for a retiree, the Plan only provides benefits under the Integration with Medicare provision discussed later in this booklet.

## **PRESCRIPTION DRUG COVERAGE**

### **RETAIL NETWORK PHARMACY**

#### **Payment Conditions**

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

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

as described in the SUMMARY OF BENEFITS Section.

Benefit payments will be restricted to:

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

### **HOME DELIVERY PHARMACY**

#### **Payment Conditions**

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

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

as described in the SUMMARY OF BENEFITS Section.

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

Benefit Payment will be restricted to:

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

## **Covered Charges**

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

- Federal Legend Drugs, including self-injectables, vitamins and minerals which may be legally dispensed only upon the written prescription of a Physician; and
- Insulin and supplies for injection of insulin.

## **Limitations for Prescription Drug Coverage**

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

- a. drugs or medicines that are not for Medically Necessary Care; or
- b. drugs or medicines that are an Experimental or Investigational Measure; or
- c. drugs or medicines that can be purchased without a Physician's prescription (except those listed under Covered Charges); or
- d. any prescription or refill in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date; or
- e. any part of a charge for drugs or medicines that exceed the Retail Network Pharmacy price (Retail Network Pharmacy coverage); or
- f. drugs or medicines for DESI (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness); or
- g. injectable drugs or medicines except self-injectables; or
- h. drugs or medicines delivered or administered by the prescriber; or
- i. administration of any drug or medicine; or
- j. immunization agents, biological sera, blood, blood plasma, or any prescription directing parenteral administration or use; or
- k. drugs or medicines covered under the Medical Plan; i.e., Home Health Care Agency, etc.; or
- l. drugs or medicines dispensed by a Hospital, Skilled Nursing Facility, rest home, or other institution in which you or one of your Dependents is confined; or
- m. drugs or medicines, or any other method, to restore fertilization or promote conception; or
- n. drugs or medicines provided for cosmetic purposes; or

- o. vitamins and minerals, unless as specified under Covered Charges; or
- p. over the counter drugs; or
- q. nutritional and diet supplements; or
- r. diet or appetite suppressants, except when related to an illness and approved by Us; or
- s. contraceptives, except when related to an illness and approved by Us; or
- t. sexual dysfunction or transsexualism; or
- u. anabolic steroids, except when related to an illness and approved by Us; or
- v. any drug or medicine to promote hair growth; or
- w. any drug containing nicotine or other smoking deterrent medication.
- x. devices or appliances, support garments, and other non-medicinal substances, regardless of intended use; or
- y. drugs or medicines prescribed or dispensed by any person in your Immediate Family or any person in your Dependent's Immediate Family; or
- z. drugs or medicines purchased outside the United States unless the Covered Person is outside the United States for one of the following reasons:
  - travel, provided the travel is for a reason other than securing medical or dental care diagnosis or treatment; or
  - a business assignment; or
  - the Employee is employed by the Employer outside the United States; or
  - Full-Time Student status, provided the dependent is either:
    - enrolled and attending an accredited school in a foreign country; or
    - is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit;or
- aa. drugs or medicines for which you or your Dependent have no financial liability or that would be provided at no charge in the absence of coverage or that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law) unless charges are imposed against the Covered Person for such drugs or medicines; or
- ab. drugs or medicines provided as the result of an injury arising out of or in the course of any self-employment for wage or profit; or

- ac. drugs or medicines provided as the result of a sickness covered by a Workers' Compensation Act or other similar law; or
- ad. drugs or medicines provided as the result of a sickness or injury that is due to war or act of war or to voluntary participation in criminal activities; or
- ae. drugs or medicines purchased after termination of coverage under this Plan.

## **Brand Name versus Generic**

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

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

## **90 Day Supplies**

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

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

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

### The Written Prescription

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

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

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

### Patient Profile/Order Form

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

### Copayment

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

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

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

### **Special Situations**

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

### **Questions**

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

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

## **COORDINATION WITH OTHER BENEFITS**

Your Prescription Drug program does not coordinate benefits with any other plan or program.

## **REIMBURSEMENT/SUBROGATION**

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

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

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

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

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

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

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

## **TRANSFER OF RIGHTS**

**(Applicable in California)**

### **Applicability**

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

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

### **Transfer of Rights**

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

### **Covered Person Obligations**

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

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

## DEFINITIONS

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

**Active Work and Actively at Work** means the active performance of all of your normal job duties at the Member's (Employer's) usual place or places of business.

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

**Dependent** means:

- your spouse, if not in the Armed Forces and not eligible as an Employee; and
- your unmarried natural or legally adopted child less than 19 years of age, if not in the Armed Forces and not eligible as an Employee; and
- your unmarried natural or legally adopted child, age 19 years but less than 24 years, if not in the Armed Forces and not eligible as an Employee, provided:
  - the child is claimed as an exemption as defined under the I.R.S. Code of the U.S. on your Federal income tax return; or
  - the child is a full-time student at an accredited school, and
- your unmarried stepchild or any child for whom you have legal guardianship, living with you, if they meet all the requirements above and we approve in writing.

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

**Employee** means an employee of a Participating Member (Employer) whose work week is scheduled for at least 20 hours in a normal work week:

- For a teacher, Employee means a teacher who is teaching at least ½ of a normal work load, as determined by the institution.
- Employee may include members of religious orders and secular priests.
- Employee does not include independent contractors, volunteers, etc., whose income from the Member (Employer) is not subject to Federal Withholding for wages or FICA.

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

**Experimental or Investigational Measures** means any confinement, treatment, service, substance, or device, regardless of any therapeutic value, not Generally Accepted by specialists in that particular field of medicine.

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

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

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

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

**Direction and Supervision** means:

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

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

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

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

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

**Medically Necessary Care** means any confinement, treatment, or service that is prescribed by a Physician and considered by Us to be necessary and appropriate to treat an illness or injury and not in conflict with Generally Accepted medical standards.

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

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

**Physician** means:

- a licensed Doctor of Medicine or Osteopathy; or
- a licensed doctor of Podiatric Medicine.

**Physical Handicap** means a Dependent child's substantial physical or mental impairment which results from injury, accident, congenital defect, or sickness.

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

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

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

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

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

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

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

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

## **PLAN INFORMATION**

### **Plan name:**

The Christian Brothers Employee Benefit Trust

### **Plan sponsor:**

Trustees of Christian Brothers Employee Benefit Trust  
c/o Christian Brothers Services  
1205 Windham Parkway  
Romeoville, IL 60446-1679

### **Plan year:**

January 1 thru December 31

### **Plan Administrator:**

Christian Brothers Services (appointed by the Trustees)  
1205 Windham Parkway  
Romeoville, IL 60446-1679

EIN No. 36-3884439

### **Plan costs:**

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

### **Agent for service or legal process:**

Managing Director, Employee Benefit Services,  
the Christian Brothers Employee Benefit Trust  
1205 Windham Parkway  
Romeoville, IL 60446-1679

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

### **Plan benefits provided by:**

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

**Plan eligibility and benefits:**

See the Summary of Benefits and table of contents in this section of the booklet to locate description of benefits and eligibility requirements.

**Plan Trustees:**

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

**DENTAL  
PREFERRED PROVIDER ORGANIZATION (PPO)**

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

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



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

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

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**BENEFIT ADVICE**

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

**1-800-807-0400**

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

**DENTAL SUMMARY OF BENEFITS  
FOR EMPLOYEES AND  
ENROLLED DEPENDENTS**

**DENTAL BENEFITS**

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

**Maximum Dental Payment Limits**

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

**Dental Benefits Payable**

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

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

**Deductible Requirements**

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

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

**Family Limit**

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

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

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

**BENEFIT ADVICE**

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

**1-800-807-0400**

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

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## **INTRODUCTION**

### **PLAN BENEFITS**

Plan Benefits are governed by the applicable benefit description booklet.

### **PLAN INTERPRETATION**

This Benefit Description booklet has been prepared with as much information as is reasonable to help you understand your benefits.

However, some terms in the Plan may require interpretation as they apply to any specific situation.

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

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

### **CONFORMITY WITH STATE MANDATES - ONLY IF MANDATES ARE APPLICABLE TO CHURCH PLANS**

The Christian Brothers Employee Benefit Trust is a “church plan” as designated by the Internal Revenue Service and Department of Labor. There may be instances where a state mandated benefit applies to the Trust. In those instances, the Christian Brothers Employee Benefit Trust will conform to the state mandate, unless the mandated benefit would conflict with the doctrine or tenets of the Roman Catholic Church.

## **HOW TO BE COVERED**

### **ELIGIBILITY FOR ENROLLMENT**

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

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

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

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

#### **How You Enroll for Coverage**

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

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

##### **Noncontributory Coverage:**

- If no contributions are required from you for the coverage, you are covered the first day you are eligible.
- If no contributions are required from you for Dependent coverage, your Dependents will be covered on the first day you are eligible for Dependent coverage.
- All effective dates of coverage are subject to the provisions described under, "Delay of Effective Date," section below.

##### **Contributory Coverage:**

- If contributions are required from you for the coverage, you are covered on the date you make proper enrollment. If you delay your enrollment more than 31 days beyond the date you were first eligible for coverage, your coverage will be subject to Deferred Coverage Limits.

- If contributions are required from you for Dependent coverage, you are covered for Dependent coverage on the date you make proper enrollment for such coverage. If you delay your enrollment more than 31 days beyond the date you were first eligible for Dependent coverage, your coverage will be subject to Deferred Coverage Limits.
- All effective dates of coverage are subject to the provisions described under, "Delay of Effective Date," section below.
- If you fail to make proper contributions as required by your Member (Employer), subsequent enrollments will be subject to Deferred Coverage Limits.

### **Delay of Effective Date**

If your coverage is to become effective on your first day of work and you do not satisfy the Active Work requirement, your coverage will be delayed until you satisfy that requirement. The Active Work requirement means the active performance of all of your normal job duties at the Member's (Employer's) usual place or places of business.

### **Late Enrollment**

If enrollment is not made within 31 days of the eligibility date, you and/or your dependent(s) will be considered Late Enrollees. For Late Enrollees, coverage will be effective the first of the month following a six month deferral period from the date enrollment is received by Us. Coverage for Late Enrollees will be subject to Deferred Coverage Limits for a period of up to 12 months from the effective date.

### **Special Enrollment**

If you or your Dependent(s) are covered by a group plan or plans provided by your Dependents' employer, and such coverage is lost involuntarily, this Plan will accept you and your Dependent(s) under conditions provided by the Plan Administrator.

It is important that you contact your Employer immediately when such loss of coverage is imminent.

## **ELIGIBLE DEPENDENTS**

Dependent means:

- your spouse, if not in the Armed Forces and not eligible as an Employee; and
- your unmarried natural or legally adopted child less than 19 years of age, if not in the Armed Forces and not eligible as an Employee; and
- your unmarried natural or legally adopted child, age 19 years but less than 24 years, if not in the Armed Forces and not eligible as an Employee provided:
  - the child is claimed as an exemption, within the meaning of the IRS code of the U.S. on your Federal income tax return; or
  - the child is a full-time student at an accredited school; and
- your unmarried stepchild or any child for whom you have legal guardianship, living with you, if they meet all requirements above and We approve in writing.

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

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

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

### **Change in Family Status**

Once you are in the Plan, it is necessary that you promptly enroll your first eligible Dependents. Also, please notify your Member (Employer) when you no longer have any eligible Dependents. If you do not enroll your first Dependent within 31 days after the Dependent becomes eligible, your Dependent's coverage will be subject to the "Late Enrollment" provision.

If you have one or more covered children, you must report the names and dates of birth of any additional children. If only children are covered and a spouse becomes eligible, a report is also required. Forms are available for reporting changes in family status.

## **WHEN YOUR COVERAGE TERMINATES**

### **Termination of Coverage**

Coverage for you terminates when:

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

Coverage for your Dependent terminates when:

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

### **Continuation Privilege**

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

#### **Employee and Dependent Continuation Privilege**

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

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

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

You should contact your Member (Employer) immediately to obtain the necessary forms required for continuation.

## **Retiree Dental Continuation Privilege**

If you retire at age 55 or older with at least five consecutive years of Dental Coverage under the Plan prior to retirement and are receiving a Social Security retirement benefit or a retirement benefit from your Member's (Employer's) retirement plan, you may be eligible to continue your Dental coverage, and your eligible Covered Dependents Dental coverage, by paying the required contribution.

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

You or your eligible Covered Dependents should contact your Member (Employer) immediately to obtain the necessary forms required for continuation.

Note: Retirees who are eligible for Medicare must have both Medicare A and B coverage. If Medicare could be in effect for a retiree, the Plan only provides benefits under the Integration with Medicare provision discussed later in this booklet.

## **DESCRIPTION OF DENTAL BENEFITS**

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

### **Maximum Dental Payment Limit**

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

### **Dental Payment Qualification**

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

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

### **Dental Benefits Payable**

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

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

### **Deductible Requirement**

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

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

### **Family Limit on Deductible**

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

## **DENTAL COVERED CHARGES**

### **Dental Payment Conditions**

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

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

as described in the Dental Summary of Benefits section.

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

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

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

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

### **Covered Charges**

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

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

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

### **Beginning Date for Treatment or Service**

Treatment or Service will be considered to begin:

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

### **Completion Date for Treatment or Service**

Treatment or Service will be considered to be completed:

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

## **SCHEDULE OF DENTAL PROCEDURES**

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

### **Dental Care Unit 1 - Diagnostic and Preventive Procedures**

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

#### **Dental Procedure**

##### **Examinations**

Oral Examination (evaluation)  
Periodic Examination (evaluation)

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

##### **Emergency Examination**

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

##### **Radiographs**

###### **Full Mouth Survey**

Complete series (including bitewings)  
Panoramic

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

###### **Bitewing**

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

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

Occlusal  
Periapical

## Extraoral X-Rays

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

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

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

## Preventive Services

Prophylaxis (cleaning of teeth)

Covered once in any six consecutive months.

Topical application of fluoride

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

Space maintainers

Applicable only to Dependent children under age 16.

Topical application of sealants

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

## Other Services

Biopsy of oral tissue  
Palliative treatment

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

Histopathologic examination

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

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

### **Dental Procedure**

#### **Restorations**

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

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

Stainless steel crown

#### **Oral Surgery**

Extraction of teeth

Alveoloplasty

Removal of dental cysts and tumors

Surgical incision and drainage of dental abscess

#### **Other surgical procedures**

Tooth reimplantation

Surgical exposure to aid eruption

Surgical repositioning of teeth

Excision of hyperplastic tissue

#### **Periodontic Services**

Scaling and root planing (each quadrant)

Covered once each quadrant in any 24 consecutive months.

Periodontal appliance

One appliance is covered in any 36 consecutive months.

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

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

### **Periodontal Surgical Procedures**

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

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

### **Endodontic Services**

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

### **Anesthesia**

General anesthesia  
IV Sedation

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

### **Other Services**

Repairs to bridges and complete or partial dentures  
Adding tooth to partial denture

Relining or rebasing complete or partial denture (upper or lower)

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

Tissue Conditioning

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

Denture Adjustment

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

Recementing

Inlay

Onlay

Crown

Bridge

Space maintainer

Consultation with specialist

Antibiotic drug injection

Pulp vitality test

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

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

### **Dental Procedure**

#### **Restorations**

##### **Inlays and onlays**

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

##### **Labial Veneers**

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

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

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

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

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

Cast post and core

Covered only for teeth that have had root canal therapy.

Steel post and composite or amalgam

Covered only for teeth that have had root canal therapy.

### **Prosthodontics, Fixed**

Fixed Bridges - initial placement or replacement

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

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

### **Prosthodontics, Removable**

Complete or partial dentures - initial placement or replacement

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

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

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

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

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

## LIMITATIONS OF DENTAL BENEFITS

Dental benefits will not be paid for:

- a. treatment, service, or material that is not for Necessary Dental Care; or
- b. any part of a charge for Treatment or Service that exceeds Prevailing Charges; or
- c. the services of any person who is not a Dentist or Dental Hygienist; or
- d. the services of any person in your Immediate Family or any person in your Dependent's Immediate Family; or
- e. personalization of dentures or crowns; or
- f. treatment, service, or material that does not meet professionally recognized standards or that is Experimental or Investigational Measures; or
- g. treatment, service, or material for implants; or
- h. drugs and medicines (except for antibiotic injections); or
- i. bite registration or occlusal analysis; or
- j. instruction for plaque control, oral hygiene, or diet; or
- k. Treatment or Service to alter or maintain vertical dimension or restore or maintain occlusion; or
- l. Treatment or Service to duplicate or replace a lost or stolen prosthetic device; or
- m. Treatment or Service that is temporary; or
- n. treatment, service, or material excluded under the section Deferred Coverage Limits, or
- o. dental care (a) due to orthodontics, or (b) primarily for cosmetic purposes; or
- p. Treatment or Service covered under the Comprehensive Medical Benefits Plan; or

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

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

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

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

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

You or a Dependent will qualify if:

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

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

## **COORDINATION WITH OTHER BENEFITS**

### **Dental Expense Coverage**

#### **Intent**

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

#### **Definitions**

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

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

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

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

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

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

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

## Effect on Benefits

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

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

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

## Order of Benefit Determination

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

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

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

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

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

Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules for Dependent children of parents who are not separated or divorced.

- Active/Inactive Employee. The benefits of a Plan which covers a person as an Employee who is neither laid off nor retired, or as that Employee's Dependent, are determined before the benefits of a Plan which covers that person as a laid-off or retired Employee or as that Employee's Dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.
- Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an Employee, Member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.
- Automatic Coverage for a Newborn Child. When This Plan and another Plan both provide benefits, the benefits of the other Plan will be determined before the benefits payable under the Automatic Coverage for a Newborn Child provision of This Plan.
- Continuation/Extension of Benefits. When This Plan and another Plan both provide benefits, the benefits of the plan covering the person as an employee, member or subscriber, or as that person's dependent, will be determined before the benefits payable under This Plan's Extension of Benefits.

## **Medicare Rules**

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

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

## **Medicare Exception**

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

Federal law will usually apply in such instances if:

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

## **Integration With Medicare**

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

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

It works this way:

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

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

## **Coordination with HMOs**

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

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

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

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

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

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

## **Exchange of Information**

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

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

## **Facility of Payment**

We may reimburse any other plan if:

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

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

## **Right of Recovery**

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

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

## **Transfer of Rights**

### **(Applicable in California):**

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

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

## **Transfer of Rights**

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

## **Covered Person Obligations**

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

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

## **REIMBURSEMENT/SUBROGATION**

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

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

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

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

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

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

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

## **CLAIM PROCEDURES**

### **Prompt Filing**

Completed claims and other information needed to prove loss should be sent to Us within 90 days after the date of loss. Proof of loss sent later will be accepted only if there is reasonable cause for the delay.

*All Claims Must Be Received by Us Within One Year from the Date of Loss to Be Eligible for Benefit Consideration.*

### **Dental Treatment Plan**

When charges for a Period of Dental Treatment (other than emergency treatment) are expected to exceed \$300, a Dental Treatment Plan must be filed with Us before treatment begins. A form is available for this purpose. Upon receipt of the Dental Treatment Plan, We will indicate the benefits payable for the proposed treatment and return the form to the attending Dentist.

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

We will process your claim as quickly as possible after We have received all the required information.

If your claim has been denied, or if you have not heard from Us within 90 days after you have sent it in, you can appeal in writing and have your claim reviewed. You have at least 60 days to appeal from the time you are notified of the denial or at least 60 days from the end of the processing period, if you've heard nothing by that time.

Besides having the right to appeal, you or your authorized representative can examine any plan documents related to your claim. You can also submit, in writing, reasons why you think the claim should not be denied.

Those reviewing your claim have to act within 60 days of receiving it. However, in special cases, they may be allowed up to 180 days. The decision will be sent to you in writing, together with an explanation of how the decision was made.

The final decision as to whether a claim is payable to you is made by the Trustee in matters dealing with long term disability and medical/dental benefits.

### **Dental Examinations**

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

## DEFINITIONS

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

**Active Work and Actively at Work** means the active performance of all of an Employee's normal occupation duties at the Member's (Employer's) usual place or places of business.

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

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

**Dental Hygienist** means a person who works under the supervision of a Dentist and is licensed to practice dental hygiene.

**Dental Treatment Plan** means the Dentist's report of proposed treatment which:

- is written on a form provided by Us; and
- lists the procedures required for the Period of Dental Treatment; and
- shows the charges for each procedure; and
- is accompanied by any diagnostic materials that We might require.

**Dentist** means:

- a person licensed to practice dentistry; and
- a licensed Physician who provides dental Treatment or Service.

**Dependent** means:

- your spouse, if not in the Armed Forces, and not eligible as an Employee; and
- your unmarried natural or legally adopted child less than 19 years of age, if not in the Armed Forces and not eligible as an Employee; and
- your unmarried natural or legally adopted child, age 19 years but less than 24 years, if not in the Armed Forces and not eligible as an Employee, provided:
  - the child is claimed as an exemption, within the meaning of the IRS code of the U.S. on your Federal income tax return; or
  - the child is a full-time student at an accredited school, and
- your unmarried stepchild or any child for whom you have legal guardianship, living with you, if they meet all the requirements above and we approve in writing.

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

**Employee** means an employee of a Participating Member (Employer) whose work week is scheduled for at least 20 hours in a normal work week:

- For a teacher, Employee means a teacher who is teaching at least ½ of a normal work load, as determined by the institution.
- Employee may include members of religious orders and secular priests.
- Employee does not include independent contractors, volunteers, etc., whose income from the Member (Employer) is not subject to Federal Withholding for wages or FICA.

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

**Experimental or Investigational Measures** mean any Treatment or Service, regardless of any claimed therapeutic value not generally accepted by specialists in that particular field of medicine or dentistry, as determined by the Claims Administrator.

**Functioning Natural Tooth** means a Natural Tooth which is performing its normal role in the chewing process in the covered person's upper or lower arch and which is opposed in the person's other arch by another Natural Tooth or prosthetic (i.e. artificial) replacement.

**Hospital** means an institution that is:

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

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

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

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

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

**Natural Tooth** means any tooth or part of a tooth that is organic and formed by the natural development of the body (i.e. not manufactured).

**Necessary Dental Care** means any treatment, service, or materials prescribed by a Dentist and considered by Us to be:

- necessary and appropriate; and
- not Experimental or Investigational Measures and not in conflict with accepted dental standards.

**Period of Dental Treatment** means all sessions of dental care that result from the same initial diagnosis and any related complications.

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

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

**Physician** means a licensed Doctor of Medicine or Osteopathy.

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

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

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

**Required Contribution/Contributions** means the amount of monies required to make coverage effective. The amount is decided by Us, from time to time.

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

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

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

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

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

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

## **PLAN INFORMATION**

### **Plan name:**

The Christian Brothers Employee Benefit Trust

### **Plan sponsor:**

Trustees of Christian Brothers Employee Benefit Trust  
c/o Christian Brothers Services  
1205 Windham Parkway  
Romeoville, IL 60446-1679

### **Plan year:**

January 1st thru December 31

### **Plan Administrator:**

Christian Brothers Services (appointed by the Trustees)  
1205 Windham Parkway  
Romeoville, IL 60446-1679

EIN No. 36-3884439

### **Plan costs:**

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

### **Agent for service or legal process:**

Managing Director, Employee Benefit Services,  
the Christian Brothers Employee Benefit Trust  
1205 Windham Parkway  
Romeoville, IL 60446-1679

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

### **Plan benefits provided by:**

Dental benefits are provided through the Christian Brothers Employee Benefit Trust

**Plan eligibility and benefits:**

See the Summary of Benefits and table of contents in this section of the booklet to locate description of dental benefits and eligibility requirements.

**How to file a claim:**

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

**Plan Trustees:**

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