PLAN DOCUMENT
AND SUMMARY PLAN DESCRIPTION

DIOCESE OF YAKIMA
HEALTH CARE BENEFITS PLAN

STANDARD PLAN

EFFECTIVE NOVEMBER 1, 2020

TPSC GROUP # 46270

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MEDICAL SUMMARY OF BENEFITS – STANDARD PLAN

This summary is provided as a highlight of health care plan benefits available to eligible Employees. If you have questions about your coverage, see your Summary Plan Description (SPD) or contact TPSC Member Services at (800) 426-9786.

BENEFIT PERIOD	Calendar Year	
BENEFIT LIMITATION	Services from Non-Preferred Providers are limited to a Usual & Customary and/or Reasonable (UCR) allowance.	
PRE-CERTIFICATION *See your Summary Plan Description (SPD) for details.*	Pre-certification is required for all Hospital admissions and certain outpatient surgeries and services. Call American Health Holding (AHH) at (888) 877-7994 before proceeding with these services.	
LIFETIME MAXIMUM BENEFIT	Unlimited	
	PREFERRED PROVIDER	**NON-PREFERRED PROVIDER**
MEDICAL DEDUCTIBLE *Applies to all services unless otherwise noted.*	**$1,000** Individual/**$2,000** Family per Calendar Year	
MEDICAL OUT-OF-POCKET MAXIMUM *Benefits are increased to 100% payment if Out-of-Pocket expenses for allowable Deductibles, Coinsurance, and Copays reach these amounts. Includes maternity out-of-pocket maximum.*	**$5,000** Individual/**$10,000** Family per Calendar Year	**$7,500** Individual/**$15,000** Family per Calendar Year
NOTE: *Allowed medical expenses apply to both Preferred Provider and Non-Preferred Provider Out-of-Pocket Maximums.*		
MATERNITY OUT-OF-POCKET MAXIMUM *Maternity Preferred Provider Out-of-Pocket expenses are limited to $3,000 for members who participate in the **Maternity Education Program**.*	**$3,000** Individual	*Charges from Non-Preferred Providers do not accrue to the Maternity Out-of-Pocket Maximum.*
OUTPATIENT PRESCRIPTION DRUG DEDUCTIBLE	**$100** Individual/**$300** Family per Calendar Year	
OUTPATIENT PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM—*Benefits are increased to 100% payment if Prescription Drug Deductibles, Copays and Coinsurance reach these amounts.*	**$1,850** Individual/**$3,700** Family per Calendar Year	
PRIMARY BENEFITS		
I. PHYSICIAN SERVICES		
Inpatient		
Hospital Visit	Paid at 80%	Paid at 60%
Surgery	Paid at 80%	Paid at 60%
Outpatient		
Office Visit/Urgent Care	**Deductible Waived, $25** Copay	Paid at 60%
Specialist/Second Surgical Opinions	**Deductible Waived, $50** Copay	Paid at 60%
Office X-ray and Lab	**Deductible Waived,** Paid at 100%	Paid at 60%
Outpatient/Office Surgery	Paid at 80%	Paid at 60%
II. PREVENTIVE CARE SERVICES—*For a list of preventive care services, see http://tpscbenefits.com/preventive-care-services.*		
Preventive Care Services *Excludes birth control, contraception counseling and related prescription drugs.*	**Deductible Waived,** Paid at 100%	Paid at 60%
III. HOSPITAL SERVICES		
Inpatient		
Room and Board	Paid at 80%	Paid at 60%
Intensive Care & Coronary Care Units	Paid at 80%	Paid at 60%
Hospital Miscellaneous Expenses	Paid at 80%	Paid at 60%
Outpatient		
Outpatient Department (Non-surgical)	Paid at 80%	Paid at 60%
Outpatient Surgical Dept./Ambulatory Surgical Center	Paid at 80%	Paid at 60%
Emergency Room		
Services and Supplies	Paid at 80%	Paid at 80%
X-ray and Lab	Paid at 80%	Paid at 80%

MEDICAL SUMMARY OF BENEFITS – STANDARD PLAN (continued)

PRIMARY BENEFITS (continued)	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
IV. DIAGNOSTIC SERVICES—*Includes interpretations; non-routine/non-preventive scans, imaging and labs; non-routine cancer screenings.*		
Inpatient—*Includes Lab & Radiology.*	Paid at 80%	Paid at 60%
Outpatient—*Includes Hospital Outpatient and independent laboratories.*		
Lab	**Deductible Waived,** Paid at 100%	Paid at 60%
Radiology	Paid at 80%	Paid at 60%
Sleep Studies	Paid at 80%	Paid at 60%
V. MATERNITY CARE—*Limited to Employees & Spouses only.*		
Initial Prenatal Visit	**Deductible Waived, $25** Copay	Paid at 60%
Professional Services *(Visits and Delivery)*	Paid at 80%	Paid at 60%
Inpatient Facility/Birthing Center	Paid at 80%	Paid at 60%
VI. CHEMICAL DEPENDENCY & MENTAL HEALTH TREATMENT		
Inpatient Facility/ Physician Services	Paid at 80%	Paid at 60%
Outpatient Facility Services	Paid at 80%	Paid at 60%
Outpatient Physician Services	**Deductible Waived, $50** Copay	Paid at 60%
VII. HOME HEALTH CARE *Limited to 100 visits per Calendar Year.*	Paid at 80%	Paid at 60%
VIII. HOSPICE—*Limited to 180 days per Calendar Year.*		
Inpatient/Outpatient	Paid at 80%	Paid at 60%
IX. OUTPATIENT PRESCRIPTION DRUGS	**MAXORPLUS PHARMACIES**	**NON-MEMBER PHARMACIES**
Retail—*Limited to a 30-day supply.*		
Generic Drug	**$ 10** Copay	**$10** Copay plus 20% Coinsurance*
Formulary Brand Name Drug	**$ 25** Copay	**$25** Copay plus 20% Coinsurance*
Non-Formulary Brand Name Drug	**$ 50** Copay	**$50** Copay plus 20% Coinsurance* **Limited to Maxor's allowable charge for the drug.*
Mail-Order—*Limited to a 90-day supply.*		
Generic Drug	**$ 25** Copay	Not available
Formulary Brand Name Drug	**$ 60** Copay	Not available
Non-Formulary Brand Name Drug	**$125** Copay	Not available
Specialty Drugs—*Limited to a 30-day supply.*		
Generic Drug—*Participant's cost limited to 10% up to maximum of $150 per Prescription.*	Paid at 90%	
Formulary Brand Name Drug—*Participant's cost limited to 20% up to maximum of $150 per Prescription.*	Paid at 80%	
Non-Formulary Brand Name Drug—*Participant's cost limited to 20% up to maximum $250 per Prescription.*	Paid at 80%	
NOTE: *Retail purchases for maintenance prescriptions may be limited to an initial fill and two subsequent refills. Additional retail purchases will cost the Mail-Order Copay and be limited to a 30-day supply.*		
X. SKILLED NURSING FACILITY—*Limited to 120 days per Incident (i.e., same Illness or Injury).*	Paid at 80%	Paid at 60%
XI. TRANSPLANTS	Paid at 80%	Paid at 60%
XII. OTHER BENEFITS		
Ambulance	Paid at 80%	Paid at 80%
Cardiac & Pulmonary Rehabilitation	Paid at 80%	Paid at 60%
Diabetic Care Training *Limited to three (3) visits per Calendar Year.*	Paid at 80%	Paid at 60%
Durable Medical Equipment (DME), Medical Supplies, Prosthetic & Orthopedic Appliances	Paid at 80%	Paid at 60%
Foot Orthotics *Limited to $500 per Calendar Year.*	Paid at 80%	Paid at 60%
Home Infusion Therapy	Paid at 80%	Paid at 60%

MEDICAL SUMMARY OF BENEFITS – STANDARD PLAN (continued)

XII. OTHER BENEFITS (continued)	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Inpatient Rehabilitation	Paid at 80%	Paid at 60%
Manipulations & Related Modalities—*Includes Acupuncture, Chiropractic, Massage, or Osteopathic treatments.*		
Limited to $1,000 per Calendar Year for all modalities combined.	Paid at 80%	Paid at 60%
Natural Family Planning *Limited to $200 per Calendar Year.*	**Deductible Waived,** Paid at 100%	**Deductible Waived,** Paid at 100%
Nutritional Counseling—*Limited to three (3) visits per Calendar Year.*	Paid at 80%	Paid at 60%
Outpatient Dialysis Treatment—*For more information, see OUTPATIENT DIALYSIS PROGRAM in the* ***DEFINITIONS*** *section of your SPD.*	Paid at 80%	Paid at 60%
Outpatient Habilitative Services—*Includes Occupational, Physical & Speech Therapies.*	Paid at 80%	Paid at 60%
Outpatient Rehabilitation—*Includes Occupational, Physical and Speech Therapies.*	Paid at 80%	Paid at 60%
PKU	Paid at 80%	Paid at 60%
Temporomandibular Jaw Disorder (TMJ) *Limited to $1,000 per Calendar Year; $5,000 per Lifetime.*	Paid at 80%	Paid at 60%
Eligible Non-Listed Services	Paid at 80%	Paid at 60%

INTRODUCTION

Diocese of Yakima, hereinafter referred to as the "Company," as the Plan Sponsor, hereby establishes the benefits, rights and privileges which shall pertain to participating Employees, hereinafter referred to as "Participants" or "Covered Persons," and the eligible dependents of such Participants.

Masculine pronouns used in this Plan Document shall include masculine or feminine gender unless the context indicates otherwise. Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

PURPOSE

The purpose of the Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of Covered Medical and Prescription Drug Expenses. This Plan Document will also serve as the Summary Plan Description.

APPLICABLE LAW

This Plan is established and maintained by a church ("church plan") for the benefit of its Employees. Although subject to other federal laws as described below, a church plan is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (ERISA) and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

The Plan provides coverage and benefits in accordance with the requirements of all applicable provisions of the Uniformed Services and Employment and Reemployment Rights Act of 1994 (USERRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996 (NMHP), the Women's Health and Cancer Rights Act of 1998, (WHCRA), the Family and Medical Leave Act of 1993 (FMLA), the Mental Health Parity and Addiction Equity Act (MHPAEA), Michelle's Law, the Health Information Technology for Economic and Clinical Health Act (HITECH), Title I of the Genetic Nondiscrimination Act of 2008, and the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act" or ACA).

As a religious employer, the Plan Sponsor is exempt from providing coverage for contraception as mandated preventive care services under section 2713 of the Public Health Service Act (PHS Act). See MEDICAL EXCLUSIONS AND LIMITATIONS for other services that are not covered by this Plan.

EFFECTIVE DATE

The Effective Date of the Plan is November 1, 2016. This Plan Document was restated effective November 1, 2018, and has been amended, as follows:

Amendment # 1 (effective November 1, 2019); and

Amendment # 2 (effective January 1, 2020); and

Amendment # 3 (effective November 1, 2020).

PLAN SPONSOR

The Plan Sponsor is the Company, whose business address[1] and telephone number is:

Diocese of Yakima

Physical Address:	*Mailing Address*:
101 S 12th Avenue	PO Box 2189
Yakima, WA 98902	Yakima, WA 98907
Phone: (509) 965-7117	

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary and Plan Administrator is the Company, whose street address and telephone number is:

Same as above.

[1] Effective September 1, 2020.

CONTRIBUTIONS

Employees may be required to pay a portion of the cost of coverage for themselves and their eligible dependents. The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis. The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor to the extent allowed by applicable law.

The amount of contributions to the Plan is to be made on the following basis:

1. The Plan Sponsor shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Plan Sponsor (if any) and the amount to be contributed (if any) by each Participant. Any amounts paid by the Plan Sponsor shall be paid out of its general assets.

2. Notwithstanding any other provision of the Plan, the Plan Sponsor's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Plan Sponsor's obligation with respect to such payments.

3. In the event that the Plan Sponsor terminates the Plan, then as of the Effective Date of termination, the Plan Sponsor and Participants shall have no further obligation to make additional contributions to the Plan.

PROTECTION AGAINST CREDITORS

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan will not be deemed to constitute a contract of employment or give any Employee of the Company the right to be retained in the service of the Company or to interfere with the right of the Company to discharge or otherwise terminate the employment of any Participant.

ELIGIBILITY

WHO MAY RECEIVE BENEFITS

Benefits are provided to Eligible Employees of the Company and their Eligible Dependents. New Employees (and their Dependents) are eligible to participate in the Plan on the first day of the month following a New Employee's date of hire.

EMPLOYEES

"Employee" means an individual classified by the Employer as a common law employee of the Employer, determined in accordance with rules and regulations issued by the Internal Revenue Service. Such term shall not include individuals classified by an Employer as independent contractors (including any person who later becomes reclassified as an employee by the Internal Revenue Service or a court of competent jurisdiction). Any individual who pays or agrees to pay self-employment tax in lieu of withholding shall be deemed to be an independent contractor.

Eligible Employees include:

Full-time Employees. Regular, full-time employees reasonably expected to work at least 30 hours per week.

Part-time Employees. Part-time employees who are reasonably expected to work less than 30 hours per week, but who work at least 20 hours per week.

Academic Employees. An employee who teaches no less than one-half of a regular, full-time academic employee.

Seminarians.

NOTE:

- ✓ **Eligibility for Medicare Limits Medical Benefits**. If a retiree is eligible to enroll for Medicare, the benefits of this Plan will be reduced by the amounts payable by Medicare Parts A and B, whether or not the individual actually enrolls for coverage under Medicare.
- ✓ **Enrollment in Medicare Part D Terminates Prescription Drug Benefits**. If a retiree **enrolls** in Medicare Part D (prescription drug coverage), then the Outpatient Prescription Drug benefit under this Plan **ceases**.

See "Coordination with Medicare" below for additional information about your benefits if you are eligible or covered by Medicare.

Ineligible Employees. Part-time Employees who work less than 20 hours per week and temporary Employees are not eligible to participate in the Plan.

Individuals who are working in violation of U.S. immigration laws or those individuals who have made false representations of any kind in order to obtain employment are also excluded from eligibility for participation in the Plan. Any loss of coverage resulting from this situation will not be a qualifying event for Continuation Coverage Rights under COBRA.

DEPENDENTS

An Eligible Employee must be enrolled in the Plan for a dependent to also be covered. Dependents may enroll only in the same benefits in which the Employee has enrolled. However, a Dependent is not required to enroll in all of the benefits in which the Employee has enrolled.

Eligible Dependents include:

Spouses. Spouse means the lawful spouse of an Employee, unless legally separated or divorced. The Plan Administrator may require documentation establishing a legal marital relationship. Common law marriages are not recognized under this Plan. A Spouse shall be a "dependent" for purposes of this Plan.

Children. Children include any eligible child under age 26, regardless of financial dependency, residency with a parent, marital status, or student status. An eligible Child shall include the following:

1. Natural or legally adopted children (including any child placed in the home during a probationary period prior to the adoption);
2. Step-children;
3. Foster children or any other child for whom the Employee is the court-appointed legal guardian;

4. Eligible children for whom the Employee is required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN); *see* the section titled **FEDERAL LAWS AND REGULATIONS**, subsection QUALIFIED MEDICAL CHILD SUPPORT ORDER for additional information;

5. Continued eligibility for children with a physical or mental impairment—Coverage may continue beyond the limiting age for children described above who are unable to support themselves because of a developmental or physical disability with no age limitation if the following has been met:

    a. The child became disabled before reaching the limiting age; and

    b. The child is incapable of self-sustaining employment by reason of a developmental or physical impairment and is chiefly dependent upon the subscriber for support and maintenance; and

    c. The Employee is covered under this plan; and

    d. The child's required contribution for coverage, if any, continues to be paid; and

    e. Within 31 days of the child reaching the limiting age or the child's original effective date under this Plan, whichever is later, the Employee furnishes the Claims Administrator documentation of the disability form the child's primary medical Physician. The Claims Administrator must approve the request for certification for coverage to continue; and

    f. The Employee provides the Claims Administrator with proof of the child's disability and dependent status within 90 days of when we request it. Proof will not be required more often than once a year following the child's attainment of the limiting age; and

    g. The child is the Employee's tax dependent as defined by the IRS.

NOTE:

- ✓ If both Spouses are Employees, each Spouse may be covered only as an Employee and not as a Dependent (Spouse) of the other.
- ✓ If both parents of a Dependent Child(ren) are Employees, the Child(ren) may be covered as a Dependent of either parent, but not both.

EFFECTIVE DATE OF COVERAGE

HOW TO ENROLL

Within 31 days of Eligibility, an Employee must properly complete plan enrollment forms to be covered by this Plan. Enrollment forms may be obtained at the Human Resources Office.

New dependents of Employees must be enrolled in this Plan within 31 days of the date of marriage or the date upon which the Employee becomes Eligible to participate in the Plan. Newborns or Newly-Adopted Children must be enrolled within 60 days from date of birth or permanent placement within the home.

If an Employee declines coverage by signing a "Waiver of Coverage" form, he and his Dependents may only enroll at the next Open Enrollment. If an Employee declines enrollment for himself or his dependents (including a spouse) because of other health insurance or group health plan coverage, however, the Employee may be able to enroll himself or his dependents in this plan if any of them lose eligibility for that other coverage as described below in SPECIAL ENROLLMENT.

CHANGES IN ENROLLMENT

The Human Resources Office must be notified immediately if any change occurs that may affect eligibility to participate in this Plan.

WHEN COVERAGE BEGINS

Provided that written application for health care coverage is completed as required above, coverage is effective for new Employees and their eligible Dependents on the first day of the month coinciding with or following the date of hire.

New Dependents may not be enrolled or covered before the Employee becomes Eligible to participate in the Plan. If the Employee is already Eligible, new Spouses and Step-Children, if any, will be covered as of the date of marriage. Newborns will be covered from the date of birth, and newly-Adopted Children or Foster Children will be covered on the date of permanent placement in the home whether by legal agreement or court order on custody.

All coverage will commence at 12:01 a.m. on the date such coverage is in effect.

OPEN ENROLLMENT

You may also enroll or make coverage selection changes during the annual open enrollment period (provided all other eligibility requirements are met). The annual open enrollment is during the month of October for coverage to be effective November 1st.

REINSTATEMENT OF COVERAGE

Employees rehired after termination from employment or returning after an approved leave of absence within six (6) months will be reinstated on the first day of the month coinciding with or following the Employee's return to work. Dependents covered on the Employee's date of separation or leave from employment, and any new dependents acquired during the absence, are included in this provision.

If an Employee was eligible to participate in the Plan prior to the date of separation, but had not enrolled, the Employer must offer coverage to the Employee on the start date of his return to work. If the Employee elects to enroll upon his return, he may also enroll any eligible Dependents he has on that date. Coverage is effective on the first day of the month coinciding with, or following, the Employee's return to work.

If previously covered under the Plan, an Employee returning to work within six (6) months of absence will be credited with all prior payments made in satisfaction of Deductibles or Out-of-Pocket Maximums upon reinstatement. However, if an Employee returns to work in the following Plan Year, new Deductibles and Out-of-Pocket Maximums may apply.

Employees rehired or returning from an approved leave of absence after six (6) months from the date of separation will be required to re-qualify as a new Employee. New Deductibles, Out-of-Pocket Maximums, Plan Limitations and Waiting Periods will apply.

SPECIAL ENROLLMENT

HIPAA requires a group health plan to offer a Special Enrollment period (regardless of any Open Enrollment period) to Employees and their Dependents who have previously declined coverage under the Plan. To qualify for a Special Enrollment, the Employee and Dependent must be currently eligible for coverage under the terms of this Plan and have had coverage under another group health plan or health insurance when coverage was previously declined.

A Special Enrollment opportunity is triggered if any of the following conditions occur:

1. **Loss of Eligibility for Coverage under a Group Health Plan or Other Health Insurance Coverage.** Loss of Eligibility includes, but is not limited to:
   a. Divorce or legal separation;
   b. A dependent is no longer considered a dependent under the Plan;
   c. Death of the employee covered by the Plan;
   d. Termination of employment;
   e. Reduction in the number of hours of employment;
   f. The Plan decided to no longer offer any benefits to a class of similarly situated individuals; or
   g. An individual in an HMO or other arrangement no longer resides, lives or works in the service area.

   Loss of eligibility ***does not*** include (a) a loss resulting from the failure of the individual to pay premiums on a timely basis; or (b) a termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan).

2. **Termination of Employer's Contributions.** An Employer's contributions to the Plan are terminated, even if the Employee could continue coverage at the higher cost. This condition also applies if an Employer offers more than one plan option and chooses to terminate the option in which the Employee is enrolled.

3. **Exhaustion of COBRA Coverage.** The Employee or dependent has exhausted his group health plan or health insurance coverage extended under COBRA. Exhaustion includes the following:
   a. Completion of the entire 18- or 36-month COBRA period;
   b. The former Employer failed to remit premiums on a timely basis as previously agreed;
   c. A period of Employer-paid COBRA coverage ended; or
   d. An individual no longer resides, lives or works in the service are in an HMO or other arrangement extended by COBRA.

Conditions 1, 2 and 3 above trigger a Special Enrollment period if the Employee or dependent are currently eligible for coverage under the Plan. The employee or the Dependent must request coverage within 30 days following the occurrence of one of these events. Coverage will be effective on the first day following the loss of other coverage so that there is no lapse in coverage.

4. **Acquisition of a New Dependent.** The Employee has acquired a new Dependent through marriage, birth, adoption, or placement for adoptions. This provision includes the addition of a dependent over the age of 18 who previously lost coverage due to loss of his dependent status, but now again qualifies as a Dependent.

   Enrollment due to marriage (including step-children) must occur within 31 days after the date of marriage. Coverage will be retroactively effective to the date of marriage. New dependents acquired due to birth, placement for adoption, or adoption must be enrolled within 60 days of this event. Coverage will be retroactively effective on the date of birth, adoption, or placement for adoption.

   Enrollment due to regaining dependent status must also occur within 30 days after the date the event occurred. Coverage will be effective on the first day of the month following the change in the dependent's status.

5. **Medicaid or CHIP Eligibility.** A Special Enrollment opportunity is triggered if either a) the Employee or Dependent loses eligibility for state Medicaid or Child Health Insurance Plan (CHIP program); or b) the Employee or Dependent becomes eligible for a premium assistance subsidy under state Medicaid or CHIP. The Employee must request coverage under the Plan within 60 days after either determination of eligibility.

TERMINATION OF COVERAGE

Coverage under this Plan may be extended if: (a) the Employee is temporarily absent from work due to Illness or Injury, but only for the duration of unused sick leave and unused vacation time; or (b) the Employee's absence is due to an Employer-approved furlough, temporary layoff, or unpaid leave of absence of up to 90-days; or (c) the Employee's absence is due to a Special Unpaid Leave of Absence.[2] All required contributions to the Plan must be made during such extension.

PARTICIPANT TERMINATION

Participant Coverage shall automatically terminate immediately upon the earliest of the following dates:

1. On the last day of the month immediately following the date of termination of the Participant's employment or layoff;
2. On the last day of the month immediately following the date the Participant ceases to meet the eligibility provisions of the Plan;
3. On the date the Participant fails to make any required contribution for coverage;
4. On the date the Plan is terminated;
5. On the date of the Participant's death;
6. On the date the Participant enters the armed forces of any country as a full-time member if active duty is to exceed 30 days, except as allowed under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

If employment is obtained by misrepresentation or fraud (including misrepresentation of immigration status in obtaining or maintaining employment), coverage is immediately lost under the Plan. Any such loss of coverage because of false representations in obtaining employment would be retroactive to the Employee's original Effective Date.

DEPENDENT TERMINATION

The Dependent Coverage of a Participant shall automatically terminate upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month immediately following the date the dependent ceases to be an eligible dependent under the Plan;
2. On the last day of the month immediately following the date of termination of the Participant's coverage under the Plan;
3. On the last day of the month immediately following the date the Participant ceases to meet the eligibility provisions of the Plan;
4. On the date the Participant fails to make any required contributions for Dependent Coverage;
5. On the date the Plan is terminated;
6. On the last day of the of the month in which the Plan Sponsor terminates the dependent's coverage;
7. On the last day of the month in which the Participant dies; or
8. On the date the dependent enters the armed forces of any country as a full-time member if active duty is to exceed 30 days.

RESCISSION OF COVERAGE

A "rescission" is defined as a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuation of coverage under the Plan is not a rescission if:

1. The cancellation or discontinuance of coverage has only a prospective effect; or
2. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Two examples involving nonpayment of premiums where coverage may be canceled retroactively:

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[2] A "Special Unpaid Leave of Absence" means any of the following legally-mandated unpaid leaves of absence that do not constitute termination of or layoff from employment: (1) leave protected by the Family and Medical Leave Act; (2) leave protected by the Uniformed Services Employment and Reemployment Rights Act; or (3) Jury Duty (as reasonably defined by the Employer).

1. Retroactive terminations in the "normal course of business" are permissible.
2. Retroactive terminations for failure to notify the Plan when dependents covered by the Plan became ineligible.

The Plan is prohibited from rescinding coverage for individuals who are covered under the Plan, except in cases where the individual has engaged in fraud or made an intentional misrepresentation of material fact, as prohibited by the terms of the Plan and with advance notice.

The Plan is required to provide at least 30-days advance written notice to each individual who would be affected before coverage may be rescinded. This 30-day period will provide individuals with an opportunity to explore their rights to contest the rescission or look for alternative coverage, as appropriate.

Coverage will be canceled prospectively to correct errors in coverage, such as mistakenly covering a part-time Employee, but not by retroactively rescinding coverage, unless there was some fraud or intentional misrepresentation by the individual.

The Plan reserves the right to recover from the Employee and his covered dependents any benefits paid as a result of the wrongful activity that is in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on the part of the Employee, as determined by the Employer, continuation coverage under COBRA may be denied to the Employee and his covered dependents.

FEDERAL LAWS AND REGULATIONS

CONTINUATION PRIVILEGE

This Plan provides a voluntary option to continue medical coverage for up to six months following termination. Former Employees and their Dependents are eligible for continued coverage if the loss of coverage is due to termination of employment; leave of absence; loss of employee eligibility; loss of dependent eligibility; death of an Employee; disability; or divorce. Employees must pay the full cost of the continued coverage as determined by the Plan Administrator.

Contact your Employer to confirm eligibility for the Continuation Privilege and to complete the proper enrollment forms.

NOTE: This Plan is exempt from providing COBRA continuation coverage to its Employees at their termination.

Church plans are not required to give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a loss of coverage under an employer's plan.

The CONTINUATION PRIVILEGE, described above, is not COBRA coverage, and provides coverage for a limited period of time following termination.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

The Family and Medical Leave Act is a federal law that allows Eligible Employees of a Covered Employer to take either paid or unpaid leave to care for family members. An Eligible Employee is entitled to continue health care coverage under this Plan during a period of employer-approved, FMLA leave at the same cost as if the FMLA leave had not been taken.

If provisions under the Plan change while you are on FMLA leave, the changes will be effective for you on the same date as they would have been had you not taken leave.

Eligible Employee. An Employee is eligible for FMLA leave, if the Employee:

1. Has been employed by the Employer for at least 12 months on the date which any FMLA leave is to commence; and
2. Has been employed for at least 1,250 hours of service during the 12-month period immediately preceding the commencement of the leave; and
3. Is employed at a work-site with 50 or more Employees within a 75-mile radius of other work-sites of the Employer.

Circumstances Qualifying for FMLA Leave. Covered Employers are required to grant leave to Eligible Employees for the following circumstances:

1. Birth of a son or daughter and to care for the newborn child;
2. Placement of a child with the Employee for adoption or foster care;
3. To care for the Employee's spouse, son or daughter, or parent with a serious health condition; or
4. Because of a serious health condition that makes the Employee unable to perform the functions of the Employee's job; or
5. Because of a qualifying exigency arising out of the fact that the Employee's Spouse, Son, Daughter, or Parent, is a military member on covered active duty or has been notified of an impending call or order to covered active duty status in the Armed Forces in support of a contingency operation (i.e. a war or similar combat operation).
6. To care for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent or next of kin of the covered service member.

Coverage under FMLA leave is limited to a total of 26 workweeks during any 12-month period that follows a Serious Illness or Injury of a service member when the Employee is that service member's Spouse, Son or Daughter, Parent, or Next of Kin.

FMLA leave may be paid or unpaid, but runs concurrently with any other similar type of leave available. Federal FMLA allows an Employer to require an employee to use all paid leave (such as, accrued vacation leave, personal leave, medical or sick leave, or family leave) before using unpaid leave.[3] Consult with your HR Department or your Employee Handbook to confirm your Employer's policy for using paid and unpaid leave while on FMLA.

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[3] Many states provide other forms of protected family and medical leave. Effective January 1, 2020, Washington state is implementing a new Paid Family and Medical Leave (PFML) that prohibits employers from *requiring* an employee to take other forms of paid time off in lieu of or concurrently with PFML.

You must continue to pay your portion of the Plan contribution, if any, during the FMLA leave. Payment must be made within 30 days of the due date established by the Plan Administrator. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

GENETIC INFORMATION NONDISCRIMINATION ACT

Under the Genetic Information Nondiscrimination Act of 2008 ("GINA"), an employer may not discriminate, harass, or retaliate against an employee in any aspect of employment because of genetic information. Genetic Information includes an individual's genetic tests; genetic tests of that individual's family members; manifestation of a genetic disease or disorder in the individual's family medical history; an individual's request for, or receipt of, genetic services or participation in clinical research; or genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual. *See* 29 CFR 1635.3.

GINA prohibits an employer from using an individual's Genetic Information in hiring, discharge, compensations, terms, conditions, or privileges of employment. An employer may not request, require, or purchase genetic information about an individual. Any genetic information voluntarily provided by an individual must be maintained as a confidential medical record and strictly limits the disclosure of genetic information about an employee.

HIPAA PRIVACY RULE[4]

Diocese of Yakima (the "Plan Sponsor") sponsors the Diocese of Yakima Health Care Benefits Standard Plan (the "Standard Plan"). Members of the Company's workforce have access to the individually identifiable health information of Plan Participants for the administrative functions of the Plan. When this health information is provided by the Plan to the Plan Sponsor, it is Protected Health Information.

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

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

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

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

How Health Information May be Used and Disclosed. In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

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

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes. In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);

[4] This section does not constitute the triennial HIPAA Privacy Notice. Contact the Plan Sponsor for a copy.

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for Payment or Plan Health Care Operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;
7. Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
8. Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);
9. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);
10. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);
11. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);
12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
13. Train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
14. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed: the Privacy Officer, Controller, Office Manager, HR Specialist, and President. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the Plan administration functions that the Plan Sponsor performs for the Plan.
    b. In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose Reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor. The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Plan Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

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

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage. The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss

carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Primary Uses and Disclosures of PHI.

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

2. *Business Associates*. The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant's information.

3. *Other Covered Entities*. The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI.

1. *Required by Law*. The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

2. *Public Health and Safety*. The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
    a. A public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;
    b. Report reactions to medications or problems with products or devices regulated by the federal food and drug administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
    c. Locate and notify persons of recalls of products they may be using; and
    d. A person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

3. *Abuse or Neglect.* The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by 2(a) above, when required or authorized by law, or with the Plan Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Plan Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

4. *Health Oversight Activities*. The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

5. *Lawsuits and Disputes*. The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Plan Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.

6. *Law Enforcement*. The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Plan Participant's PHI in response to a law enforcement official's request if he/she is, or are

suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

7. *Decedents*. The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.

8. *Research*. The Plan may use or disclose PHI for research, subject to certain limited conditions.

9. *To Avert a Serious Threat to Health or Safety*. The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.

10. *Workers' Compensation*. The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

11. *Military and National Security*. The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI.

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

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

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

Individual's Rights. The Plan Participant has the following rights regarding PHI about him/her:

1. *Request Restrictions*. The Plan Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Participant may request the Plan restrict disclosures to Family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

2. *Right to Receive Confidential Communication*. The Plan Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Plan Participant would like to be contacted. The Plan will accommodate all Reasonable requests.

3. *Copy of This Notice*. The Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Officer.

4. *Accounting of Disclosures*. The Plan Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Plan Participant is entitled to such an accounting for the six (6) years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure; (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed; and (d) a statement of the purpose of the disclosure that reasonably informs the Plan Participant of the basis of the disclosure and certain other information. If the Plan Participant wishes to make a request, please contact the Privacy Officer.

5. *Access*. The Plan Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Plan Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the

Privacy Officer. In very limited circumstances, the Plan may deny the Plan Participant's request. If the Plan denies the request, the Plan Participant may be entitled to a review of that denial.

6. *Amendment*. The Plan Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Plan Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.

Questions or Complaints. For more information about the Plan's Privacy practices, have questions or concerns, or believe that your Rights have been violated, you may contact the Plan Administrator using the contact information below:

Diocese of Yakima

Physical Address:	*Mailing Address*:
101 S 12th Avenue	PO Box 2189
Yakima, WA 98902	Yakima, WA 98907
Phone: (509) 965-7117	

You may also file a complaint with the U.S. Department of Health and Human Services for Civil Rights by: 1) sending a letter to 200 Independence Avenue SW, Suite 515F, HHH Building, Washington DC 20201; 2) calling the Customer Response Center at (800) 368-1019; or 3) visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

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

HIPAA SECURITY RULE

The Diocese of Yakima as Plan Sponsor for the Standard Plan intends for this section to comply with the requirements of Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA Security Standards") by establishing Plan Sponsor obligations with respect to the security of Electronic Protected Health Information. The Plan Sponsor shall have access to Electronic Protected Health Information (Electronic PHI) from the Plan only as permitted under this Plan Document or as otherwise required or permitted by HIPAA. Neither this Plan nor the Plan Sponsor is permitted to use or disclose Electronic PHI in a manner inconsistent with 45 CFR 164.504(f).

Definitions.

"Electronic Protected Health Information (ePHI)" is defined in Section 160.103 of the Security Standards (45 CFR 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

"Health Breach Notification Rule" is defined in 16 CFR Part 318, as amended from time to time, and generally means as the acquisition of unsecured PHR identifiable health information of an individual in a personal health record without the authorization of the individual.

"Protected health information" means individually identifiable health information that is transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium.

"Security Incidents" is defined within Section 164.304 of the Security Standards (45 CFR 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions: Standards for Security of Individually Identifiable Health Information ("Security Rule"). The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

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

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

2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR 164.504(f)(2)(iii), is supported by Reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement Reasonable and appropriate report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI. The required breach notifications—in accordance with the Health Breach Notification Rule (16 CFR Part 318)—are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the individual whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach.
2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.
3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each Calendar Year.
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as copays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. The MHPAEA regulations also require plans and issuers to ensure parity with respect to nonquantitative treatment limitations (such as medical management standards).

This Plan applies its terms uniformly and enforces parity between covered medical/surgical benefits and covered mental health and substance disorder benefits in each these requirements: financial cost-sharing, treatment limitations, and nonqualititative treatment limitations. The Plan Administrator must make the Plan's criteria for determinations regarding the Medical Necessity of Mental Health or Chemical Dependency treatment available at your request.

NONDISCRIMINATION

In accordance with the Patient Protection and Affordable Care Act, the Diocese of Yakima Health Care Benefits Plan does not discriminate on the basis of race, color, national origin, age, disability or sex. As required by HIPAA, the Plan does not discriminate against a Participant or the Participant's Dependents in eligibility or benefits based on certain health factors[5] when enrolling in this Plan. In addition, a participant may not be charged more than similarly situated individuals based on any health factors.

As required by Internal Revenue Code Section 105(h)(2), the Plan does not discriminate in eligibility to participate or benefits provided in favor of highly compensated individuals. All rules, procedures, and decisions of the Plan Administrator shall be made, adopted, and applied in such fashion as to not discriminate in favor of Highly Compensated or Key Employees. The Plan Administrator shall take such actions necessary to ensure that the Plan does not reduce or adjust contributions and/or benefits in a discriminatory manner.

[5] "Health factors" include health status, medical conditions, including physical and mental illnesses; claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.

PATIENT PROTECTIONS UNDER AFFORDABLE CARE ACT

This Plan allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members as a patient. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For information on how to select a health care provider, or a list of participating primary care or obstetrics/gynecology health care professionals, contact the Plan Administrator or TPSC Member Services at (800) 426-9786.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a medical child support order that creates or recognizes the right of a Participant's eligible Dependent to receive benefits under the Plan. A National Medical Support Notice (NMSN) is treated as a QMCSO if properly executed. Either a court or administrative agency with the authority to enter a child support order may issue a QMCSO or NMSV.

The Claims Administrator is responsible for processing a QMCSO or NMSV. Upon receipt of either, the Claims Administrator must notify the Participant and the "Alternate Recipient" (or Dependent child) that it has received such an order. Then the Claims Administrator must determine whether the order is "qualified" as defined below. When the Claims Administrator had made its decision, it must provide notice of its determination to the Participant, the Dependent child, and the issuing agency.

A "qualified" order designates the type of coverage (e.g. medical, dental, or all coverage available) in which the Dependent child must be enrolled. If the Plan has more than one coverage option, the Claims Administrator must notify the issuing agency of the available options. If the issuing agency does not respond within 20 days of notice, the Claims Administrator may enroll the Participant and/or the Dependent child under "default" options.

An order that requires coverage that is not available under the Plan is not a qualified order (e.g. vision coverage, but the Plan offers medical and dental only). The Claims Administrator is not required to take any additional action other than to notify the Participant, the Dependent child, and the issuing agency of its determination.

If the Claims Administrator determines that the order is qualified, it may enroll the child in the Plan. If the Participant must be enrolled for the Dependent(s) to be eligible, the Claims Administrator may also enroll the Participant in the Plan. A Participant may not terminate coverage unless allowed to do so under the terms of the Plan or the order.

UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

It is the intent of this Plan to comply with all provisions of the Uniform Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Under USERRA, Employers must reemploy returning servicemembers (former Employees) in the same or comparable job as if there had been no military absence.

In addition, an Employee going into military service may elect to continue Plan coverage. Rights to continue coverage apply only to Employees and their Dependents covered under the Plan before leaving for military service.

Coverage may be continued as follows:

1. **Active Duty for 30 Days or Less.** Coverage may continue as if the servicemember had remained employed;
2. **Active Duty for Less than 24 Months.** Coverage may continue for the period beginning on the date that military leave commenced and ends on the day after the date upon which the person was required to apply for, or return to, employment, but fails to do so; or
3. **Active Duty for 24 Months.** Coverage may continue for a 24-month period beginning on the date that Uniformed Service leave commences.

If coverage is continued for 31 days or more, the Plan may require an Employee to pay up to 102% of the full contribution under the Plan.

Regardless of whether an Employee elects to continue coverage during military service, the Employee has the right to be reinstated in the health plan when reemployed. Generally, no waiting periods or exclusions may be applied, except for any Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, military service.

For more information about any of these mandatory federal rights, please contact the Plan Administrator, your Human Resources Department, or TPSC Member Services at (800) 426-9786.

MEDICAL PLAN TERMS – STANDARD PLAN

Benefits are subject to all provisions of this Plan Document and Summary Plan Description. Covered Persons are entitled to receive Medically-Necessary services and supplies for the treatment of an Illness or Injury as described in the section **BENEFITS PROVIDED BY YOUR MEDICAL PLAN** below. Under the terms of the Plan, the Covered Person is responsible for paying his share of the Covered Expense, as described below:

Allocation and Apportionment of Benefits. The Plan Administrator reserves the right to allocate any Allowable Charge to the applicable Deductible and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

Coinsurance. Coinsurance is the percentage share payable by a covered person on claims for which the plan provides benefits at less than 100% of the allowed amount.

Copay. A Copay is a fixed amount that the Covered Person pays at the time of service.

Deductible. The Deductible is the dollar amount of Covered Expenses that a Covered Person generally must pay during the year before the Plan begins to pay its share of any benefit. As shown in the **MEDICAL SUMMARY OF BENEFITS**, this Plan has *two separate* Deductibles: one for **Medical** expenses and the other for **Outpatient Prescription Drugs**.

Locating a Member Pharmacy. To locate a member pharmacy, refer to your Plan ID card. You may contact the pharmacy benefit manager directly, the Plan Administrator, or TPSC Member Services.

Locating a Preferred Provider. To locate a Preferred Provider, refer to your Plan ID card. You may contact the Preferred Provider Network directly, the Plan Administrator, or TPSC Member Services at (800) 426-9786.

Maximum Benefits. Lifetime Maximum Benefits for **Essential Health Benefits** (as defined below) are unlimited. Annual and/or Lifetime Maximum Benefits for services that are not **Essential Health Benefits**, if any, are as shown in the **MEDICAL SUMMARY OF BENEFITS**.

Out-of-Pocket Maximum. The amount that a Covered Person is required to pay for services and supplies received is subject to an annual Out-of-Pocket Maximum. As shown in the **MEDICAL SUMMARY OF BENEFITS**, this Plan has *two separate* Out-of-Pocket Maximums: one for **Medical** expenses and the other for **Outpatient Prescription Drugs**. Expenses Incurred for Medical services and supplies apply solely to the Medical Out-of-Pocket Maximum. Expenses Incurred for Outpatient Prescription Drugs apply solely to the Outpatient Prescription Drug Out-of-Pocket Maximum.

Medical Out-Of-Pocket Maximum. Deductibles, Copays, and Coinsurance apply to the Medical Out-of-Pocket Maximum and increase your benefit to 100% payment when the Maximum has been met. Outpatient Prescription Drugs, amounts in excess of Maximum Allowable Charges, and non-covered services do not apply to the Out-of-Pocket Maximum and are not paid even after you reach your Out-of-Pocket Maximum.

NOTE: Allowed Expenses for medical services and supplies apply to both the Preferred Provider and the Non-Preferred Provider Medical Out-of-Pocket Maximums.

Outpatient Prescription Drug Out-Of-Pocket Maximum. Deductibles, Copays, and Coinsurance apply to the Outpatient Prescription Drug Out-of-Pocket Maximum and increase your benefit to 100% payment when the Out-of-Pocket Maximum has been met. Medical expenses, amounts in excess of Maximum Allowable Charges for a prescription drug, and non-covered expenses do not apply to the Outpatient Prescription Drug Out-of-Pocket Maximum and are not paid even after you reach your Out-of-Pocket Maximum.

Maternity Out-of-Pocket Maximum. Members who participate in the Maternity Education Program (see below) and receive services from a Preferred Provider will have a separate Out-of-Pocket Maximum for Maternity expenses as shown in the **MEDICAL SUMMARY OF BENEFITS**. Once the Maternity Out-of-Pocket Maximum has been met, additional maternity expenses are paid at 100% benefit. Expenses that are applied to the Maternity Out-of-Pocket Maximum are also included in the Medical Out-of-Pocket Maximum.

BENEFITS PROVIDED BY YOUR MEDICAL PLAN

In order to be eligible for benefits under this provision, expenses actually Incurred by a Covered Person must meet all of the following requirements:

1. They are ordered by a Physician and administered by a Physician and/or Licensed Health Care Provider;
2. They are Medically Necessary for the diagnosis and treatment of an Illness or Injury unless otherwise specifically included as a Covered Expense; and
3. They are not excluded under any provision or section of this Plan.

NOTE: Covered Expenses for each Plan benefit are described as follows. After application of Maximum Allowable Charges and the appropriate amounts for Deductibles, Copays, and Coinsurance, benefits are paid as shown in the **MEDICAL SUMMARY OF BENEFITS** above.

I. PHYSICIAN SERVICES

Covered Expenses include but are not limited to:

A. **Inpatient Services.** Physician visits while in the Hospital, surgical procedures, and follow-up care.

B. **Office Visits.** Outpatient visits to a Physicians' office (including Urgent Care Center and walk-in clinic visits), virtual visits (telephone, on-line or mobile app), medical treatments, allergy injections, and consultations.

C. **Office Surgery.** Minor surgical procedures performed while in the physician's office.

D. **Office X-rays and Lab.**

E. **Outpatient Surgery.** Same-day surgical procedures performed at an Outpatient Department or Ambulatory Surgical Center.

F. **Specialist Visits or Second Surgical Opinions.** Office visits to a physician practicing in a specialized field of medicine other than Primary Care or visits to a physician to obtain a Second Opinion about a pending surgical procedure.

II. PREVENTIVE CARE SERVICES

Preventive care services are provided under the Plan as outlined in the MEDICAL SUMMARY OF BENEFITS. The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA) has designated specific services, items and medications as preventive benefits and available with no cost-sharing when provided by an in-network provider. Preventive care services, items and medications include those recommended by the U. S. Preventive Services Task Force (with an "A" or "B" rating), immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention, and preventive care and screenings for Children and for women as provided for in guidelines supported by the Health Resources and Services Administration ("HRSA").

Based on the Covered Person's age, gender and risk factors, these services include, but are not limited to:

A. **General Adult Preventive Care.** Well-adult physical exams; colorectal cancer screening for persons age 50 or above (or under age 50 and at high risk); depression screening; obesity screening/counseling; health diet; physical activity counseling; and tobacco cessation counseling;

B. **Children and Adolescent Preventive Care.** Well-child physical exams; developmental and behavioral assessment; hearing screening; depressing screening; obesity screening/counseling; health diet; physical activity counseling; and skin cancer counseling;

C. **Women's Preventive Care.** Well-woman exams; pap smears; routine pre-natal testing; routine mammography screening; and breastfeeding support and supplies. Contraceptive devices, medications and sterilization are *not* covered.

D. **Immunizations.** Immunizations and vaccinations as recommended by the Center for Disease Control for adults, children, and adolescents; and

E. **Preventive Medications.** Covered preventive medications require a physician's written prescription. See Outpatient Prescription Drugs below.

Accessing covered Preventive Care Services may require more than one visit to a Physician or Licensed Health Care Provider. For example, colonoscopies, developmental assessments, or immunizations might require multiple visits.

A detailed list of covered preventive services is provided at *http://tpscbenefits.com/preventive-care-services*. For services available for intensive behavioral counseling for obesity; healthy diet and physical activity; or tobacco cessation, contact TPSC Member Services at the phone number shown on your Medical ID Card.

III. HOSPITAL SERVICES

Charges made by a Hospital for:

A. **Room & Board.** Daily Room and Board and general nursing services, or confinement in an Intensive Care Unit or Coronary Care Unit. Room and Board (other than in a Coronary Care Unit and Intensive Care Unit) is limited to the Hospital's average Semi-Private room rate. If the facility has only private rooms, the Plan will determine benefits based on the average Room and Board charge of other facilities in the geographic area (according to UCR).

B. **Outpatient Department or Ambulatory Surgical Center (ASC).** Charges made by an Outpatient Department or ASC for medical treatment, testing, or surgery that does not require hospital admission.

C. **Emergency Room.** Hospital Emergency Room or Minor Emergency Medical Clinic, including related services and supplies, such as diagnostic imaging (including x-ray), laboratory services, surgical dressings, and drugs, furnished by and used in the Emergency room.

D. **Services and Supplies.** Medically Necessary services and supplies other than Room and Board furnished by the Hospital, including but not limited to: Inpatient or Outpatient miscellaneous expenses and supplies; Outpatient treatments; operating room, surgical supplies, anesthesia services and supplies, drugs, dressings, equipment and oxygen; facility charges for diagnostic and therapeutic services (facility charges include any services received by a Hospital-employed provider and billed by the Hospital); blood derivatives and their administration; hemodialysis; and X-ray and linear therapy.

IV. DIAGNOSTIC SERVICES

Covered Expenses include charges for Inpatient and Outpatient Diagnostic laboratory, pathology, imaging and scans (such as X-rays and EKGs), and microscopic tests, including their administration and interpretation. This includes charges for Diagnostic mammograms and Medically Necessary chiropractic X-rays.

Pre-Certification is also required for certain Advanced Imaging procedures, including, but not limited to, MRI, MRA, PET, CT, capsule endoscopy, scintimammography, and genetic testing. See PRE-CERTIFICATION OF HOSPITALIZATION OR ADVANCED IMAGING below.

This benefit includes services billed as:

A. **Physician Services.**

B. **Inpatient Facility Services.**

C. **Outpatient Facility Services.**

D. **Pre-Admission Testing.** This includes diagnostic laboratory tests, X-rays, and electrocardiograms (EKG) obtained as an Outpatient prior to a scheduled admission as an Inpatient to a Hospital, but only if the Hospital will accept the results of these tests and not simply repeat them.

V. MATERNITY & NEWBORN CARE BENEFIT

A. **Maternity Care.** Routine obstetrical/maternity benefits, including Medically Necessary termination of Pregnancy and Cesarean surgeries, will be provided for Employees and covered Spouses only. Included in this benefit are charges for a Birthing Center.

Under the Newborns' and Mothers Protection Act of 1996, a Hospital stay for the mother or Newborn child following a vaginal delivery may not be less than 48 hours. A Hospital stay for the mother or Newborn child following a Caesarean section may not be less than 96 hours. However, if the mother wishes to leave earlier than 48 hours (or 96 hours as applicable), the mother's or Newborn's attending health care provider may discharge them.

The attending health care provider or Covered Person is not required to obtain authorization from the Plan or the medical reviewing agency for prescribing a shorter stay than 48 hours (or 96 hours). An "attending health care provider" does not include a Plan, Hospital, or Managed Care Organization.

Dependent Children are not eligible for benefits under this provision, except for preventive care services required under the Affordable Care Act and treatment of Complications of Pregnancy. Benefits are also not provided for pregnancies that are for the purpose or the result of a surrogate pregnancy.

B. **Newborn Care.** Newborn coverage is not automatic. A Newborn must be enrolled on the Plan within 60 days from birth to be eligible for benefits.

All charges for the Newborn nursery (Hospital or Birthing facility), routine pediatric care, and preventive care services provided are covered as charges of the Newborn, not the mother. Provided the Newborn is enrolled within 60 days, benefits will be provided on the same basis as for any other eligible expense if the Newborn is ill, Injured, premature, or requires care other than initial routine care.

VI. CHEMICAL DEPENDENCY & MENTAL HEALTH TREATMENT

Chemical Dependency and Mental Health Treatment are provided as shown below:

A. **Inpatient.** Charges made by a Chemical Dependency or Mental Health Treatment facility in accordance with a written treatment plan filed by the attending Physician and/or Licensed Healthcare Provider with the Claims Administrator. Covered expenses include:

1. *Room & Board.* Daily Room and Board and general nursing services. Room and Board is limited to the facility's average Semi-Private room rate. If the facility has only private rooms, the Plan will determine benefits based on the average Room and Board charge of other facilities in the geographic area (according to UCR).
2. *Physician Services*. Physician Services include medical and psychiatric evaluations; psychotherapy (individual and group), counseling (individual and group), behavior therapy, family therapy (individual and group) for the Covered Person.
3. *Services and Supplies*. Medically Necessary services and supplies other than Room and Board furnished by the Facility;
4. *Prescription Drugs*. Charges for prescription drugs prescribed by the attending Physician and/or Licensed Healthcare Provider, and administered while confined in an approved treatment facility.

B. **Partial Confinement Treatment.** Charges made by a Chemical Dependency or Mental Health Treatment facility in accordance with a written Partial Confinement Treatment Plan submitted to the Claims Administrator by the attending Physician. *See* XII. OTHER BENEFITS, paragraph W. **Partial Confinement Treatment** below for additional information.

C. **Outpatient.** Charges for Medically Necessary treatment for a Covered Person who is not an Inpatient or Partially Confined. Covered Expenses include:

1. *Mental Health or Psychiatric Evaluations.*
2. *Individual Psychotherapy, Counseling, and/or Therapy.*
3. *Group Therapy.* Charges for group therapy only for Covered Persons being treated for Chemical Dependency.

D. **Autism Spectrum Disorder.** Charges for Medically-Necessary comprehensive behavioral interventions, including a combination of applied behavior analysis or behavioral psychology. Applied Behavioral Analysis is covered provided the Child's physician submits a written treatment plan to the Plan Administrator before treatment begins.

1. *Initial Treatment Plan*. The treatment plan must include:

   a. The physician's statement that the child has been diagnosed with Autism Spectrum Disorder;

   b. The child's target behaviors having an impact on development, communication, interaction with peers or others; and the frequency, rate, symptom intensity or duration, or other objective measures of baseline levels are recorded; and

c. An individualized treatment plan in which specific target behaviors have specific goals or objectives of treatment;

d. Specific interventions to be used in the prescribed treatment to address each goal or objective; and

e. Designated monitoring procedures to quantify progress.

2. *Periodic Re-evaluation of Treatment Plan*. Re-evaluation must be performed every six (6) months to assess the need for ongoing ABA therapy. The re-evaluation must demonstrate that the frequency of target behaviors has diminished since the last review, and if not, there has been modification of the treatment or additional assessments have been conducted.

   The re-evaluation must also include a plan for gradual tapering of higher levels of intervention and moving to support from other sources (for example, schools) as progress occurs.

3. *Parental Involvement/Training*. Parents must participate in training in behavioral techniques to provide reinforcement in environments other than the therapeutic setting. Re-training must be included as part of the re-evaluation treatment plan.

4. *Board Certified Behavior Analyst*. All providers of ABA Therapy must be a Board Certified Behavior Analyst (BCBA), including a Board Certified Assistant Behavior Analyst (BCaBA) under the supervision of a Certified Analyst. All other providers must be Licensed Health Care Providers acting within the scope of their license.

Chemical Dependency and Mental Health Treatment Limitations and Exclusions.

1. A Physician must submit a written treatment plan to the Claims Administrator for either Inpatient or Partial Confinement Treatment.

2. Chemical dependency services must be furnished by a state-approved treatment program.

3. The following are excluded from the chemical dependency and mental health benefit:

   a. Services not included in the written Partial Confinement Treatment Plan.

   b. Non-medical, long-term, or custodial care.

   c. Recovery or residential centers or facilities designed to provide **only** a substance-free residential setting.

   d. Detoxification (refer to the Hospital Services benefit above for coverage details).

   e. Education, training and educational materials.

   f. Alcoholics Anonymous and similar programs.

   g. Personal care items.

   h. Services performed by a member of the patient's Family or household.

VII. HOME HEALTH CARE

Charges made by a Home Health Care Agency for care in accordance with the written Home Health Care Plan filed by the attending Physician with the Claims Administrator. Each visit is limited to four (4) hours of care. These charges are only covered for care and treatment of an Injury or Illness when Hospital or skilled nursing confinement would otherwise be required.

Covered Expenses include:

A. Part-time or intermittent nursing care by a Licensed Health Care Provider, including, but not limited to, a Registered Nurse, a Licensed Practical Nurse, a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse;

B. Home health aide services by an aide who is providing intermittent care under the supervision of a Licensed Health Care Provider, including, but not limited to, a Registered Nurse, occupational, physical,

or speech therapist. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in the patient's condition and needs and completing appropriate records;

C. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital, but only to the extent that they would have been covered under this Plan if the Covered Person had remained in the Hospital;

D. Nutritional guidance;

E. Nutritional supplements, such as diet substitutes administered intravenously or by enteral feeding; and

F. Occupational, Physical, Respiratory or Speech Therapy as Medically Necessary for the condition.

Specifically excluded from coverage under the home health care benefit are the following:

1. Meals on Wheels or similar home-delivered food services;
2. Non-medical or Custodial Care except as specifically included as a Covered Expense;
3. Services and supplies not included in the Home Health Care Plan;
4. Services of a person who ordinarily resides in the home of the Covered Person, or is a Close Relative of the Covered Person;
5. Supportive environmental materials such as handrails, ramps, telephones, air conditioners or similar appliances or devices;
6. Transportation services; or
7. Respite care.

VIII. HOSPICE

Charges made by a Hospice will be provided for a Covered Person who is in the latter stages of a terminal Illness and who is homebound, and would otherwise require hospitalization. Covered Expenses include:

A. Confinement in a Hospice or at home.

B. Ancillary charges furnished by the Hospice while the Participant is confined.

C. Medical supplies and drugs prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition.

D. Physician's services and/or nursing care by a Licensed Health Care Provider, including, but not limited to, a Registered Nurse, Licensed Practical Nurse, mental health specialist, social worker, or a chaplain.

E. Home health aide services and home health care.

F. Nutritional advice and nutritional supplements, such as diet substitutes administered intravenously or through hyperalimentation.

G. Respite Care will be provided up to a maximum of 120 hours of care per three (3)-month benefit period in the most appropriate setting.

Specifically excluded from coverage under the Hospice benefit are the following:

1. Non-medical or Custodial Care except as specifically included as a Covered Expense.
2. Meals on Wheels or similar home-delivered food services.
3. Services performed by a member of the patient's Family or household.
4. Supportive environmental materials, such as handrails, ramps, telephones, air conditioners or similar appliances or devices.
5. Transportation services.

IX. PRESCRIPTION DRUGS

The Outpatient Prescription Drug benefit is subject to a separate Deductible, as shown in the **MEDICAL SUMMARY OF BENEFITS**. Benefits are not payable until the Deductible amount has been Incurred by a Covered Person.

Outpatient Prescription Drugs may be obtained as follows:

A. **Purchase from MaxorPlus Member Pharmacies and Present a MaxorPlus ID Card.** Covered Persons must pay the applicable Copay (as shown in the MEDICAL SUMMARY OF BENEFITS) at the time of purchase of covered prescriptions, subject to the Limitations and Exclusions set forth below. Purchases are limited to a 30-day supply.

B. **Purchase from a Non-Member Pharmacy (or Fail to Present a MaxorPlus ID Card).** Covered Persons must pay the cost of the prescription in full and file a claim for reimbursement directly with **MaxorPlus** (less the applicable Copay as shown in the MEDICAL SUMMARY OF BENEFITS). Reimbursement is limited to **MaxorPlus**' Maximum Allowable Charge for the drug, and purchases are limited to a 30-day supply.

C. **Purchase through the Maxor Mail-Order Pharmacy.** Covered Persons may purchase prescriptions through the **Maxor Mail-Order Pharmacy** and must pay the applicable Copay for mail-order services (as shown in the MEDICAL SUMMARY OF BENEFITS). The Mail-Order Pharmacy will mail covered prescriptions directly to the Covered Person's home. Mail-order prescriptions are limited to a 90-day supply.

D. **Covered Drugs.** Subject to the Outpatient Prescription Drug Limitations and Exclusions below, the Outpatient Prescription Drug benefit includes, but is not limited to, the following:

1. **Federal Legend Drugs,** including vitamins and minerals that require a written prescription;

2. **Diabetic needs,** such as alcohol swabs, insulin pump needles, glucose monitors and lancet devices.

3. **Preventive Care Services.** The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA) have designated specific medications as preventive benefits and available with no cost-sharing when provided by an in-network pharmacy. This Plan, however, does not cover contraceptive devices or medications that are generally covered as a Preventive Care Medication. For a detailed list of all medications covered under this benefit, please go to: *http://tpscbenefits.com/preventive-care-services* or contact TPSC Member Services at the phone number shown on your Medical ID Card.

4. **Specialty Medications.** The Outpatient Prescription Drugs benefit includes coverage for certain products that are referred to as specialty medications. Specialty medications are prescribed to treat certain conditions, such as anemia, cancer, cystic fibrosis, growth hormone deficiency, hepatitis C, multiple sclerosis and respiratory syncytial virus.

   For the purposes of this Plan, specialty medications are defined as those: a) that can be self-administered orally or by injection by a physically-capable patient; and b) which may require special shipping and handling, such as refrigeration. As a result, the Plan requires that dispensing of these specialty medications and additional related services be provided by the designated specialty medications provider, CuraScript. These medications can be filled at a retail pharmacy for the first fill only, and thereafter, must be ordered through Maxor Mail Order Pharmacy. Specialty medications are limited to a 30-day supply.

   If a patient, because of his Illness, is physically incapable of administering specialty medications to himself as prescribed, the Plan may provide coverage when administered by a Physician and/or Licensed Health Care Provider.

   Specialty medications that are required to be administered through Outpatient infusion may be administered through a specialty pharmacy vendor, as determined by the Plan. Reimbursement to providers for these specialty medications will be based on the lower of pricing available to such specialty pharmacy vendor or usual preferred provider pricing.

Outpatient Prescription Drug Limitations and Exclusions.

1. Certain medications may require pre-authorization before dispensing.

2. The formulary is subject to change.

3. If the Covered Person has primary prescription drug coverage through another plan, this Plan will not coordinate benefits.

4. Retail purchases for maintenance medications may be limited to an initial fill and two subsequent refills. Additional retail purchases will cost the Mail-Order Copay and be limited to a 30-day supply.

5. Prescriptions will be automatically filled with a Generic Drug if the Physician has indicated that a generic substitution is acceptable. The Physician, however, may indicate that a Brand Name Drug must be dispensed.

6. If a Covered Person elects to receive a Brand Name Drug when a Generic Drug is available, the Covered Person will be responsible for the applicable Brand Name Drug Copay, plus the difference in cost between the Generic and Brand Name Drugs.

7. Prescriptions that are not normally dispensed in the United States may require a pre-authorization.

8. The following are excluded from the Outpatient prescription drug benefit:
   a. Contraceptive devices or medications, including drugs to induce abortion;
   b. Experimental and/or Investigational drugs, including compounded medications for non-FDA approved use. This Exclusion will not apply with respect to drugs that:
      1) Have been granted investigational new drug (IND) or Group C treatment IND status <u>OR</u> are being studied in a Phase III level national clinical trial sponsored by the National Cancer Institute; and
      2) Based on available scientific evidence, are effective or show promise of being effective for Illness, as determined by the Plan.
   c. Therapeutic devices or appliances; support garments and other non-medical substances; hair growth agents; anorexients (weight loss medications); prescription vitamins (except as provided for prenatal vitamins and in the Preventive Care Services benefit above); infertility medications; impotence medications; drugs with cosmetic indications; steroids for body building; Fluoride (except as specifically provided in the Preventive Care Services benefit above); growth hormones; over-the-counter medications (except as specifically provided in the Preventive Care Services benefit above); and replacement of lost or stolen prescriptions.

X. SKILLED NURSING FACILITY

Charges made by a Skilled Nursing Facility for the following services and supplies furnished by the facility, up to the Semi-Private rate. This benefit is only provided when the Covered Person is at a point in his recovery where Inpatient Hospital care is no longer Medically Necessary, but skilled care in a Skilled Nursing Facility is. The Covered Person's attending Physician must actively supervise care while the Covered Person is confined in the facility.

Such confinement must commence within 14 days of being discharged from a Hospital, and the Hospital confinement must have been for a period of not less than three (3) consecutive days. The Hospital and Skilled Nursing admissions must be related to the same Illness or Injury.

Covered Expenses include:

A. **Room & Board.** Covered Expenses include Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily Room and Board charge allowed will not exceed the facility's average Semi-Private charges or an average Semi-Private rate made by a representative cross section of similar institutions in the area.

B. **Services.** Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physicians' fees.

C. **Supplies.** Drugs, biologicals, solutions, dressings and casts, furnished for use during the convalescent period.

A confinement in a Skilled Nursing Facility will **<u>not</u>** be considered to be Medically Necessary if the patient's Illness or Injury could safely and appropriately be diagnosed or treated while not confined.

XI. TRANSPLANT SERVICES

Benefits for an organ transplant procedure will be provided according to the terms, conditions, and limitations described below. **All transplants must be pre-authorized.**

A. **Organ Transplant Network.** As a result of the pre-authorization review, the Covered Person may be asked to consider obtaining transplant services from a participating Center of Excellence facility arranged by the Plan Administrator. The purpose of designating Centers of Excellence networks is to perform necessary transplants in the most appropriate setting for the procedure, to improve the quality and probability of a successful outcome, and to reduce the average cost of the procedures. Using a participating Center of Excellence facility is not mandatory but may be considered to be in the best health interest of the Covered Person and provide a less-costly alternative.

   If the Covered Person chooses to obtain transplant services from a Non-Preferred Network that would otherwise be covered under this Transplant benefit, benefits for the donor will be limited as described in Appendix A below.

B. **Second Opinion.** In addition, a second opinion must be obtained and submitted to the Claims Administrator for pre-authorization prior to undergoing any transplant procedure. This mandatory second opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

C. **Covered Procedures.** Coverage is provided for Transplant Services for:

   Bone Marrow Allogeneic
   Bone Marrow Autologous
   Heart
   Heart/Lung (simultaneous)
   Kidney
   Kidney/Pancreas (simultaneous)
   Liver
   Lung
   Pancreas
   Small Bowel

   In addition, other transplant procedures may be covered when determined appropriate by the Plan.

D. **Human Tissue Only.** Only human tissue to tissue transplants will be considered as eligible for coverage under the Plan. All other transplant procedures, including Experimental and/or Investigational, non-human organ or artificial organ implant procedures are specifically excluded. No benefits will be provided for selective islet cell transplants of the pancreas, transplant of a lung or other organ (except kidney) from a living donor unless such donor has been declared brain dead by the attending provider.

E. **Bone Marrow Transplants.**

   1. Allogenic (related or unrelated) bone marrow transplants will be provided, limited to the following malignancies or conditions: acute leukemias (lymphocytic or non-lymphocytic), chronic myelogenous leukemia, aplastic anemia, lymphoma (Hodgkin and Non-Hodgkin), neuroblastoma Stage III and IV in Children over one year of age, or multiple myeloma.
   2. Autologous (self-donor) bone marrow transplants or stem cell support will be provided, limited to the following malignancies or conditions: Lymphoma (Hodgkin or Non-Hodgkin), neuroblastoma, acute leukemias (lymphocytic or non-lymphocytic) or multiple myeloma. Bone marrow transplants and stem cell support for other conditions will not be covered.
   3. Services and supplies related to removal and treatment of the bone marrow and the hospitalization from the day of bone marrow infusion until the patient is discharged will be applied toward the benefit maximum.

F. **Organ Procurement.** The reasonable and customary cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, will be considered Covered Expenses.

G. **Covered Persons.** A Covered Person may be either the donor to or the recipient of the transplant procedure. For some transplants, more than one Covered Person may be both a Donor and a Recipient.

1. *Coverage for Donors*. Covered Expenses Incurred by the donor who is *not* covered under this Plan will be Covered Expenses to the extent that such expenses are not payable by the donor's plan.
2. *Coverage for Recipients*. If the recipient is covered under this Plan, Covered Expenses Incurred by the recipient will be eligible for benefits.
3. *Coverage for Both Donors and Recipients*. If both the donor and the recipient are covered under this Plan, Covered Expenses Incurred by each person will be treated separately for each person.

H. **Transportation, Lodging, and Meals.** Travel expenses, including transportation, lodging, and meals, are limited to a Lifetime Benefit Maximum of $10,000.

Transplant Limitations and Exclusions. The transplant benefit does not cover:

1. Any treatment related to the use of embryonic stem cells;
2. Implantation within the human body of artificial or mechanical devices designed to replace human organs;
3. Donor costs for a transplant that is not covered under this benefit; however, complications and unforeseen effects from a Covered Person's organ or bone marrow donation will be covered under this Plan as any other Illness;
4. Recipients who are not a Covered Person under the Plan.
5. Organ or bone marrow search or selection costs (including registry charges), except as provided under donor costs; or
6. Services and supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.

For explanation of specific terms relating to these transplant benefits, see the **DEFINITIONS** section below.

XII. OTHER BENEFITS

A. **Allergy Services.** Allergy testing.

B. **Ambulance.** The cost of transport to a Hospital by a licensed ground or air Ambulance. Transport must be to the nearest Hospital able to treat the Covered Person's condition. Ambulance service is covered only when another means of transportation would be dangerous to the Covered Person's health. Benefits may also be provided for transportation between facilities when Medically Necessary.

A licensed air Ambulance service will be covered to the nearest Hospital equipped to render the necessary treatment only if ground transportation would endanger the Covered Person's health and the purpose of the air Ambulance is not for personal or convenience reasons.

C. **Anesthesia.** The cost and administration of an anesthetic.

D. **Blood.** The processing and administration of blood or blood components.

E. **Cardiac & Pulmonary Rehabilitation.** Medically Necessary cardiac and pulmonary rehabilitation.

F. **Chemotherapy.** Chemotherapy and radiation therapy or treatment.

G. **Cornea and Skin Transplants.** Coverage is as any other medical or surgical procedures and is not subject to any of the provisions, limitations, or exclusions of section XI. TRANSPLANT SERVICES above.

H. **Dental Injury—Accidental Injury to Sound Natural Teeth.** Services to repair damage to the jaw and Sound Natural Teeth if provided when Injury is the direct result of an accident and are not covered by the Dental Plan. No benefits will be provided for Injury caused by biting or chewing. Covered Expenses are limited to the least expensive procedures that would provide professionally-acceptable results.

I. **Diabetes Education & Training.** Covered services include self-management education, training, and medical nutritional counseling to manage diabetes.

J. **Durable Medical Equipment (DME), Medical Supplies, Oxygen, and Prosthetic & Orthopedic Appliances.** Coverage includes:

1. **DME.** Covered Expenses include the lesser of:
   a. The rental (up to the purchase price, including sales tax); OR
   b. The purchase (including sales tax) of this equipment if economically justified.

   Examples of covered DME include but are not limited to: wheelchairs, Hospital beds, respirators or other Durable Medical Equipment required for temporary therapeutic use.

2. **Foot Orthotics.** Charges for the purchase of foot orthotics when prescribed for a specific diagnosed medical condition, such as, but not limited to: bone spurs, heel spurs, or plantar fasciitis. Covered Expenses include testing and casting related to the purchase of the orthotics.

3. **Medical Supplies.** Necessary medical supplies, such as dressings, sutures, respiratory equipment and supplies, trusses, or crutches.

4. **Oxygen.** Oxygen, equipment and supplies for its administration, including, but not limited to, an oxygen concentrator, filters, humidifier, oxygen cylinders and tubing.

5. **Prosthetic & Orthopedic Appliances.** Prosthetics Appliances to replace limbs, eyes or larynx; Orthopedic Appliances, such as braces, casts, splints, orthosis, or other diagnostic mechanism to improve function of movable parts of the body.

NOTE: No benefit is provided for cosmetic prostheses (except as provided for under the Mastectomy and Breast Reconstruction benefits of this Plan).

For repairs or replacements of Durable Medical Equipment, Prosthetic and Orthopedic Appliances, the Covered Person must have:

1. The attending Physician's prescription; and
2. A written explanation from the Physician as to why repair or replacement is necessary; and
3. An itemized repair or replacement cost statement.

Repairs are limited to the maximum that would be allowed for replacement of the equipment. Replacement due to equipment being lost or stolen is not covered.

NOTE: Items that may be useful to persons in the absence of Illness or Injury, such as air conditioners, purifiers, humidifiers, special furniture, bicycles, whirlpools, hot tubs, spas, dehumidifiers, exercise equipment, health club memberships, etc., are not included, whether or not they have been prescribed or recommended by a Physician.

K. **Home Infusion Therapy.** Professional services, supplies, drugs, and solutions required for Home Infusion Therapy.

L. **Infertility Diagnostic Treatment.** Charges for the diagnosis of infertility limited to initial lab tests, hysterosalpingogram, hysteroscopy, pelvic ultrasound, and transvaginal ultrasound for the restoration of fertility or the promotion of conception.

M. **Inpatient Rehabilitation.** Charges for Inpatient rehabilitation to regain, maintain, or prevent deterioration of a skill or function that has been acquired, but then lost or impaired due to Illness, Injury, or a disabling condition. Benefits also include Inpatient habilitative treatment of congenital anomalies for a Newborn Child or for a person to acquire, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

   Inpatient services are **not** deemed to be Medically Necessary if the patient's Illness or Injury could safely and appropriately be diagnosed or treated while not confined. Benefits may be extended if determined to be Medically Necessary for the patient's condition. Inpatient services that are primarily for the purpose of Rehabilitation will be provided the same as any other Inpatient treatment.

N. **Manipulations & Related Modalities.** This benefit includes charges made for chiropractic and osteopathic manipulations. Related physical treatment modalities covered under this benefit include acupuncture and massage therapy.

O. **Mastectomy and Breast Reconstruction Services.** If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient for:

1. All stages of reconstruction of the breast on which mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Breast prostheses; and
4. Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

P. **Natural Family Planning.** Counseling services or office visits for instructions on Natural Family Planning.

Q. **Naturopathic Physician.** Naturopathic Physicians (ND) are covered the same as any other Physician for treatment of a covered Illness, Injury or condition, provided that treatment rendered is within the scope of their license. This benefit also covers Vitamin B-12 intramuscular injections as indicated for a Vitamin B-12 deficiency. Coverage for certain procedures, such as manipulations or rehabilitation, may be limited as shown in the **MEDICAL SUMMARY OF BENEFITS**.

R. **Nutritional Counseling.** Medically-necessary nutritional counseling to treat a chronic illness or condition includes assessment of a person's overall nutrition, development of an individualized diet, counseling, and/or specialized nutrition therapy.

S. **NY Surcharge.** Charges for surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or any other similar state statutes requiring such surcharges will be considered Covered Expenses by this Plan. Local, state and federal taxes associated with supplies or services covered under this Plan will also be considered Covered Expenses by this Plan.

T. **Outpatient Dialysis Program.** Subject to the requirements of the Plan's Outpatient Dialysis Program, charges for professional treatment, supplies, medications, labs, and facility fees related to outpatient dialysis services are covered for, but are not limited to, hemodialysis, peritoneal dialysis, and hemofiltration. Before treatment begins, contact the Claims Administrator at (800) 426-9786 to notify the Plan of upcoming treatment. See **Outpatient Dialysis Program** in the **DEFINITIONS** section below for details.

U. **Outpatient Habilitative Services.** Charges for occupational, physical, or speech therapy are covered to acquire, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition. Benefits include treatment of congenital anomalies for a Newborn Child. If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to therapy.

All services or therapies must be Medically-Necessary and provided by a Physician or Licensed Health Care Provider, but may be provided in a variety of Inpatient or Outpatient settings. (See **Inpatient Rehabilitation** above.)

V. **Outpatient Rehabilitation.** Charges for Occupational, Physical, or Speech Therapy provided in a variety of Outpatient settings to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to Illness, Injury, or disabling condition. Benefits include treatment of congenital anomalies for a Newborn Child. If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to therapy.

All services or therapies must be Medically-Necessary and provided by a Physician or Licensed Health Care Provider, but may be provided in a variety of Inpatient or Outpatient settings. (See **Inpatient Rehabilitation** above.)

W. **Partial Confinement Treatment.** Charges for Medically-Necessary Partial Confinement Treatment when Inpatient confinement would otherwise be required for care and treatment of an Injury or Illness. Services must be for more than four (4) hours, but less than 24 hours per day and provided for intermediate short-term or medically-directed intensive treatment. The attending Physician must submit a written Partial Confinement Treatment Plan to the Claims Administrator prior to beginning treatment and must review and evaluate the patient's progress on a regular basis.

Specifically excluded from the Partial Confinement Treatment benefit are the following:

1. Non-medical, long-term or Custodial Care.
2. Services performed by a member of the patient's Family or household.
3. Services not included in the written Partial Confinement Treatment Plan.
4. Charges for Recovery Houses.
5. Education, training and educational materials.
6. Items or treatment not Medically Necessary to the care or recovery of the patient.

X. **Patient Care Services.** Patient Care Services in conjunction with a Qualified Clinical Trial. Patient Care Services are defined as health care items or services that are furnished to an Individual enrolled in a Qualified Clinical Trial, which is consistent with the Usual & Customary standards of care for someone with the patient's diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the Qualified Clinical Trial.

Patient Care Services do not include any of the following:

1. An FDA approved drug or device shall be a Patient Care Service only to the extent that the drug or device is not paid for by the manufacturer, the distributor or the provider of the drug or device, or
2. Non-health care services that a patient may be required to receive as a result of being enrolled in the Qualified Clinical Trial , or
3. Costs that would not be covered for non-investigational treatments, or
4. Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Qualified Clinical Trial, or
5. The costs of services, which are not provided as part of the Qualified Clinical Trial's stated protocol or other similarly intended guidelines.

Y. **PKU.** Phenylketonuria (PKU) dietary formula.

Z. **Temporomandibular Joint (TMJ) Disorders.** Medical services and supplies for treatment of TMJ disorders are covered on the same basis as any other medical condition. Medical services and supplies are those which are:

1. Reasonable and appropriate for the treatment of a disorder of the Temporomandibular Joint, under all the factual circumstances of the case; and
2. Effective for the control or elimination of one or more of the following, caused by a disorder of the Temporomandibular Joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and
3. Recognized as effective, according to the professional standards of good medical practice, and
4. Not Experimental and/or Investigational or primarily for cosmetic purposes.

MEDICAL PLAN LIMITATIONS AND EXCLUSIONS

The following Exclusions and Limitations apply to expenses Incurred by all Covered Persons:

1. **Alternative Treatments.** Charges for alternative or holistic treatments, such as acupressure, Rolfing, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health;

2. **Cosmetic Procedures.** Charges Incurred in connection with the care or treatment of, or surgery performed for, a Cosmetic Procedure, unless Medically Necessary:
   a. Due to an Injury;
   b. For correction of congenital deformity in a Covered Child;
   c. For reconstructive surgery as necessary for the prompt treatment of an Illness or Injury; or
   d. For reconstructive breast surgery following a mastectomy as provided under the Mastectomy and Breast Reconstruction Services benefit of this Plan.

3. **Counseling and Other Therapies.** Counseling, education or training services, including family, marital, social, sexual, or lifestyle counseling; Milieu therapy; art, cultural, dance, horseback therapy, music, social or swim therapies; non-medical self-help activities, such as "Outward Bound" or "Wilderness Survival," outreach or vocational assistance, or work hardening; and recreational activities, such as exercise, fitness, or maintenance-level programs;

4. **Court-Ordered Treatment.** Charges for services Incurred as a result of a court order;

5. **Dental Care.** Services, supplies or charges for preventive dental care, restoration, bridges, dentures, or orthodontia, except Medically Necessary treatment due to accidental Injury to Sound Natural Teeth;

6. **Dependent's Pregnancy.** Any care connected with a dependent Child's Pregnancy, except for preventive care services required under the Affordable Care Act or for the treatment of Complications of Pregnancy;

7. **Education.** Charges for professional services on an Outpatient basis that can be credited toward earning a degree or furthering the education or training of a Covered Person (regardless of the diagnosis) that are in connection with mental Illness, Alcoholism, drug addiction, functional nervous disorders, mental and nervous disorders of any type or cause;

8. **Effective Date.** Charges Incurred prior to the Effective Date of Coverage under the Plan or after coverage is terminated;

9. **Elective or Voluntary Termination of Pregnancy**;

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

11. **Excluded Charges.** Charges Incurred in connection with services and supplies that are not Medically Necessary for treatment of the Injury or Illness; or are in excess of: a) the Maximum Allowable Charge, as determined by the Claims Administrator; b) any negotiated rate with a provider; c) actual billed amounts; or d) Usual & Customary and/or Reasonable (UCR) charges;

12. **Experimental and/or Investigational Services.** Charges for Experimental and/or Investigational procedures, drugs, or research studies, or for any services or supplies not considered legal in the United States. Other exceptions to this Exclusion are:
   a. Patient Care Services in conjunction with a Qualified Clinical Trial; or
   b. Chemotherapy treatment using drugs not specifically covered by an FDA approval if:
      1) The Covered Person is not part of any study or non-Qualified Clinical Trial, and

2) The Covered Person is being treated for cancer, and

3) The drug, device, treatment or procedure has been granted investigational new drug (IND) or Group C treatment IND status OR is being studied in a Phase III level national clinical trial sponsored by the National Cancer Institute, and

4) Based on available scientific evidence, is effective or shows promise of being effective for Illness, as determined by the Plan;

13. **Foot Care.** Routine or palliative foot care; care of corns, calluses, bunions (except capsular and bone surgery) toenails, or other symptomatic foot problems, except for appliances or treatment for the prevention of complications associated with diabetes;

14. **Foot Supports.** Arch supports, shoe inserts, or corrective shoes, except as specifically provided as a benefit of this Plan;

15. **Foreign Medical Services.** Charges Incurred outside the United States if the Covered Person traveled to such a location for the *sole* purpose of obtaining medical services, drugs, or supplies;

16. **Hair Replacement.** Hair transplant procedures, wigs, artificial hair pieces or drugs which are prescribed to promote hair growth;

17. **Hearing Care.** Charges for the purchase and fitting of hearing aids and cochlear implants; or the purchase or fitting of such similar aid devices;

18. **Hospital Confinement.** Charges for Hospital confinement that is primarily for diagnostic purposes, common colds, or removal of small tumors (unless the services cannot be provided without the use of Inpatient hospitalization or Inpatient hospitalization for the Covered Person's medical condition is deemed Medically Necessary by the utilization review organization), physiotherapy, hydrotherapy, convalescent or rest care, sanitarium or rest cures, or confinement in an institution that is primarily a place for the treatment of chronic or long-term Injuries or Illnesses;

19. **Hospitalization for Dental Care.** Charges for Hospital care for dental procedures, unless adequate treatment cannot be provided without the use of Hospital facilities and the Covered Person has a medical condition besides the one requiring treatment that makes Hospital care Medically Necessary;

20. **Illegal Activities.** Any charge for care, supplies, treatment, and/or services for any Injury or Illness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a Reasonable doubt is not required to be deemed an illegal act. This Exclusion does not apply if the Injury: (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a physical or mental medical condition beyond the control of the Covered Person;

21. **Impotency.** Charges for treatment of impotency or penile implants;

22. **Infertility Treatment.** Charges for treatment of infertility, to restore fertility, or to induce Pregnancy, including but not limited to: artificial insemination, corrective or reconstructive surgery; embryo transfer, fertility drugs; gamma intra-fallopian transfer (G.I.F.T.); hormone injections; or in-vitro fertilization. However, a Pregnancy resulting from such conception will be covered under the regular benefits of this Plan, as applicable;

23. **Legal Obligation.** Charges Incurred for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage;

24. **Medically-Related Travel.** Air travel, transportation by private automobile or taxi service or other ground transportation, whether or not recommended by a Physician, except as provided herein under the Ambulance benefit;

25. **Motor Vehicle Accident.** Services and supplies to the extent that benefits are payable under the terms of any contract or insurance offering, including, but not limited to, motor vehicle medical, motor vehicle no-fault, or other personal Injury protection (PIP) coverage and commercial premises or homeowner's medical premises coverage, or similar type of coverage or insurance. Any benefits provided by this Plan contrary to this Exclusion are provided solely to assist the Covered Person. By providing such benefits, this Plan is not waiving any right to reimbursement, recovery, or to subrogation as provided in this Plan;

26. **Negligence.** Any charge for care, supplies, treatment, and/or services for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician;

27. **Non-Covered Services or Supplies.** Any other services or supplies that are not specifically listed as a benefit of this Plan;

28. **Non-Medical Charges.** Charges for missed or cancelled appointments; mailing and/or shipping and handling expenses; or expenses for preparing medical reports, itemized bills or claim forms. This Exclusion does not apply to expenses incurred by the Plan for utilization review, audits or investigation of a claim for benefits if approved by the Plan Administrator;

29. **Orthognathic Surgery.** Upper or lower jaw augmentation or reduction procedures (orthognathic surgery);

30. **Over-the-Counter Supplies.** Charges for vitamins; nutritional supplements; over-the-counter drugs and supplies; food supplements; herbal, naturopathic or homeopathic medicines or devices; aromatherapy, hair analysis; or devices not Medically Necessary (as determined by the Plan Administrator) for the treatment of an Injury or Illness;

31. **Personal Care.** Charges Incurred for services or supplies: a) which constitute personal comfort or beautification items; b) for television or telephone use; c) in connection with Custodial Care; or d) for education or training expenses actually Incurred by other persons;

32. **Physician Supervision.** Charges for any fees for a Physician or Licensed Health Care Provider for treatment that the Physician or Licensed Health Care Provider did not personally provide or have direct oversight;

33. **Private Duty Nursing**;

34. **Professional Athletics.** Charges for Injuries related to professional or Semi-Professional Athletics, including practice;

35. **Public Services.** Services and supplies that are payable by any charitable grant, foundation, government, public program, or national health plan of any other country, except as otherwise required by law;

36. **Relatives or Household Members.** Charges for services rendered by a Physician and/or Licensed Health Care Provider, if such Physician and/or Licensed Health Care Provider is a Close Relative of the Covered Person or resides in the same household as the Covered Person;

37. **School Services.** Charges for academic or career counseling; assessment and treatment services that are primarily vocational and academic; school-ordered assessment and treatment not considered Medically Necessary;

38. **Sterilization.** Charges for voluntary sterilization or the reversal of a sterilization procedure;

39. **Subrogation, Reimbursement, and/or Third Party Responsibility.** Any charge for care, supplies, treatment, and/or services of an Injury or Illness not payable by virtue of the Plan's Third Party Recovery, Subrogation and Reimbursement provisions, which appear elsewhere in this Plan Document;

40. **Surrogate Pregnancy.** Pregnancies that are the result of or for the purposes of surrogate maternity;

41. **Transgender Procedures.** Charges for diagnosis or treatment of trans-sexualism, gender dysphoria or sexual reassignment;

42. **Travel Expenses.** Travel expenses, a) whether or not recommended by a Physician and/or Licensed Health Care Provider, b) Incurred by a Physician and/or Licensed Health Care Provider attending a Covered Person, or c) for a person accompanying a Covered Person, except as specifically provided in the Transplant Benefit;

43. **Unrecognized Medical Treatments.** Charges for services, supplies or treatments not recognized by the American Medical Association as generally accepted and Medically Necessary for the diagnosis and/or treatment of an Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value, except if covered as an approved experimental and/or investigation treatment;

44. **Vision Care.** Charges Incurred in connection with the purchase or fitting of eyeglasses, contact lenses (except following cataract surgery); any surgical procedure to correct near-sightedness or far-sightedness, including radial keratotomy, photorefractive keratectomy; or visual analysis, therapy or training, or orthoptics;

45. **War or Terrorist Act.** Charges Incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country. An act of terrorism will not be considered an act of war, declared or undeclared;

46. **Weight Reduction.** Charges Incurred in connection with surgical procedures for weight reduction (including reversals or complications from these surgeries); pre- and post-bariatric surgery nutritional counseling; and weight loss programs regardless of the medical indications, except as allowed under the Affordable Care Act Preventive Services; and

47. **Worker's Compensation.** Charges Incurred as the result of an Illness or Injury arising out of, or in the course of, employment for which the Covered Person is entitled to benefits under any worker's compensation, occupational disease, or similar law (including any occupational Injury or Illness arising out of self-employment).

PRE-CERTIFICATION OF HOSPITAL ADMISSION

Diocese of Yakima has contracted with American Health Holding to be its medical reviewing agency to review for medical or surgical necessity when hospitalization is recommended. **PRE-CERTIFICATION DOES NOT GUARANTEE PAYMENT OF BENEFITS**. Pre-certification is to determine that hospitalization is necessary; payment of benefits is subject to Eligibility and other plan provisions.

The following program(s), administered by American Health Holding will assist the patient in becoming better informed about the proposed treatment while assuring quality of care and cost containment.

<u>PRE-CERTIFICATION OF HOSPITALIZATION AND ADVANCED IMAGING</u>

When a Physician recommends Hospitalization, the Covered Person, the Physician, or the Hospital must call American Health Holding as soon as possible <u>but no later than 48 hours before the scheduled admission</u>.

Pre-certification is required for the following Hospital admissions:

1. All acute Hospital admissions (including Chemical Dependency, Maternity, Mental Health, and Inpatient Rehabilitation) and Skilled Nursing Facility admissions;
2. All Inpatient or Partial Confinement admissions at a Psychiatric Health Facility or an Alcoholism Treatment Center, Drug Addiction Treatment Facility or Residential Treatment Facility; and
3. Outpatient Advanced Imaging procedures, such as scintimammography, MRI, MRA, PET, CT, capsule endoscopy, and genetic testing.

NOTE: Contact American Health Holding (AHH) at (888) 877-7994 before Hospital admissions and Outpatient Diagnostic procedures.

If American Health Holding determines that an admission is not medically or surgically necessary, they will recommend alternate health care settings or treatment that will maintain both quality health care and cost-effective options. The Covered Person will also be notified of his right to appeal such a decision.

<u>EMERGENCY HOSPITALIZATION</u>

If Emergency Hospitalization is necessary, the Covered Person, a Family member, your Physician or the Hospital are advised to contact American Health Holding within 48 hours following admission.

NOTE: Contact AHH at **(888) 877-7994** within 48 hours to report an Emergency Hospitalization.

If you call American Health Holding on the weekend or at night, you should leave a message on the voice mail answering machine. Your message should include:

1. The Covered Person's name;
2. Patient's name, if other than the Covered Person;
3. Identify the patient as a Covered Person with the Diocese of Yakima Plan;
4. Telephone number where the Covered Person or a Family member can be reached;
5. Name of Hospital where patient is being admitted;
6. Reason for Hospital admission; and
7. Date of admission.

<u>CONTINUED STAY REVIEW</u>

The American Health Holding health care professionals will continue to monitor the patient's Hospital stay to the designated discharge date. If the patient's condition requires a longer stay than initially designated, they will review the patient's medical situation to determine if the additional days are Medically Necessary.

MEDICAL CASE MANAGEMENT

This Plan may provide case management services to address chronic Illnesses and catastrophic Injuries or disabilities. The case manager collaborates with the patient and his health care team to promote quality of care, while assuring the best use of the Plan's and the patient's health care dollars.

The case manager assesses information from the patient, his family and his Physician to develop a written treatment plan to meet the patient's Medically Necessary needs. This treatment plan identifies specific goals and recommends appropriate treatments to achieve them. The case manager closely monitors all treatments to ensure that the health care services are benefiting the patient and continue to be cost-effective. The Plan Administrator, however, continues to make all determinations of benefits regarding any recommended treatments.

MATERNITY EDUCATION PROGRAM

To support wellness during pregnancy for mother and child, this Plan is offering a Maternity Education Program for education and one-on-one support from a maternity nurse specialist. The maternity nurse will speak regularly with the member to provide educational information, help with managing healthy diet and exercise, and discuss any questions that may arise. Through health management and continuous assessment, any risk factors for mother or baby may be addressed quickly to maintain a health pregnancy and a healthy baby.

Participation in the Maternity Education Program is voluntary, but members who participate are eligible to limit their maternity expenses to the Maternity Out-of-Pocket Maximum, as shown in the **MEDICAL SUMMARY OF BENEFITS** above. When Out-of-Pocket maternity expenses reach the Maternity Out-of-Pocket Maximum, all additional maternity expenses will be paid at 100% benefit.

CLAIMS PROCEDURES

The procedures outlined below must be followed by Covered Persons ("Claimants") to obtain payment of health benefits under this Plan.

CLAIMS DEFINITIONS

"*Assignment of benefits*" means an arrangement whereby the Claimant assigns their right to seek and receive payment of benefits provided under this Plan to a Physician or Licensed Health Care Provider. If a provider accepts an "Assignment of Benefits" for services, supplies, and/or treatment rendered, the provider's rights are the same as those of the Plan Participant.

"Claim for benefits" means any request for a plan benefit or benefits made by a Claimant in accordance with a plan's reasonable procedures for filing benefit claims.

"Claimant" means an individual who makes a claim for payment or reimbursement of costs as a benefit under this Plan. The term Claimant may also include an *"authorized representative."*

"Clean Claim" means a claim for benefits that may be processed in accordance with the terms of this document without obtaining additional information from the service provider or a third party. It is a claim that has no defect or impropriety. A defect or impropriety includes a lack of required supporting documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review to establish Usual & Customary, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

HEALTH CLAIMS

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

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

WHEN HEALTH CLAIMS MUST BE FILED

Health claims must be filed with the Claims Administrator within 12 months of the date charges for the service were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Charges are considered Incurred when treatment or care is given or supplies are provided. **Claims filed later than that date will be denied.** However, on termination of the Plan, final claims must be received within 90 days of termination.

HOW TO FILE A CLAIM

Most Health Care Providers will file claims on the Claimant's behalf. Electronically submitted claims are processed most efficiently. If unable to file electronically, the Covered Person, his Physician and/or Licensed Health Care Provider, or an authorized representative must file a "paper" claim as described below.

Required Claim Information. The following information is required in order to qualify a request for benefits as a Clean Claim (as defined above):

1. The Company/Employer name;
2. The Plan Participant's name, ID number and current address;
3. The patient's name, ID number and address if different from the Participant's;

4. The Physician and/or Licensed Health Care Provider's name, tax identification number, address, degree and signature;
5. Date(s) of service(s);
6. Place of service(s);
7. Diagnostic Code;
8. Procedure Codes (describes the treatment or services rendered);
9. Assignment of Benefits (as defined in this section), signed (if payment is to be made to the Physician and/or Licensed Health Care Provider);
10. Release of Information Statement, signed; and
11. Explanation of Benefits (EOB) information if another plan is the primary payer.

Whether a provider or the Participant submits the claim, each claim must contain the required data elements on the standard claim forms (HCFA-1500 (revision 12/90 and later); UB92; or ADA (revision 12/90 and later)), any attachments and/or additional elements or revisions to data elements, attachments and additional elements, of which the provider or Participant has knowledge. Either a paper claim form or electronic file record must be complete, legible, and accurate.

The Plan Administrator may require attachments or other information in addition to these standard forms to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document.

Claims must be submitted individually for each Claimant. Multiple claims should not be stapled together.

Where to File. Completed claims should be sent to the Claims Administrator:

TPSC Benefits
P.O. Box 2950
Tacoma, Washington 98401-2950
FAX: (253) 564-5881

The claim will be "filed" when received at the address listed above. If a Covered Person has any questions regarding eligibility, benefits or claims information, TPSC Benefits should be contacted at: (800) 426-9786.

Failure to provide requested information may result in claims being denied or payment reduced.

TYPES OF CLAIMS

Under the Plan, there are two types of claims: Pre-Service Claims and Post-Service Claims.

Pre-Service Claims. A pre-service claim means any claim for a benefit where the terms of the Plan require advance approval of obtaining medical care. A pre-service claim may be either for urgent care or non-urgent care.

Pre-Service Non-Urgent Care Claims. A "Pre-Service Non-Urgent Care Claim" is a claim for medical benefits or treatment under the Plan, where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. A Pre-Service Non-Urgent Care Claim will be completed and notification made to the Covered Person and his Physician as soon as possible, but no later than 15 days after receipt of the request.

Pre-Service Urgent Care Claims. A "Pre-Service Urgent Care Claim" is any claim for medical benefits or treatment under the Plan with respect to which the application of the time periods for making non-urgent care determinations a) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or b) in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A Pre-Service Non-Urgent Care Claim will be completed and notification made to the Covered Person and his Physician as soon as possible, but no later than 72 hours after receipt of the request.

Post-Service Claims. A "Post-Service Claim" is a claim for a benefit under the Plan after medical services or treatment have been rendered. A claim determination that involves only the payment of reimbursement of the cost of medical care that has already been provided will be made as soon as reasonably possible, but no later than 30 days from the day after receiving the claim.

Concurrent Care Claims. A "Concurrent Care" Claim is made when the participants is already receiving care, but the claim is usually a request for an extension of treatment, whether measured over a period of time or by a number of treatments, etc. If a claim is for an urgent extension of concurrent care and the request is made with 24 hours of the end of the time period or number of treatments, a determination must be made as soon as possible, but no later than 24 hours after receipt of the request. Otherwise, the normal time limits apply based on the type of claim.

Status of Claim. All submitted claims and appeals will fall into one of the categories described above. The handling of an initial claim or later appeal will be governed, in all respects, by the appropriate category of claim or appeal, and each time a claim or appeal is examined, a new determination will be made regarding the category into which the claim or appeal falls at that particular time.

EXTENSION OF TIME

The Plan will make every effort to meet the timeframes stated above. If a determination cannot be made within the stated timeframes due to circumstances beyond the control of the Plan, the Plan may unilaterally extend processing of Pre-Service Non-Urgent Care Claims and Post-Service Claims once for up to 15 days.

No extension is available for Pre-Service Urgent Care Claims or an urgent extension of Concurrent Claims.

INCOMPLETE CLAIMS

If any information needed to process a claim is missing, the claim is an "incomplete claim." The Claims Administrator may request more information as provided herein.

Failure to provide requested information may result in claims being denied or payment reduced.

Incomplete Pre-Service Urgent Care Claims. If a pre-service urgent care claim is not properly filed or incomplete, the Claims Administrator will notify the Claimant orally and/or by written notification (if requested by the Claimant) as soon as possible, but not later than 24 hours, after receipt of the claim. Notice must identify the specific information needed to complete the claim.

However, the Plan Administrator must make a determination on the basis of the information provided no later than 72 hours after receipt of the claim. If the Plan has not received sufficient information to approve the claim, the Plan may deny it and issue an adverse determination notice.

Other Incomplete Claims. If a Pre-Service Non-Urgent Care or a Post-Service claim is incomplete, the Plan may deny the claim or may take a 15-day extension of time, as described above. If the Plan needs an extension of time because the Claimant failed to provide information necessary to process the claim, and the Claimant is notified of this fact, the timeframe for the Plan to make the decision is suspended from the date of the notification.

The extension notice must include a description of the missing information and specify a timeframe of at least 45 days for the Claimant to provide the missing information. Beginning either on the date the Claimant's response is received or on the date that the Claimant's response was due (if no response is received), the Plan must make a determination within the 15-day extension period. A Claimant may voluntarily agree to extend the date for determination even under circumstances where the Plan has no authority to extend the deadline.

Incorrectly Filed Claims. If a Claimant fails to follow the Plan's rules or procedures as described above, the Claimant will not have correctly filed a claim. The Plan Administrator will notify the Claimant either orally and/or in writing (if requested by the Claimant) as soon as possible. If the claim is a pre-service urgent care claim, notice must be within 24 hours of receipt of the claim. If the claim is a pre-service non-urgent care claim, notice must be provided within five (5) days of receipt. No notice is required for incorrectly filed post-service claims.

If an adverse determination is made on the claim because of the failure to correctly file the claim, the Plan must identify the rule in its notice. The adverse determination notice must indicate that the rule was the basis for denying the claim or provide a copy of the rule to the Claimant.

The Plan Administrator has discretion in extending time for responses for any individual claim. However, the Plan has the discretion to deny claims at any point in the administrative process if it does not have sufficient information. If an adverse determination is made, the Claimant may then appeal the determination.

ADVERSE BENEFIT DETERMINATIONS

An adverse benefit determination generally means "a denial, reduction, or termination of, or failure to provide or make a payment (in whole or in part) for a benefit." An adverse benefit determination includes:

1. A determination that the Covered Person is not eligible to participate in the Plan;
2. A rescission of coverage;
3. A termination of benefits;
4. A denial of benefits based on a determination that:
   a. The service or treatment is not covered (or is excluded) by the Plan;
   b. Plan limits have been met or exceeded; or
   c. The benefit is Experimental and/or Investigational or not Medically Necessary or appropriate; or
5. A reduction in benefits, such as a payment for less than the total amount of expenses submitted.

Most adverse benefit determinations are in response to a claim having been filed. However, the Plan may make an adverse benefit determination without a claim being filed (e.g., a determination that a Covered Person is not eligible).

NOTICE OF ADVERSE BENEFIT DETERMINATION

Once the Claims Administrator has reviewed the claim, the Plan must notify the Claimant in writing of its determination. The most common notice to a Claimant is an Explanation of Benefits (EOB). An EOB will be an adverse benefit determination if it meets the definition above ("a denial, reduction, or termination of, or failure to provide or make a payment (in whole or in part) for a benefit").

Every notice of an adverse benefit determination must include sufficient information for the Claimant to appeal the adverse determination. The adverse benefit determination must include the following:

1. Information sufficient to identify the claim involved, including the date of service, the Health Care Provider, and the claim amount (if applicable), as well as the diagnosis code, the treatment code, and the corresponding meanings of these codes.
2. A statement of the specific reason(s) for the decision;
3. Reference(s) to the specific Plan provision(s) on which the determination is based;
4. A description of any additional material or information necessary to perfect the claim and why such information is necessary;
5. A description of the Plan procedures and time limits for appeal of the determination;
6. A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination or a statement that such information will be provided free of charge upon request;
7. If the determination involves scientific or clinical judgment, the Plan will disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request;
8. In the case of Pre-Service Urgent Care Claims, an explanation of the expedited review methods available for such claims;
9. A statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman; and
10. The following statement: "All claim review procedures provided for in the Plan must be exhausted before any legal action is brought."

Notification of the Plan's adverse determination on Pre-Service Urgent Care Claims may be provided orally, but written notification shall be furnished no later than three (3) days after the oral notice.

The Claimant may call the (TPSC) Claims Administrator at (800) 426-9786, to discuss the adverse claim determination if there are concerns. The Claimant may also express those concerns in writing and may submit additional information that to clarify any of the circumstances that led to the adverse claim determination.

Although the Claims Administrator may accept a request for an appeal by phone or in writing, it will not consider general questions or clarifications to be an appeal unless the Claimant specifically states that he is making a formal appeal. The process for filing a formal appeal is outlined below.

RIGHT TO APPEAL

The Claimant has the right to appeal an adverse benefit determination as described above. In addition, a decision to reduce or terminate benefits for a previously-approved course of treatment is also deemed to be an adverse benefit determination. The Plan must provide the Claimant with reasonable advance notice of the reduction or termination to allow him to appeal the Plan's decision before the benefit reduction or termination takes place.

The Claimant is entitled to a "full and fair review" of the adverse determination. "Full and fair review" means that:

1. The Covered Person will have the opportunity to submit written comments, documents, records, and other information related to the claim.

2. At the Covered Person's request (and free of charge), the Covered Person will be provided with reasonable access to (and copies of) all documents, records, and other information relevant to his claim for benefits. Included in this category are any documents, records or other information in his claim file, whether or not those materials were relied upon by the Plan in making its adverse determination. The Covered Person also has the right to review documentation showing that the Plan followed its own internal processes for ensuring appropriate decision-making.

3. The review of the Covered Person's claim will take into account all comments, documents and other information without regard to whether such information was submitted or considered in the initial benefit determination.

4. Any appeal of an adverse determination will not give deference to the initial decision on the Covered Person's claim, and the review will be conducted by a designated Plan representative who did not make the original determination and does not report to the Plan representative who made the original determination.

5. In deciding an appeal of any adverse benefit determination that is based on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is Experimental and/or Investigational or not Medically Necessary or appropriate), the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the particular field of medicine involved in the medical judgment. This health care professional will not be the same professional who was originally consulted in connection with the adverse determination; neither will this health care professional report to the health care professional who was consulted in connection with the adverse determination. The Plan will uphold the findings of the independent review in responding to the appeal.

6. The Plan will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination of the Covered Person's claim, whether or not that advice was relied upon in making the benefit determination.

INTERNAL APPEALS

The Plan has two internal appeals processes for Claimants: an Initial Appeal and a Final Appeal. If the Claimant is dissatisfied with the outcome of these internal appeals, the Claimant has the right to appeal to an Independent External Review organization. Procedures for these appeals are provided below.

Initial Appeal of Adverse Benefit Determination. To initiate an appeal, the Claimant must submit a request to appeal to the Plan **within 180 days** of receipt of an adverse benefit determination in order. The Claimant may submit a request to appeal in writing and may provide any additional information or documentation that may support the claim. An oral request for review is acceptable for Pre-Service Urgent Care Claims and may be made by calling the Claims Administrator at (800) 426-9786 and asking the Plan to register the oral appeal.

After the Covered Person submits the claim for appeal, the Plan will make a decision on the appeal as follows:

Appeal of Pre-Service Urgent Care Claims. The Plan's expedited appeal process for Pre-Service Urgent Care Claims will allow the Covered Person to request (orally or in writing) an expedited appeal, after which, all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Claimant by telephone, fax, or other expeditious method. The Claimant will be notified (in writing or electronically) of the appeal decision as soon as possible, but not later than 72 hours after the Plan receives the request for review of the prior benefit determination.

For Pre-Service Urgent Care Claims, the Covered Person may also request that an Independent External Review take place at the same time that the Covered Person pursues the Plan's internal appeal process.

Appeal of Pre-Service Non-Urgent Claims. For Pre-Service Non-Urgent Claims, the Covered Person will be notified (in writing or electronically) of the appeal decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days.

Appeal of Post-Service Claims. For Post-Service Claims, the Covered Person will be notified (in writing or electronically) of the appeal decision within a reasonable period of time, but not later than 30 days.

Denial of Initial Appeal. If the Covered Person's initial appeal is denied, the Plan must send him written or electronic notification that explains why the appealed claim was denied and will include the following:

1. A statement of the specific reason(s) for the decision;
2. Reference(s) to the specific Plan provision(s) on which the determination is based;
3. A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination or a statement that such information will be provided free of charge upon request;
4. If the determination involves scientific or clinical judgment, the Plan will disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request;
5. A statement indicating the Covered Person's right to receive, upon request (and free of charge), reasonable access to (and copies of) all documents, records, and other information relevant to the determination. Included in this category are any documents, records or other information in his claim file, whether or not those materials were relied upon by the plan in making its adverse determination; and
6. The following statement: "All claim review procedures provided for in the Plan must be exhausted before any legal action is brought."

Final Appeal of Adverse Benefit Determination. If the Covered Person is dissatisfied with the outcome of the Initial Appeal, he may make a Final Appeal. To begin the Final Appeal, the Covered Person must follow the same process required for the Initial Appeal. The Covered Person must submit a written request for appeal **within 60 days** following the receipt of the decision on the Initial Appeal.

After the Covered Person submits the claim for appeal, the Plan will make a decision on the appeal as follows:

Final Appeal of Pre-Service Urgent Care Claims. The Plan's expedited appeal process for Pre-Service Urgent Care Claims will allow the Covered Person to request (orally or in writing) an expedited appeal, after which, all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Covered Person by telephone, fax, or other expeditious method. The Covered Person will be notified (in writing or electronically) of the appeal decision as soon as possible, but not later than 36 hours after the Plan receives the second appeal.

Final Appeal of Pre-Service Non-Urgent Care Claims. For Pre-Service Non-Urgent Care Claims, the Covered Person will be notified (in writing or electronically) of the appeal decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days.

Final Appeal of Post-Service Claims. For Post-Service Claims, the Covered Person will be notified (in writing or electronically) of the appeal decision within a reasonable period of time, but not later than 30 days.

Denial of Final Appeal. If the Covered Person's second and Final Appeal is denied, the Plan will send the Covered Person written or electronic notification that explains why the appeal was denied and will include the following:

1. A statement of the specific reason(s) for the decision;
2. Reference(s) to the specific Plan provision(s) on which the determination is based;
3. A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination or a statement that such information will be provided free of charge upon request;
4. If the determination involves scientific or clinical judgment, the Plan will disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request;

5. A statement indicating the Covered Person's right to receive, upon request (and free of charge), reasonable access to (and copies of) all documents, records, and other information relevant to the determination. Included in this category are any documents, records or other information in his claim file, whether or not those materials were relied upon by the plan in making its adverse determination; and
6. The following statement: "All claim review procedures provided for in the Plan must be exhausted before any legal action is brought."

INDEPENDENT EXTERNAL REVIEW

Provided the Claimant has exhausted the internal appeals, he may have the right to have his claim reviewed by an Independent [External] Review Organization (IRO). Appeal to an IRO is limited to adverse benefit determinations involving medical judgment; experimental or investigational treatment; nonquantitative treatment limitations of Mental Health Parity and Addiction Equity Act (MHPAEA); or rescission of coverage. Medical judgment includes the Plan's requirements regarding medical necessity, medical appropriateness, health care setting, level of care, or effectiveness of a covered benefit. The request for an Independent External Review must be made within four (4) months of the date of the decision on the Final Appeal (final internal adverse claim determination).

In certain instances, the Claimant may be able to request an expedited Independent External Review. An expedited review to an IRO is warranted when the timeframe for completing the internal appeals process would seriously jeopardize the life or health of the Claimant, or their ability to regain maximum function; or if the final adverse benefit determination concerns an admission, the availability of care, a continued stay or health care service for which the Claimant received Emergency services, but has not yet been discharged from a facility.

Finally, if the Plan fails to substantially comply with this appeals process, the Claimant may request an expedited review. Minor or inadvertent failures would not justify an expedited review to an IRO.

The Plan must contract with at least three (3) different IROs and must assign appeals among them on a random or rotating basis. The Plan may assess a minimal fee to the Claimant of up to **$25** (which will be returned if the IRO rules in favor of the Claimant). No more than $75 may be assessed against a Claimant in a single Plan Year. If payment of the fee presents an undue financial hardship on the Claimant, this fee will be waived.

The IRO's final decision is binding on the Plan and the Claimant, except to the extent other remedies are available under state or federal law.

EXHAUSTION OF REMEDIES/LEGAL ACTION

This Plan requires a Claimant to exhaust all of the Plan's internal and external appeals before filing such action. If the last appeal is denied, the Claimant must then file a lawsuit no later than one (1) year after the date on that Notice of Adverse Determination, or the Claimant loses the right to bring an action on the denied claim.

CLAIMS REVIEW

Pursuant to the authority and discretion of the Plan Administrator (as described in the **PLAN ADMINISTRATOR** section below), the Plan Administrator may use its discretionary authority to utilize an independent third-party vendor (Claims Delegate) to review claims for reimbursement from medical service providers. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority to select claims for review or audit. A review is employed to identify charges that are billed in error; not Medically Necessary; in excess of Maximum Allowable Charges; or not Usual & Customary and/or Reasonable (UCR). Claims must also be consistent with any applicable term or condition stated within this Plan Document. *See* the **DEFINITIONS** section below for a detailed description of any of these terms.

To complete a comprehensive review, the Claims Delegate may access a patient's medical charts and records, in addition to medical billings, itemized statements of charges, and descriptions of the Services provided. Any additional information required for billing or medical record review will be requested directly from the service provider and/or the Claimant. If the service provider and/or the Claimant fail to provide the additional information within the designated time limits, the Claims Delegate may deny the Claim.

Upon completion of its review, the Claims Delegate will submit a report to the Plan Administrator that identifies any charges deemed to be billed in error; not Medically Necessary; in excess of Maximum Allowable Charges; not Usual & Customary and/or Reasonable (UCR); or otherwise inconsistent with any applicable term or condition stated within this Plan Document. Following review of the Claims Delegate's report, the Plan Administrator has the discretionary authority to deny a claim in whole or limit or reduce a claim to a UCR charge as provided in this Plan Document, but it may also increase the payment to the Provider, if appropriate.

If a claim is denied in whole or part, the Plan will provide the Claimant with a Notice of Adverse Benefit Determination as described above. The Claimant and/or the Facility may appeal the denial in accordance with the **CLAIMS PROCEDURES** detailed in this section.

GENERAL PROVISIONS

ALTERNATE BENEFITS

Alternate benefit means payment for those services or supplies which are not otherwise Covered Expenses of the Plan, but that the Plan Administrator believes to be Medically Necessary and cost-effective. If the Plan Administrator approves payment for alternate benefits, the Covered Person will be notified of such approval and the duration of such approval.

The fact that alternate benefits are paid by the Plan shall not obligate the Plan to pay such benefits for other Covered Persons, nor shall it obligate the Plan to pay continued or additional alternate benefits for the same Covered Person. Payments for alternate benefits are Covered Expenses for all purposes under the Plan.

AVAILABILITY OF BENEFITS

Benefits quoted to providers are not a guarantee of claim payment. Claim payment will be dependent upon eligibility at the time of service and all terms and conditions of the Plan.

For a written pre-treatment estimate, a provider of service must submit to the Claim Administrator their proposed course of treatment, including diagnosis, procedure codes, place of service and proposed cost of treatment. In some cases, medical records or additional information may be necessary to complete the estimate of benefits.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby deemed amended to conform to the minimum requirements thereto.

EXAMINATION

If necessary to assist in making a benefit determination, the Plan may request that the patient be examined by a Physician selected and paid by the Plan. If the patient chooses not to comply with this request, benefits will be denied.

MISCELLANEOUS

Section titles are for conveniences of reference only, and are not to be considered in interpreting this Plan. No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Plan.

RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, Limitations or Exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Covered Person on whose behalf such payment was made.

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

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

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agrees to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

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

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

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

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

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

STATEMENTS

In the absence of fraud, all statements made by a Covered Person will be deemed representations and not warranties. No such representations will void the Plan benefits or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such Covered Person.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition.

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

2. Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, the Plan Participant(s) agrees the Plan shall have an

equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

3. In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

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

Subrogation.

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

2. If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus Reasonable costs of collection.

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

4. If the Plan Participant(s) fails to file a claim or pursue damages against:
   a. The responsible party, its insurer, or any other source on behalf of that party;
   b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   c. Any policy of insurance from any insurance company or guarantor of a third party;
   d. Workers' compensation or other liability insurance company; or
   e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage,

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

Right of Reimbursement.

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

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

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

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

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

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

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

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

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

Obligations.

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
   a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions and/or cooperating in trial to preserve the Plan's rights;
   b. To provide the Plan with pertinent information regarding the Illness, disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;
   c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
   d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
   e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
   f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

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

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

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

Minor Status.

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

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

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

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

TIME LIMITATION

If any time limitation of the Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity, is less than that permitted by the law of the state in which the Plan is existent, such limitation is hereby extended to agree with the minimum period permitted by such law.

WORKER'S COMPENSATION NOT AFFECTED

This Plan does not affect any requirement for and is not in lieu of coverage provided by Worker's Compensation Insurance.

COORDINATION OF BENEFITS

The coordination of benefits provision is intended to prevent the payment of benefits that exceed Allowable Expenses. It applies when the Participant or any eligible dependent that is covered by the Plan is also covered by any other plan or plans. When more than one coverage plan exists, one Plan normally pays its benefits in full and the other plans pay reduced benefits. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed one hundred percent (100%) of Allowable Expenses. Only the amount actually paid by the Plan will be charged against any Plan maximums.

COORDINATION OF BENEFITS DEFINITIONS

"Allowable Expenses" means the Usual & Customary charge for any Medically Necessary, Reasonable, and eligible item of expense, at least a portion of which is covered under a plan. When some other plan pays first in accordance with the Coordination Order of Benefit Determinations provision (below), this Plan's Allowable Expenses shall in no event exceed the other plan's Allowable Expenses. When some other plan provides benefits in the form of services rather than cash payments, the Reasonable cash value of each service rendered—in the amount that would be payable in accordance with the terms of this Plan—shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had claim been duly made therefore.

"Claim Determination Period" means a Calendar Year or that portion of a Calendar Year during which the Covered Person for whom claim is made has been covered under this Plan.

"Plan" as used in this Section will mean any plan providing benefits or services for or by reason of medical and prescription treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group, whether on an insured or uninsured basis, including but not limited to:
    a. Hospital indemnity benefits; and
    b. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims;
2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
4. A licensed Health Maintenance Organization (H.M.O.);
5. Any coverage for students which is sponsored by, or provided through, a school or other educational institution; or
6. Any coverage under a governmental program and any coverage required or provided by any statute.

The Plan will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

COORDINATION ORDER OF BENEFIT DETERMINATION

Certain rules are used to determine which of the plans will pay benefits first. A plan with no Coordination of Benefits provision will determine its benefits before a plan with a Coordination of Benefits provision.

If the plans do contain a Coordination of Benefits provision, the following rules will apply:

1. A plan that covers a person as other than a dependent will determine its benefits before a plan that covers a person as a dependent.

2. A plan that covers a person as a laid-off Employee, a retired Employee or the dependent of a laid-off or a retired Employee will determine its benefit after the plan that does not cover such person as a laid-off Employee, a retired Employee or the dependent of a laid-off or a retired Employee. If one of the plans 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.

3. When a claim is made for a Dependent Child who is covered by more than one plan,

a. If there is a decree establishing financial responsibility for medical expenses of the Dependent Child (that is, a "Qualified Medical Child Support Order"), benefits as a Dependent of the parent with financial responsibility are determined before benefits as a Dependent of the parent without financial responsibility **for the duration of the decree**.

b. If there is no decree establishing financial responsibility for medical expenses of the Dependent Child, these are the rules for determining which plan pays first:

1) If the Child resides with <u>both</u> parents:

a) The benefits as a Dependent of the parent whose birthday falls earlier in the Calendar Year are determined before those of the plan of the parent whose birthday falls later in that year; except,

b) If both parents have the same birthday, the benefits of the plan that has covered the parent longer are determined before those of the plan that has covered the other parent for a shorter period;

c) If the other plan does not have the rules stated in this item 3(b)(1) or (2), but instead has the rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rules in the other plan will determine the order of benefits.

2) If the Child resides with only one (1) of the parents, these are the rules for determining which plan pays first:

a) The plan of the parent with custody, then

b) The plan of the spouse of the parent with custody, then

c) The plan of the parent without custody; then

d) The plan of the spouse of the parent without custody.

4. If the above rules still do not establish an order, benefits are determined first under the plan that has covered the Employee for the longest period of time.

<u>COORDINATION WITH MEDICARE</u>

If an Employee remains actively employed after becoming entitled to (i.e. enrolled in) Medicare benefits, this Plan will continue to be the primary payer of health care benefits. Medicare would be the secondary payer of benefits.

The Plan also coordinates with Medicare as follows:

1. **End-Stage Renal Disease (ESRD)**. The Plan will be primary coverage for the first thirty (30) months of dialysis treatment; after this period, the Plan will be secondary to Medicare for this disease only; and

2. **Mandated Coverage under Another Group Plan**. If a Participant is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

If an Employee voluntarily declines or terminates coverage under this Plan, then Medicare would become the sole and primary payer.

<u>EXCESS INSURANCE</u>

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

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

1. Any primary payer besides this Plan;

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

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

4. Worker's Compensation or other liability insurance company; or

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

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plan or Plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, this Plan will be fully discharged from liability.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

RIGHT OF RECOVERY

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

SECONDARY COVERAGE

Plan beneficiaries who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the beneficiary incurring costs which are not covered by this Plan, which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by this Plan.

VEHICLE LIMITATION

When medical payments are available under any vehicle insurance, the Plan will pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the vehicle insurance carrier. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

PLAN ADMINISTRATION

The Plan Sponsor may appoint an individual or entity to act as the Plan Administrator and who serves at the convenience of the Plan Sponsor. The Plan Sponsor grants the greatest, legal degree of discretionary authority to interpret the Plan Document, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms. If the Plan Administrator resigns, dies, dissolves, removed from the position, or is otherwise unable to perform the duties of the Plan Administrator, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

DUTIES OF THE PLAN ADMINISTRATOR

The Plan Administrator must administer this Plan in accordance with its terms and establish its policies, practices, and procedures, and in compliance applicable federal laws. The Plan Administrator may retain the services of qualified professionals to assist in the administration of the Plan.

Specifically, the Plan Administrator may appoint and supervise a third-party administrator to pay claims for reimbursement of benefits provided by this Plan Document. The Plan Administrator shall establish a procedure for filing a claim for benefits and for Plan Participants to appeal any denial of such claim as consistent with applicable law. The Plan Administrator shall review appeals of denied claims and may uphold or reverse such decisions.

The Plan Administrator has the discretion to decide the facts and circumstances of a claim for benefits and may approve or deny a claim in whole or in part. Any reduction or increase of a claim for reimbursement shall be based on the Plan Administrator's determination of Medical Necessity, Maximum Allowable Charges, Usual & Customary and/or Reasonable (UCR), or the negotiated rate in a contractual arrangement with a provider.

The Plan Administrator's determinations of the eligibility, benefits, and reimbursement of any claim are entitled to great deference under law. Subject to the Claimant's rights to appeal as provided in the **CLAIMS PROCEDURES** section above, the Plan Administrator's determinations will be final and binding on all interested parties.

In addition, the duties of the Plan Administrator include the following:

1. To determine all questions of eligibility, enrollment, and coverage under the Plan;
2. To make factual findings;
3. To keep and maintain the Plan Documents and all other records pertaining to the Plan;
4. To perform all necessary reporting as required;
5. To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
6. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
7. To perform each and every function necessary for or related to the Plan's administration.

AMENDING AND TERMINATING THE PLAN

The Plan Sponsor intends to maintain this Plan indefinitely; however, the Plan Sponsor, through its officers and directors, may amend, suspend or terminate the Plan in whole or in part at any time in its sole discretion. The Plan Sponsor shall enact any amendment, suspension or termination in accordance with the requirements of its legal status, including, but not limited to, Articles of Incorporation, Bylaws, Partnership Agreement, or other business agreement governing the Plan Sponsor's decision-making procedures and in accordance with applicable federal and state laws.

The Plan Sponsor shall provide notice of any amendment, suspension, or termination of the Plan or any of its benefits to participants. If the Plan is terminated, a Participant's claim for benefits is limited to expenses Incurred before the date of termination. The Plan Sponsor shall designate a date certain for all amendments, suspensions, or terminations to be effective.

DEFINITIONS

NOTE: The following words and phrases shall have these general meanings. ***The inclusion of a particular definition is not an indication of whether or how the Plan covers any related services or supplies.*** For specific information about your Plan, please rely on the descriptions in your Plan Document and Summary Plan Description, or contact TPSC Member Services at (800) 426-9786, ext. 210.

Accidental Injury. An injury that results accidentally or from any external, violent and anticipated causes. For instance, an unintentional bodily injury resulting from any external force and against the normal course of events can be categorized as an accidental injury.

Alcoholism. A morbid state caused by excessive and compulsive consumption of alcohol that interferes with the patient's health and social or economic functioning.

Alcoholism Treatment Center, Drug Addiction Treatment Facility, or Residential Treatment Facility. A treatment facility that is approved by the Washington State Department of Social and Health Services (or another state) for treatment of Alcoholism, drug addiction and/or mental illness that meets the following criteria:

1. Has a Physician and/or Licensed Health Care Provider on site 24 hours per day;
2. Completes a systemic physical examination by a Physician and/or Licensed Health Care Provider and a health history screening by interview or standardized questionnaire;
3. Patient must be admitted by a Physician and/or Licensed Health Care Provider;
4. Has medical treatment available 24 hours per day/seven (7) days a week, actively supervised by an attending Physician;
5. Has the ability to assess and recognize medical complications that threaten life or bodily functions, and to obtain needed services either on-site or externally;
6. Has 24-hour supervision with evidence of close and frequent observation;
7. Provides living arrangements that foster community living and peer interaction and are consistent with developmental needs;
8. Offers group therapy sessions with a Physician and/or Licensed Health Care Provider;
9. Has the ability to involve family and other support systems in therapy (required for Children and adolescents, encouraged for adults);
10. Has individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
11. Provides a level of skilled intervention consistent with patient risk;
12. Provides active discharge planning initiated upon admission to the program;
13. Provides access to at least weekly sessions with a Physician and/or Licensed Health Care Provider for individual psychotherapy;
14. Charges patients for its services;
15. Services are managed by a Physician and/or Licensed Health Care Provider that functions under the direction/supervision of a licensed Psychiatrist (Medical Director);
16. Meets any applicable licensing standards established by the jurisdiction in which it is located; and
17. Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

Recovery Houses are not covered. Residential Crisis Treatment Centers or Residential Treatment Facilities designed to provide **only** a substance-free residential setting are not covered.

Ambulance. A specifically designed and equipped automobile or other vehicle such as an airplane, boat or helicopter which meets all local, state and federal regulations for transporting the sick and injured.

Ambulatory Surgical Center. An institution or facility, either free standing or as part of a Hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a 24-hour period. An office maintained by a Physician for the practice of medicine or Dentistry, or for the primary purpose of performing terminations of Pregnancy, shall not be considered to be an Ambulatory Surgical Center.

Benefit Period. A time period of one (1) year as shown on the Summary of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the one (1) year period so established; or
2. The day the Covered Person ceases to be covered for benefits of this Plan.

Benefit Recapture Period. The period of time that a participant can reinstate coverage and credit will be given towards the Deductible and Out-of-Pocket Maximum for the time previously covered under this Plan if reinstated during the same Calendar year in which employment terminated.

Birthing Center. Any freestanding health facility, place, professional office or institution that is not a Hospital, or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop Complications of Pregnancy or require pre- or post-delivery confinement.

Brand Name Drug. A drug manufactured by a pharmaceutical company which has chosen to patent the drug's formula and register its brand name.

Calendar Year. A period of time commencing on January 1 and ending on December 31 of the same given year.

Centers of Excellence. Medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Claims Administrator will determine what network Centers of Excellence are to be used.

Claims Administrator. The person or firm retained by the Plan Administrator who is responsible for performing certain ministerial functions for the Plan.

Close Relative. The spouse, parent, brother, sister, child, aunt, uncle or grandparent of the Covered Person or the Covered Person's spouse.

COBRA. Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, that provides for continuation of health care coverage after termination of employment.

Company. The Diocese of Yakima and any participating parishes or affiliates.

Complications of Pregnancy. Benefits are available to a covered Employee, Spouse, or dependent child for services rendered to treat the following Complications of Pregnancy:

1. Severe hemorrhage from any cause;
2. Spontaneous/missed abortions (miscarriages);
3. Severe cardiac disease;
4. Severe infection;
5. Severe renal disease; or
6. Pulmonary edema and maternal cardiovascular accident (CVA).

In no event will the term Complication of Pregnancy include cesarean section delivery as an alternative to vaginal delivery, false labor, occasional spotting, Physician-prescribed rest, morning sickness, hyperemesis gravidarum, pre-eclampsia, or similar conditions associated with the management of a difficult pregnancy but not constituting a classifiably distinct Complication of Pregnancy.

Coronary Care Unit. A section, ward, or wing within the Hospital which is separated from other facilities and:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill coronary patients;
2. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and
3. Provides constant observation and treatment by Registered Nurses or other highly trained Hospital personnel.

Cosmetic Procedure. A procedure performed solely for the improvement of a Covered Person's appearance rather than for the restoration of bodily function.

Covered Expenses. The Usual & Customary and/or Reasonable (UCR) charges or the Preferred Provider allowance for Necessary or Medically Necessary treatments, services, or supplies that are listed as a covered benefit of the Plan. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of a Covered Expense.

Covered Person. Any Participant or dependent of a Participant meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

Custodial Care. That type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist a Covered Person in the activities of daily living regardless of disability. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

Dependent Coverage. Eligibility under the terms of the Plan for benefits payable as a consequence of Covered Expenses Incurred for an Illness or Injury of a properly-enrolled dependent.

Drug Addiction Treatment Facility. See definition of Alcoholism Treatment Center, Drug Addiction Treatment Facility or Residential Treatment Facility.

Durable Medical Equipment. Equipment that is:

1. Able to withstand repeated use;
2. Primarily and customarily used to serve a medical purpose; and
3. Not generally useful to a person in the absence of Illness or Injury.

Emergency. A sudden and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson, acting reasonably, to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. Examples include, but are not limited to, heart attacks; cardiovascular accidents; poisonings; loss of consciousness or respiration; broken bones; automobile accidents; severe bleeding; or convulsions.

Employee. See definition of Covered Person.

Employer. See definition of Company.

Enrollment Date. The earlier of: a) the first day of coverage, or b) if there is an eligibility Waiting Period for benefits, the first day of the eligibility Waiting Period.

ERISA. The Employee Retirement Income Security Act of 1974 or any provision or section thereof which is herein specifically referred to as such Act, provision or section may be amended from time to time.

Essential Health Benefits. Under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and Newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

This Plan may not cover all services defined as “Essential Health Benefits.” *See* the section titled **BENEFITS PROVIDED BY YOUR MEDICAL PLAN** for details on specific services covered by this Plan.

Exclusions. Services and charges not covered under this Plan.

Experimental and/or Investigational. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan Administrator to be:

1. Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
2. Not approved by the U.S. Food and Drug Administration (FDA), or other appropriate regulatory agency to be lawfully marketed for the proposed use;
3. The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "**Qualified Clinical Trials**" section below; or
4. The subject of an ongoing Phase I, II, or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "**Qualified Clinical Trials**" section below.

Family. A Participant and his eligible dependents.

Fluoride. A substance which when topically applied or applied to drinking water is effective in resisting tooth decay.

Formulary Brand Name Drug. A drug found on a list of preferred Brand Name Drugs developed by a committee of pharmacists and Physicians. This committee meets regularly to discuss new drug trends. These preferred Brand Name Drugs are as effective yet, generally less costly, than non-preferred Brand Name Drugs (Brand Name Drugs NOT listed on the Formulary List).

It is important to note that the formulary will not restrict your access to medications; it simply requires that you pay more if you are prescribed a Brand Name Drug, or if a Generic Drug is not available.

Generic Drug. A drug that is generally equivalent to a higher-priced Brand Name Drug that meets all FDA bioavailability standards.

Genetic Information. Information about genes, gene products, and inherited characteristics that may derive from an individual's laboratory tests or medical examination.

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HIPAA Privacy Rule grants health care consumers a greater level of control over the use and disclosure of personally identifiable health information. In general, health care providers, health plans, and clearinghouses are prohibited from using or disclosing health information except as authorized by the patient or specifically permitted by the regulation. The HIPAA Standards Rule sets standards for the electronic exchange and security of a consumer's health information.

Home Health Care Agency. A public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.
2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one Physician and at least one Registered Nurse to govern the services provided and it must provide for full-time supervision of such services by a Physician or Registered Nurse.
3. It maintains a complete medical record on each individual.
4. It has a full-time administrator.

Home Health Care Plan. A program for continued care and treatment of the Covered Person established and approved in writing by the Covered Person's attending Physician. The attending Physician must certify in the Home Health Care Plan that the proper treatment of the Illness or Injury would require confinement as a resident Inpatient in a Hospital in the absence of the services and supplies provided as part of the Home Health Care Plan.

Home Infusion Therapy. Administration of fluids into a vein by means of a needle or catheter, most often used for the following purposes: a) to maintain fluid and electrolyte balance; b) to correct fluid volume deficiencies after excessive loss of body fluids; c) for those unable to take sufficient volumes of fluids orally; or d) to provide prolonged nutritional support to those with gastrointestinal dysfunction.

Hospice. A health care program providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse, and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital. An institution that meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient's expense;
2. It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located which pertain to Hospitals;
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury;
4. Such treatment is provided for compensation by or under the supervision of Physicians with continuous 24-hour nursing services by Registered Nurses;
5. It qualifies as a Hospital, a psychiatric Hospital, or a tuberculosis Hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
6. It is a provider of services under Medicare; and
7. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

Hospital Miscellaneous Expenses. The actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services (including intensive nursing care however designated), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

Illness. A bodily disorder, disease, physical sickness, mental infirmity, or functional nervous disorder of a Covered Person. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one Illness.

Immediate Family. A Covered Person's husband or wife; mother or father; child or sibling; step-parent or step-child; step-brother or step-sister; father-in-law or mother-in-law; son-in-law or daughter-in-law; brother-in-law or sister-in-law; grandparent or grandchild; or spouse of grandparent or grandchild.

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

Injury. Trauma or damage to the Covered Person's body from an external force.

Inpatient. The classification of a Covered Person when that person is admitted to an institution (such as a Hospital, Hospice, or Skilled Nursing Facility) for treatment, and charges for Room and Board are Incurred as a result of such treatment.

Intensive Care Unit. A section, ward, or wing within the Hospital which is separated from other facilities and:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;
2. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and
3. Provides constant observation and treatment by Registered Nurses or other highly trained Hospital personnel.

Licensed Practical Nurse. An individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

Lifetime. Benefit maximums accrued while covered by this Plan. Lifetime does not mean the lifetime of the Covered Person.

Limitations. Restrictions such as age, period of time covered and Waiting Periods, which may limit coverage or benefits under this Plan.

Maintenance Drugs. Medications 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.

Massage Therapy. The scientific manipulation of soft body tissues (muscle, connective tissues, tendons and ligaments) for the purpose of normalizing those tissues and consists of manual techniques that include applying fixed or movable pressure, holding, and/or causing movement of or to the body.

Maximum Allowable Charge. The benefit payable for a specific coverage item or benefit under the Plan.

For Preferred Providers, the Maximum Allowable Charge(s) will be:

1. The allowable charge specified under the terms of the Plan;
2. The negotiated rate established in a contractual arrangement with a provider; or
3. The actual billed charges for the covered services.

For Non-Preferred Providers, the Maximum Allowable Charge(s) will be the lesser of:

1. The Usual & Customary and/or Reasonable (UCR) amount;
2. The allowable charge specified under the terms of the Plan;
3. The negotiated rate established in a contractual arrangement with a provider; or
4. The actual billed charges for the covered services.

The Plan has the discretionary authority to decide if a charge is Usual & Customary and/or Reasonable (UCR) and/or a Medically Necessary service.

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medically Necessary or Medical Necessity. A medical service or supply that:

1. Is provided by or under the direction of a Physician or other duly licensed health care practitioner who is authorized to provide or prescribe it **and**
2. Is determined by the Plan Administrator or its designee to meet **all** of the following requirements:
    a. It is consistent with the symptoms or diagnosis and treatment of the illness or injury; **and**
    b. It is not provided primarily for the convenience of the patient, Physician, Hospital, Health Care Provider, or health care facility; **and**
    c. It is an "appropriate" service or supply given the patient's circumstances and condition; **and**
    d. It is a "cost-efficient" supply or level of service that can be safely provided to the patient; **and**
    e. It is safe and effective for the Illness or Injury for which it is used.

A medical service or supply will be considered to be "appropriate" if:

1. It is a diagnostic procedure that is called for by the health status of the patient, and is (a) as likely to result in information that could affect the course of treatment and (b) no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient's overall health condition.
2. It is care or treatment that is (a) as likely to produce a significant positive outcome and (b) no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient's overall health condition.

A medical service or supply will be considered to be "cost-efficient" if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses Incurred in connection with the service or supply.

The fact that the Physician may provide, order, recommend or approve a service or supply **does not mean** that the service or supply will be considered to be Medically Necessary for the medical coverage provided by the Plan.

A hospitalization or confinement to a Skilled Nursing Facility or other specialized health care facility will **not** be considered to be Medically Necessary if the patient's Illness or Injury could safely and appropriately be diagnosed or treated while not confined.

Medicare. The programs established by Title I of Public Law 89-98 (79 Statutes 291) as amended entitled "Health Insurance for the Aged Act," and which includes Parts A, B and D and Title XVIII of the Social Security Act (as amended by Public Law 89-97, 79), as amended from time to time.

Minor Emergency Medical Clinic. A free-standing facility which is engaged primarily in providing minor Emergency and episodic medical care to a Covered Person. A board-certified Physician, a Registered Nurse, and a registered x-ray technician must be present at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered to be a Minor Emergency Medical Clinic, by whatever actual name it may be called; however, a clinic located on or in conjunction with or in any way made a part of a regular Hospital shall be excluded from the terms of this definition.

Named Fiduciary. The Company, as the Plan Administrator.

Newborn. An infant from the date of his birth until the initial Hospital discharge or until the infant is 31 days old, whichever occurs first.

Non-Formulary Brand Drug. A drug NOT listed on the Formulary Brand Name Drug list. A Non-Formulary Brand Name Drug may be prescribed, but will cost more than a Generic or Formulary Brand Name Drug.

Occupational Therapy. Therapy designed to help the Covered Person attain the maximum level of physical and psycho-social independence following Illness or Injury or to maintain skills that would deteriorate without treatment. This includes fine motor coordination, perceptual-motor skills, sensory testing, adaptive/assistive equipment, activities of daily living and specialized upper extremity and hand therapies

Orthopedic Appliance. A rigid or semi-rigid support used to restrict or eliminate motion in a diseased, injured, weak or deformed body member.

Orthotics. Mechanical appliances or apparatus for orthopedics used to support, align, prevent, or correct deformities or to improve function of movable parts of the body.

Outpatient. The classification of a Covered Person when that Covered Person receives medical care, treatment, services or supplies at a clinic, a Physician's office, or at an institution where the patient is not a registered bed patient, such as a Hospital, an Outpatient Psychiatric facility or an Outpatient Alcoholism Treatment Center or Drug Addiction Treatment Facility.

Outpatient Dialysis Program. The requirements to which benefits provided under this Plan for treatment received in connection with Outpatient Dialysis Treatment are subject. This program will be the exclusive means for determining the amount of benefits to be provided to a Covered Person and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

Reasons for the Dialysis Program. The dialysis program has been established for the following reasons:

1. The concentration of dialysis providers in the market in which a Covered Person resides may allow such providers to exercise control over prices for dialysis-related products and services,
2. The potential for discrimination by dialysis providers against the Plan because it is a non-federal government and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Covered Persons,
3. Evidence of (i) significant inflation of the prices charged to Covered Persons by dialysis providers, (ii) the use of revenues from claims paid on behalf of Covered Persons to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-federal government and non-commercial plans by the dialysis providers as profit centers, and
4. The fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Covered Persons, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Covered Persons' interests, such as subsidies for other plans and discriminatory profit-taking.

Dialysis Program Components. The components of the dialysis program are as follows:

1. Application. The dialysis program will apply to all claims filed by, or on behalf of, a Covered Person for reimbursement of products and services provided for purposes of Outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").

2. Claims affected. The Dialysis Program will apply to all dialysis-related claims incurred on or after **November 1, 2018**, regardless of when the initial claim was received by the Plan with respect to the Covered Person, provided that all claims must nonetheless be made on a timely basis as otherwise required by the Plan.

3. Mandated cost review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination, the Plan Administrator will consider factors including:

   a. Market concentration: The Plan Administrator will consider whether the market for Outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration, multiple dialysis facilities under common ownership or control will be counted as a single provider.

   b. Discrimination in charges: The Plan Administrator will consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to Outpatient dialysis providers by federal government and commercial plans for the same or materially comparable goods and services.

4. Payment limitations. In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been material factors resulting in an increase of the charges for Outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the claims and all future claims for Outpatient dialysis goods and services from the same provider with respect to the Covered Person, to the following payment Limitations, under the following conditions:

   a. Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the Covered Person, dialysis-related claims received prior to the cost review determination may, but are not required to, be paid at the face or otherwise applicable rate.

   b. Where the provider is or has been a participating provider under a Preferred Provider organization (PPO) available to the Covered Person, upon the Plan Administrator's determination that payment Limitations should be implemented, the rate payable to such provider will be subject to the Limitations of this section.

   c. The Maximum Allowable Charge for dialysis-related claims subject to the payment Limitation will be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all applicable Coinsurance and/or Deductibles.

   d. With respect to dialysis-related claims, the Plan Administrator will determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding Calendar Year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

   e. The Covered Person, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator will increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

   f. All charges must be billed by a provider in accordance with generally-accepted industry standards.

5. Provider agreements. Where appropriate, and a willing appropriate provider acceptable to the Covered Person is available, the Plan Administrator may enter into an agreement establishing the rates payable for Outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this section of the Plan and clearly state that such agreement is intended to supersede this section.

6. <u>Discretion</u>. The Plan Administrator will have full authority and discretion to interpret, administer and apply this section, to the greatest extent permitted by law.

Partial Confinement Treatment. Medical, psychiatric, nursing, counseling, or therapeutic services provided in a facility for the intermediate short-term or medically-directed intensive treatment of an Illness or Injury and must meet the following conditions:

1. It is carried out in a Hospital, Psychiatric Health Facility, Alcoholism Treatment Center, Drug Addiction Treatment Facility, Residential Treatment Facility or Skilled Nursing Facility;
2. It consists of Medically Necessary treatment for the condition of the patient in accordance with the written Partial Confinement Treatment Plan;
3. It does not require full-time confinement; and
4. It is supervised by a Physician who reviews and evaluates its effect on a weekly basis.

Partial Confinement Treatment Plan. A program for continued care and treatment of the Covered Person established and approved in writing by the Covered Person's attending Physician. The attending Physician must certify in the Partial Confinement Treatment Plan that the proper treatment of the Illness or Injury would require Inpatient confinement in the absence of the services provided as part of the Partial Confinement Treatment Plan.

Participant. An eligible Employee of the Company who meets the qualifications as stated in this Plan.

Participant Coverage. Coverage hereunder providing benefits payable as a consequence of an Injury or Illness of a Participant.

Patient Care Services. Health care items or services that are furnished to an individual enrolled in a Qualified Clinical Trial, which is consistent with the Usual & Customary standards of care for someone with the patient's diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the Qualified Clinical Trial.

Patient Care Services do not include any of the following:

1. An FDA approved drug or device shall be a Patient Care Service only to the extent that the drug or device is not paid for by the manufacturer, the distributor or the provider of the drug or device, or
2. Non-health care services that a patient may be required to receive as a result of being enrolled in the Qualified Clinical Trial, or
3. Costs that would not be covered for non-investigational treatments, or
4. Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Qualified Clinical Trial, or
5. The costs of services, which are not provided as part of the Qualified Clinical Trials' stated protocol or other similarly intended guidelines.

Physical Therapy. Therapy designed to help the Covered Person improve physical capabilities: a) to a previous level of good health; b) to the level of health that existed prior to Illness or Injury; c) to acquire function where development is not occurring at a normal rate; or d) to maintain function that would be lost without the therapy.

Physician. A legally-licensed Physician or Surgeon (MD), Chiropractic Physician (DC), Dentist (DDS or DMD), Naturopathic Physician (ND), Osteopathic Physician (DO), Podiatric Physician (DPM), Advanced Registered Nurse Practitioner (ARNP), Osteopathic Physician Assistant (OPA), or Physician Assistant (PA).

Physician and/or Licensed Health Care Provider. Legally-licensed medical or dental providers permitted to perform services within the scope of their license and as provided in this Plan, including, but not limited to: Physician (as defined above), Acupuncturist (L.Ac), Certified Nurse Midwife (CNM), Registered Nurse (RN), Licensed Practical Nurse (LPN), Home Infusion Therapist or Respiratory Care Practitioners; Community Mental Health Center and Mental Health Providers (CAC, CCMH, LCSW, LMHP, MSW, PhD); Dietician (D, RD or CD) or Certified Nutritionist (CN); Audiologist, Licensed Massage Therapist (LMT), Occupational Therapist (OT), Physical Therapist (PT) or Speech Therapist (ST); Hospital, Ambulatory Surgical Center, Birthing Center; Skilled Nursing Facility, Home Health Agency, Hospice; Alcoholism Treatment Center, Drug Addiction Facility, Psychiatric Health Facility, or Residential Treatment Facility; and/or Laboratory and Radiologic Technologists.

A Physician and/or Licensed Health Care Provider shall not include the Covered Person, any Close Relative of the Covered Person, or one who resides in the same household as the Covered Person.

Physician Visit. A meeting between a Physician, or Licensed Health Care Provider, and a patient for treatment.

Plan. This Diocese of Yakima Health Care Benefits Plan – Standard Plan.

Plan Document. This Plan Document and Summary Plan Description.

Plan Sponsor. The Company.

Preferred Provider. A provider within the Preferred Provider Service Area who has signed a Preferred Provider participant agreement with a Preferred Provider organization that has been contracted by the Plan or any other reciprocal provider network. These participating providers have agreed to offer their services at special rates to enrollees of this Plan.

Services of Non-Preferred Providers will be processed as if a Preferred Provider had been used, subject to Usual & Customary and/or Reasonable (UCR) charges, if the Participant or his Covered Dependent:

1. Receives Inpatient care and services from a Non-Preferred Provider immediately following Emergency room care and until the patient is stabilized. Following the patient's stabilization, benefits will be paid at Non-Preferred Provider benefit levels unless the patient chooses to move to a Preferred Provider facility;
2. Uses the services of a Preferred Provider x-ray facility who subsequently uses a Non-Preferred Provider radiologist for reading the x-ray;
3. Uses the services of both a preferred provider facility and a preferred provider surgeon and receives services from a non-preferred provider anesthesiologist;
4. Uses the services of both a preferred provider facility and a preferred provider surgeon and receives services from a non-preferred provider assistant surgeon;
5. Uses the services of a preferred provider which subsequently uses a non-preferred provider laboratory to process test material; or
6. In the case of a medical emergency, uses a preferred provider facility and receives care from a non-preferred provider surgeon, anesthesiologist or other ancillary provider.

If a Preferred Provider ceases to be a Preferred Provider (for reasons other than quality of care, fraud or failure to adhere to the network's policies and procedures), coverage may be continued for a specified time period for treatment in progress for a Covered Person who is:

1. In her 3rd trimester of pregnancy; or
2. Receiving care for end-stage renal disease and dialysis; or
3. Receiving Outpatient mental health treatment; or
4. Terminally ill, with anticipated life expectancy of six (6) months or less; or
5. Undergoing an active course of treatment for which changing to a different provider would be likely to cause significant risk of harm to the Cover Person's health; or
6. Undergoing chemotherapy or radiation therapy for treatment of cancer; or
7. A candidate for a solid organ or bone marrow transplant.

The Covered Person shall inform the Claims Administrator of the provider's termination within 60 days of such termination.

Preferred Provider Service Area. As defined by the Plan Administrator. If the Participant, or his Covered Dependent, does not reside within the Preferred Provider Service Area and services are received from a Non-Preferred Provider, benefits will be paid at the Preferred Provider level (limited to the Usual & Customary and/or Reasonable [UCR] allowance) and will apply to the Preferred Provider Out-of-Pocket Maximum.

If the Participant, or his Covered Dependent, resides within the Preferred Provider Service Area and services are obtained from a Non-Preferred Provider, benefits will be paid at the Non-Preferred Provider level **and will not** apply to the Preferred Provider Out-of-Pocket Maximum unless:

1. The Claimant has traveled outside of the Preferred Provider Service Area and Emergency medical services are required; OR
2. There is no Preferred Provider facility within the Preferred Provider Service Area that is able to render Medically Necessary treatment. In this case, the Claimant must provide documentation to the Claims Administrator for approval.

Pregnancy. The period from conception to birth.

Primary Care Physician. A Physician and/or Licensed Health Care Provider who practices primarily in General Practice, Family Practice, Geriatric Medicine, Internal Medicine, OB/GYN, or Pediatrics, or who is a Nurse Practitioner (ARNP) or Physicians Assistant (PA).

Prosthetic Appliance. A device or appliance that is designed to replace a natural body part lost or damaged due to Illness or Injury, the purpose of which is to restore full or partial bodily function or appearance, or in the case of covered dental expenses, shall mean any device which replaces all or part of a missing tooth or teeth.

Psychiatric Care, also known as psychoanalytic care. Treatment for a mental Illness or disorder, a functional nervous disorder, Alcoholism or drug addiction by a duly licensed psychiatrist, Psychologist, licensed social worker or licensed professional counselor acting within the scope and Limitations of their respective license, provided that such treatment is Medically Necessary, and within recognized and accepted professional psychiatric and psychological standards and practices.

Psychiatric Health Facility. An administratively distinct governmental, public, private or independent unit or part of such unit that is licensed and certified by the state of locality's Department of Health or Department of Mental Health. A Psychiatric Health Facility provides short-term, acute Psychiatric Care on either a voluntary or involuntary basis to mentally ill persons. This care shall include, but not be limited to, the following basic services: psychiatry, clinical psychology, psychiatric nursing, social work, rehabilitation and drug administration and which provides for a licensed psychiatrist (M.D. or D.O.) who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

The term Psychiatric Health Facility does not include an institution, or that part of an institution, used mainly for nursing care, rest care, convalescent care, a Recovery House, care of the aged, Custodial Care or educational care.

Psychologist. An individual holding a doctoral degree in a graduate study program in psychology having no less than two years of supervised experience and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs psychological services.

Qualified Clinical Trial. A clinical trial that meets all the following conditions:

1. The clinical trial is intended to treat cancer in a patient who has been so diagnosed, and
2. The clinical trial has been peer-reviewed and is approved by at least one of the following:
    a. One of the United States National Institutes of Health;
    b. A cooperative group or center of the National Institutes of Health;
    c. A qualified non-governmental research entity identified in guidelines issued by the National Institutes' of Health for center support grants;
    d. The United States Departments of Defense or Veterans Affairs; or
    e. With respect to Phase II, III, and IV clinical trials only, a qualified institutional review board, and
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise, and
4. The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial, and
5. The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with the current legal and ethical standards, and
6. The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial, and
7. The clinical trial does not unjustifiably duplicate existing studies, and
8. The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.

Reasonable and/or Reasonableness. In the Plan Administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must comply with generally accepted billing practices for unbundling or multiple procedures.

Services, supplies, care and/or treatment that result from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Recovery House. Living arrangements that allow those who traditionally face marginalization a place to restore from the effects of alcohol or drug abuse as well as domestic conflict and mental illness. It may also be referred to as a "sober house" or "halfway house." It is primarily designed to provide only a substance-free residential setting and may involve strict codes of conduct, often reinforced by living arrangement contracts. Residents stay while they establish a sober support network, secure new employment and find new housing. Residents are typically only asked to remain sober and comply with a minimal recovery program. Recovery Houses are not covered.

Registered Nurse. An individual who has received specialized nursing training and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Rehabilitation Services. Services provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.

Residential Crisis Treatment Center. A temporary alternative for people experiencing an acute psychiatric episode or intense emotional distress who might otherwise face voluntary or involuntary commitment. It provides crisis stabilization, medication monitoring, and evaluation to determine the need for the type and intensity of additional services. It often includes treatment for co-occurring disorders based on either harm-reduction or abstinence-based approach to wellness and recovery. Residential Crisis Treatment Centers that do not provide Psychiatric Care or are designed to provide only a substance-free residential setting are not covered.

Residential Crisis Treatment Centers that do provide Medically Necessary treatment must also meet the qualifications of a Hospital, Psychiatric Health Facility, Alcoholism Treatment Center, Drug Addiction Treatment Facility, Residential Treatment Facility or Skilled Nursing Facility in order to be eligible for facility benefits.

Residential Treatment Facility. See definition of Alcoholism Treatment Center, Drug Addiction Treatment Facility or Residential Treatment Facility.

Respiratory Therapy. The introduction of dry or moist gasses into the lungs for treatment purposes.

Respite Care. Care provided by a Home Health Care Agency in accordance with the written Home Health Care Plan for the purpose of giving temporary relief from care giving duties to a Covered Person's unpaid caregiver.

Room and Board. All charges by whatever name called, which a Hospital, Hospice, Skilled Nursing Facility or other facility makes as a condition of occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care by whatever name called.

Semi-Private. A class of accommodations in a Hospital or convalescent nursing facility in which at least two patients' beds are available per room.

Semi-Professional Athletics. Athletic activities for gain or pay that require an unusually high level of skill and a substantial time commitment from the participants, who are nevertheless not engaged in the activity as a full-time occupation.

Skilled Nursing Facility. An institution or distinct part thereof operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide nursing and physical restoration services on an Inpatient basis for persons convalescing from Injury or Illness. Patients are engaged in physical restoration services to assist them to reach a degree of body functioning so that the patient may engage in self-care in essential daily living activities;
2. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse;
3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse;
4. It maintains a complete medical record on each patient;
5. It has an effective utilization review plan;
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, education or Custodial Care, or care of mental disorders; and
7. It is approved and licensed by Medicare.

This term also applies to expenses Incurred in an institution referring to itself as a convalescent nursing facility, extended care facility, convalescent nursing home, or any such other similar nomenclature.

Sound Natural Teeth. A tooth that is stable, functional, free from decay and advanced periodontal disease.

Source Brand Drug. A Brand Name Drug with no Generic Drug equivalent.

Specialist. Any Physician and/or Licensed Health Care Provider who does <u>not</u> practice primarily in General Practice, Family Practice, Geriatric Practice, Internal Medicine, OB/GYN, or Pediatrics, and who is not a Nurse Practitioner (ARNP) or Physicians Assistant (PA).

Speech Therapy. Therapy designed to help: a) to restore speech lost due to impairment following an Illness or Injury including, but not limited to, cardiovascular accident, tracheostomy, swallowing disorders, laryngectomy and neuromuscular disease; b) to acquire speech functions where development is not occurring at a normal rate; or c) to maintain speech capabilities that would be lost without the therapy.

Temporomandibular Joint. The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward. A Temporomandibular Joint disorder has one or more of the following characteristics: pain in the musculature associated with the Temporomandibular Joint, internal derangements of the Temporomandibular Joint, arthritic problems with the Temporomandibular Joint, or an abnormal range of motion or limitation of motion of the Temporomandibular Joint.

Totally Disabled. A physical state of a Covered Person resulting from an Illness or Injury which wholly prevents:

1. In the case of a Participant, from engaging in any and every business or occupation and from performing any and all work for compensation or profit; and
2. In the case of a dependent, from performing the normal activities of a person of like age and sex in good health.

Transplant Services. Procedures that are done to replace a diseased organ with a healthy one from another person (donor). In addition to those described at XI. <u>TRANSPLANT SERVICES</u> above, benefits are subject to the following terms and limitations:

<u>Evaluation</u>. Services and supplies related to a Transplant and provided to a Covered Person to determine if the Covered Person is an acceptable candidate for a Hospital's transplant program. This includes Transplant-related services for outpatient surgery, laboratory, radiologic and other diagnostic tests and examinations provided by or through a Physician.

<u>Organ and Tissue Procurement.</u> Services and supplies provided for organ and tissue procurement, including removal, preservation and transportation. Where there is a live donor, this benefit includes donor screening, donor transportation to and from the Hospital where the donation occurs and health services associated with the removal of the organ and/or tissue. This benefit is only available when a Covered Person is the recipient of the Transplant.

<u>Professional Fees for Surgical and Medical Services</u>. Professional fees for surgical services and other medical care associated with a Transplant and provided by or through a Physician and rendered in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.

<u>Inpatient Hospital Services</u>. Confinement related to a Transplant, including room and board, and services and supplies provided during Confinement (in a Semi-private Room) in a Hospital. Certain Transplant Services rendered during a Covered Person's Confinement are subject to separate benefit restrictions.

<u>Outpatient Emergency Transplant Services</u>. Services provided to stabilize and/or initiate treatment of Emergency conditions, related to a Transplant, and provided on an outpatient basis at either a Hospital or an Alternate Facility.

Home Health Agency Services. Part-time, intermittent services of a Home Health Agency, when related to a Transplant and provided under the direction of a Physician. Home Health Agency Services must be provided in your home, by or under the supervision of a registered nurse.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services. Confinement (in a Semi-private Room), including medical services and supplies, when related to a Transplant and provided under the direction of a Physician. Transplant Services must be provided in a Skilled Nursing Facility or Inpatient Rehabilitation Facility and are Covered only for Transplant-related care and treatment which otherwise would require Confinement in a Hospital.

Ambulance Services. Emergency ambulance transportation for the Covered Person and one companion, via ground or air, by a licensed ambulance service to and/or from the treating Hospital where Transplant Services are to be rendered. If the Covered Person is a minor, benefits are payable for two companions.

Outpatient Rehabilitation Services. Short-term outpatient rehabilitation services. Coverage is provided only for physical therapy, occupational therapy and cardiac/pulmonary rehabilitation that are related to a Transplant. Rehabilitation services must be performed in a Hospital or Skilled Nursing Facility or through a Home Health Agency or other provider.

Travel, Meals, and Lodging Reimbursement. Subject to the limitations and conditions set forth in section XI. TRANSPLANT SERVICES above, the following expenses are reimbursable when Covered Transplant Services are incurred by a Covered Person who must travel from his/her home to and/or from a Hospital where the Transplant and post-discharge follow-up care is provided. The Company must receive valid receipts for such charges before reimbursement will be made.

Treatment. Confinement, treatment, service, substance, materials, or device.

Urgent Care Center. A free-standing facility which is engaged primarily in providing minor Emergency and episodic medical care to a Covered Person. A board-certified Physician, a Registered Nurse, and a registered x-ray technician must present at all times while the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered to be an Urgent Care Center, by whatever actual name it may be called; however, a clinic located on or in conjunction with or in any way made a part of a regular Hospital shall be excluded from the terms of this definition.

Usual & Customary (U&C). Covered Expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same "area" by 90% of providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual & Customary, fee(s) must comply with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term "Usual & Customary" does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Plan Participant by a provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual & Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Waiting Period. The period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan is effective.

PLAN INFORMATION

1. **Name of Plan.** Diocese of Yakima Health Care Benefits Plan – Standard Plan

2. **Employer Identification Number (EIN) Assigned by the Internal Revenue Service:** 91-0586353

3. **Plan Number Assigned by the Plan Sponsor:** 501

4. **Type of Plan.** Self-Funded Medical and Prescription Drug Plan

5. **Type of Administration.** Contract administration with the Claims Administrator. The funding for the benefits is derived from the funds of the Plan Sponsor (and contributions made by covered Employees, if any). The Plan is self-insured.

6. **Name, Business Address, and Telephone Number of the Plan Sponsor.**

   Diocese of Yakima

Physical Address:[6]	Mailing Address:
101 S 12th Avenue	PO Box 2189
Yakima, WA 98902	Yakima, WA 98907
Phone: (509) 965-7117	

7. **Name, Business Address, and Telephone Number of the Plan Administrator (Named Fiduciary).**

   Same as above.

8. **Legal Entity; Service of Process.** The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator at the address as shown in #6 above.

9. **Name, Business Address, and Telephone Number of the Claims Administrator.**

   TPSC Benefits
   P.O. Box 1894
   Tacoma, Washington 98401-1894
   Phone: (253) 564-5850
   FAX: (253) 546-5881

10. **Plan Year.** The Plan Year is a Fiscal Year beginning November 1st through October 31st.

11. **Participating Employers.** Member Employer Parishes and Organizations of the Diocese of Yakima, including:

Diocese of Yakima Pastoral Center	Yakima, WA
Diocese of Yakima Clergy	Yakima, WA
Diocese of Yakima Seminarians	Yakima, WA
Blessed Sacrament Church	Grandview, WA
Calvary Cemetery	Yakima, WA
Christ the King Church	Richland, WA
Christ the King School	Richland, WA
Holy Apostles Church,	East Wenatchee, WA
Holy Family Church,	Yakima, WA
Holy Redeemer Church	Yakima, WA
Holy Rosary Church	Moxee, WA
Holy Spirit Church	Kennewick, WA
Holy Trinity Church	Goldendale, WA
Our Lady of Fatima Church	Moses Lake, WA
Our Lady of Guadalupe Church	Granger, WA

[6] Effective September 1, 2020.

11. **Participating Employers (cont'd):**

Our Lady of Lourdes Church	Selah, WA
Our Lady of the Desert Church	Mattawa, WA
Our Lady of the Snows Church	Leavenworth, WA
Sacred Heart Church	Prosser, WA
St Aloysius Church	Toppenish, WA
St Andrew Church	Ellensburg, WA
St Frances De Sales Church	Chelan, WA
St Francis X Cabrini, Division 507	Benton City, WA
St Francis Xavier Church	Cashmere, WA
St Henry Church	Grand Coulee, WA
St John the Baptist Church	Cle Ellum, WA
St John's Church	Naches, WA
St Joseph Child Care Center	Kennewick, WA
St Joseph Church	White Salmon, WA
St Joseph Church	Sunnyside, WA
St Joseph Church	Yakima, WA
St Joseph Church	Kennewick, WA
St Joseph Church	Wenatchee, WA
St Joseph School	Kennewick, WA
St Joseph School	Wenatchee, WA
St Joseph/Marquette School	Yakima, WA
St Mary Church	White Swan, WA
St Michael Archangel Church	Royal City, WA
St Paul Cathedral	Yakima, WA
St Paul Cathedral School	Yakima, WA
St Peter Claver Church,	Wapato, WA
St Pius Church	Quincy, WA
St Rose of Lima Church	Ephrata, WA
St Rose of Lima School	Ephrata, WA

APPENDIX A: BENEFITS PAYABLE FOR TRANSPLANT SERVICES FROM NON-PREFERRED PROVIDERS

Benefits for an organ transplant procedure provided by a Non-Preferred Provider will be provided according to the same terms, conditions, and limitations as described above in the section **BENEFITS PROVIDED BY YOUR MEDICAL PLAN**, subsection XI. TRANSPLANT SERVICES.

For Transplants received from Non-Preferred Health Care Providers, 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 Benefit Maximum of $150,000 for each Covered Person.

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

Services subject to the transplant episode and a Lifetime Benefit 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 included out-patient immunosuppressant drugs); cadaver organ donor procurement; complications related to the procedures; and follow-up care for services received during the 12-month period from the date of transplant.

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 Covered Charges.

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

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

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

APPENDIX B: SPECIAL COVERAGE FOR COVID-19 TESTING AND TREATMENT (EFFECTIVE JAN. 1, 2020)

The outbreak of corona virus (COVID-19) has resulted in the implementation of measures intended to assist individuals and families through this public health emergency. Congress has recently mandated that group health plans provide certain medical services related to COVID-19 testing at no cost sharing for plan participants. Consistent with this mandate, your Plan will implement these provisions for its participants, as follows:

1. **Eligibility.** All enrolled Employees and their Dependents are eligible for the benefits stated below.

2. **Extension of Coverage.** The Plan allows for extension of coverage for Employees who are absent and are: a) using accrued personal time off (PTO); b) on a Special Unpaid Leave of Absence; or c) eligible for COBRA due to a Qualifying Event. Coverage may also be extended for up to 90 days during an Employer-approved furlough, temporary layoff, or an unpaid leave of absence.

3. **Termination or Layoff.** Employees (and their Dependents) who have been terminated or laid off have continued coverage to the end of the month in which they have been terminated or laid off. Termination, layoff, and a reduction of hours are COBRA Qualifying Events allowing affected Employees to enroll in COBRA continuation coverage.

4. **Mandated Extension of Coverage.** Federal and state laws may require employer-sponsored coverage to be extended to employees while on protected leave:

   a. **Paid Sick Leave.** The new Washington Paid Family & Medical Leave (PFML), effective January 1, 2020, requires an employer to extend employer-sponsored coverage to an employee who is absent from work while on PFML. The Employee must make their required premium contributions as determined by the Employer during their absence.

      The FFCRA has also mandated extended paid sick leave. Consult with your Human Resources Department to determine how your company will implement these paid sick leave laws.

   b. **Family and Medical Leave Act.** Federal and state unpaid Family and Medical Leave laws (FMLA) require an employer to extend employer-sponsored medical coverage to an employee who is absent from work while on FMLA. The Employee must make their required premium contributions as determined by the Employer during their absence.

      The FFCRA has mandated extended Family and Medical Leave that would be partly unpaid and partly paid leave. Consult with your Human Resources Department to determine how your company will implement applicable family and medical leave laws.

   c. **Uniformed Services Employment and Reemployment Rights Act (USERRA).** Coverage may be extended for an Employee who is temporarily absent from work due to being called to active military duty under the USERRA. An Employer must continue coverage if the servicemember is deployed for 30 days or less. If the servicemember is on active duty for less than 24 months, coverage may be extended provided the Employee continues make their contributions to the Plan.

5. **Health Care Provider Visits.** Health care provider visits include in-person visits, telemedicine (or telehealth) visits, urgent care center visits, and emergency room visits that result in a referral for an FDA-approved COVID-19 test will be covered at no cost-sharing (i.e. Deductible, Copay and/or Coinsurance are waived).

6. **Diagnostic Testing.** If referred by the health care provider for testing, an FDA-approved COVID-19 test and all costs of administration and interpretation will be covered at no cost-sharing (i.e. Deductible, Copay and/or Coinsurance are waived).

7. **Outpatient Prescription Drugs.** Depending on your Pharmacy Plan, you may be able to obtain a refill of your covered prescription drugs prior to the expiration of the usual waiting time between refills. An early refill will cost the same and be subject to the same supply limit as any other refill. You should check with your Pharmacy to get more specific information about their refill policy.

8. **Additional Treatment.** Any additional Medically-Necessary treatment will be paid as any other condition, such as hospitalization, home care services, nursing facilities, or prescription drugs, as shown in the **MEDICAL SUMMARY OF BENEFITS.** Deductible, Copays, or Coinsurance will apply, except as specifically noted in the **MEDICAL SUMMARY OF BENEFITS** or this **APPENDIX**.

9. **Precertification.** No prior authorization or pre-certification is required for testing or a provider visit. If you are admitted to the hospital, however, contact American Health Holding at (888) 877-7994 as soon as possible.

10. **Extension of Certain Timeframes.** Certain timeframes affecting Special Enrollment, COBRA and Claim Appeals have been extended to protect an employee's health coverage portability and continuation coverage rights. Time requirements are extended for rights arising from an event that occurred during the National Emergency or for time requirements that would have otherwise expired during the "Outbreak Period."

    The "Outbreak Period" is the time from March 1, 2020, until the National Emergency is declared to end plus 60 days. For example, if the National Emergency is ended on May 31, 2020, the Outbreak Period would end 60 days later on July 30, 2020. Measuring the deadlines for exercising these rights would begin on July 31, 2020.

    If you believe that you have a right that may be affected by this extension, contact your Employer's Human Resources or Personnel Department or TPSC Member Services at (800) 426-9786 for more information.