Archdiocese of Washington
Health Care Plan

Priest Coverage

January 1, 2011

SUMMARY PLAN DESCRIPTION
TABLE OF CONTENTS

INTRODUCTION

The Archdiocese of Washington Health Care Plan (hereafter called the "Plan") is a self-funded group plan and is designed to assist you with the payment of medical, dental and vision expenses. Note: NCAS administers medical claims, only. Dental and vision claims are administered by separate companies.

This booklet is a Summary Plan Description. Using non-technical language, it describes your benefits under the Plan and will answer most of your questions. It contains a Schedule of Benefits, descriptions of the benefits listed in the Schedule, a list of the limitations of the Plan, definitions, instructions for filing claims and procedures on what to do if you have any problems with a claim.

The benefits and provisions of the Plan have been described as carefully as possible. A Table of Contents has been included to help you find the answers to your questions quickly. No one, **including NCAS**, can orally modify any Plan benefits or limitations. In order to fully understand your benefits and to avoid confusion, you should read this booklet carefully and completely.

The Plan includes a Preferred Provider Organization (PPO) option. A PPO is a network of hospitals and Physicians who render health care services to Participants. Employees will have a choice of obtaining medical services from a PPO (In-Network) or Non-PPO (Out-of-Network) provider. The In and Out-of-Networks differ in their payment schedule and claims filing procedures. In most instances, there is a higher rate of reimbursement for services rendered by PPO providers. To take advantage of the higher reimbursement, you must use a PPO provider.

Please contact the provider or the applicable PPO prior to receiving services to confirm the provider's participation in the PPO. Providers drop out of the PPO on occasion. In order to receive the PPO discounts, your provider must be in the PPO at the time the services are rendered.

Your Plan has a pre-admission/admission review requirement. If you are going to be or is admitted to the hospital, the Managed Care Vendor must be notified. Surgical procedures have an option for a Second Surgical Opinion.

If you do not notify the Managed Care Vendor for an inpatient admission, Covered Services will be reduced by $250. Refer to Chapter III for additional information. The Managed Care Vendor and its telephone number are located on your identification card.

If you have any questions, contact the Claims Administrator, NCAS. NCAS handles the day-to-day business of the Plan and will be glad to answer your questions. Their telephone number is **(703) 934-6227** or **1 (800) 888-6227**.

Note Regarding HIPAA Privacy:

NCAS complies with the privacy requirements outlined in the Health Insurance Portability and Accountability Act, otherwise known as HIPAA. The HIPAA Privacy Regulations are designed to provide protection against the unauthorized use and disclosure of a patient's health information.

If you call with a question about a member's claim, NCAS is required to confirm that the caller can identify several key pieces of information about the claimant. In addition to the member's name, the caller will be required to provide three (3) of the following forms of identity:

- Membership number
- Member date of birth
- Member address
- Member phone number
- Member zip code

Under certain circumstances, a completed Personal Representative or Authorization form will be required for an adult member. Adult members include the employee. To find out more about these new HIPAA regulations and obtain forms, go to www.ncas.com on the Internet.

CHAPTER I

ELIGIBILITY

WHO IS ELIGIBLE?

Priest – Eligibility under the Priest Plan will commence on the day of ordination or incardination in the Archdiocese, or on the date such Person is assigned by, and serving the Archdiocese.

Deacons (Transitory) - Eligibility under the Priest Plan will commence on the date of ordination or incardination in the Archdiocese.

Seminarians – Eligibility for certain Seminarians under the High Option Plan, will commence on the first day of the month following or coincident with the beginning of studies for the Archdiocese.

ENROLLMENT

HOW DO I ENROLL?

Employee - To become covered by the Plan, you must complete an enrollment application. During your new Employee orientation, you will be given an application to complete. You should return the completed form to the local Benefits Administrator within 30 days from your eligibility date.

Changing Status - If your employment status changes so that you are eligible to participate in the Plan, you must complete an enrollment form within 30 days of the date of eligibility.

EFFECTIVE DATE OF COVERAGE

WHEN DOES MY COVERAGE BECOME EFFECTIVE?

PRIEST PLAN

Initial Enrollment - The effective date of the eligible Priest, Deacon or Seminarian is on the **later** of the following dates:

a. The Plan's effective date, January 1, 2011;
b. The date of your Ordination or Incardination as Priest or Deacon (Transitory) of the Archdiocese of Washington;
c. The first of the month following receipt of approval of your application for coverage as a Priest assigned by and serving the Archdiocese of Washington.

Current Employees Who Become Eligible – For an Employee who, because of an employment status change, becomes eligible for coverage and who, properly completes an enrollment application, coverage for the Employee for whom coverage is elected, becomes effective on the 31st day after meeting the eligibility requirement.

TERMINATION

WHEN DOES MY COVERAGE TERMINATE?

Employee - Employee coverage shall automatically terminate immediately upon the earliest of the following dates, unless the covered Employee elects Extension of Benefits:

a. The last day of the month in which employment terminates;
b. The last day of the month in which the Employee ceases to be eligible;
c. The date this Plan is terminated (if Extension of Benefits is not available);

Certificate of Creditable Coverage – Each terminating Participant will receive a Certificate of Creditable Coverage, certifying the period of time the individual was covered under this Plan. If you have any questions or need to request a Certificate of Creditable Coverage, please contact your Benefits Administrator.

Extension of Benefits – Upon termination, the Employee currently enrolled is eligible for an extension of benefits for three months. The full premium must be paid by the employee. This provision does not apply to Qualified Early Retirement Employees; coverage ends the last day of the month in which the covered employee attains age 65 or earlier if premiums have not been paid.

During this extended coverage period, no changes can be made except to reduce (if applicable) or discontinue Medical and/or Dental/Vision coverage.

CHAPTER II

MEDICAL BENEFITS

PRIEST PLAN SCHEDULE OF MEDICAL BENEFITS		
You are entitled to the Covered Services described in this booklet. Payments from Out-of Network providers are based on the Allowed Benefit (see DEFINITIONS), in the amounts specified in the schedule shown below. In-Network payments are based on the allowable amount as contracted between the provider and the PPO Network in the amounts specified in the schedule shown below. Covered Services are subject to the Calendar Year Deductible as indicated and to the GENERAL LIMITATIONS AND EXCLUSIONS and other provisions of your Plan.		
Pre-Admission Certification: The Plan includes a Pre-admission certification requirement for all Hospital admissions. Failure to comply may result in reduced benefits**.** Please refer to Chapter V for those requirements.		
Individual Maximum:		
Hospice Care – Inpatient and Outpatient	6 months	
Individual Calendar Year Maximums:		
Extended Care (Skilled Nursing) Facility	30 days	
Chiropractic Care	$1,500 (In-Network only)	
Physical Therapy	30 visits	
TYPE OF EXPENSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical Deductible, Per Calendar Year:		
Individual	$150	$200
Out-of-Pocket Maximum, Per Calendar Year:		
Individual	$750	$1,500
The Out-of-Pocket Maximum is the amount you are responsible for paying for a covered service. Any amount satisfied applies toward both the In and Out-of-Network Out-of Pocket limits. Expenses for the following services do not count towards the out-of-pocket maximum: deductible, co-payments, pre-certification penalties, non-covered services and charges in excess of the Allowed Benefit. When the Out-of-Pocket Maximum is met benefits will increase to 100% of the Allowed Benefit for the remainder of the Calendar Year.		

TYPE OF EXPENSE	PRIEST PLAN	
	IN-NETWORK	OUT-OF-NETWORK
Hospital and Other Facility Expenses:		
Inpatient	90% Subject to deductible Pre-certification required	75% Subject to deductible Pre-certification required
Emergency Room (includes hospital and provider services)	$100 copay, then 90% Copay waived if admitted	$100 copay, then 90% Copay waived if admitted
Outpatient – Surgery, lab, x-ray, diagnostic services	90% Subject to deductible	75% Subject to deductible
Extended Care Facility	80% Subject to deductible Pre-certification required	75% Subject to deductible Pre-certification required
Ambulatory Surgical Facility	90% Subject to deductible	75% Subject to deductible
Office Visit or Clinic Visit in the Hospital	$20 copay, then 100%	75% Subject to deductible
Therapies – Chemotherapy, Physical, Speech, Occupational, Radiation, Renal dialysis, Respiratory (physical therapy limited to 30 visits per calendar year)	90% Subject to deductible	75% Subject to deductible
Professional Expenses		
Anesthesia - Inpatient and Outpatient	90% Subject to deductible	75% Subject to deductible
Chiropractic Care ($1,500 max per Calendar Year)	50% Subject to deductible	N/A
Diagnostic tests, radiology, pathology – Inpatient or Outpatient Hospital	90% Subject to deductible	75% Subject to deductible
Emergency Room Professional	90% Subject to deductible	90% Subject to deductible
Physician Visits - Inpatient	90% Subject to deductible	75% Subject to deductible
Physician Visits - Office	$20 copay, then 100%	75% Subject to deductible
Therapies – Chemotherapy, Physical, Speech, Occupational, Radiation, Renal dialysis, Respiratory (physical therapy limited to 30 visits per calendar year)	90% Subject to deductible	75% Subject to deductible
Second Surgical Opinion	100%	75% Subject to deductible
Surgery – Inpatient	90% Subject to deductible	75% Subject to deductible
Surgery - Outpatient Hospital or Facility	90% Subject to deductible	75% Subject to deductible
Surgery - Physician's office	$20 copay, then 100%	75% Subject to deductible

TYPE OF EXPENSE	PRIEST PLAN	
	IN-NETWORK	OUT-OF-NETWORK
Other Eligible Expenses:		
Allergy Testing	$20 copay, then 100%	75% Subject to deductible
Allergy Shots/Serum	90% Subject to deductible	75% Subject to deductible
Ambulance	90% Subject to deductible	90% Subject to deductible
Cardiac Rehabilitation	90% Subject to deductible	75% Subject to deductible
Durable Medical Equipment	90% Subject to deductible	75% Subject to deductible
Home Health Care (100 visit maximum)	90% Subject to deductible	75% Subject to deductible
Home Infusion Therapy	90% Subject to deductible	75% Subject to deductible
Hospice (maximum of 6 months)	100%	100%
Laboratory, X-Rays and Diagnostic Tests (not included with office visit)	90% Subject to deductible	75% Subject to deductible
Medical Supplies	90% Subject to deductible	75% Subject to deductible
Pre-admission Testing	90% Subject to deductible	75% Subject to deductible
Private Duty Nursing	90% Subject to deductible	75% Subject to deductible
Prosthetic Device and Orthotic Device	90% Subject to deductible	75% Subject to deductible
Urgent Care Centers	$20 copay, then 100%	75% Subject to deductible
Organ Transplants		
Inpatient Hospital	90% Subject to deductible Pre-certification required	75% Subject to deductible Pre-certification required
Anesthesia	90% Subject to deductible	75% Subject to deductible
Transplant procedure	90% Subject to deductible	75% Subject to deductible
Lab, x-rays, diagnostic tests	90% Subject to deductible	75% Subject to deductible
Travel, lodging, meals	90% Subject to deductible	
Donor expenses	90% Subject to deductible	75% Subject to deductible
Procurement	90% Subject to deductible	75% Subject to deductible
Preventive Care		
Preventive and Wellness Services for eligible adults in compliance with the Patient Protection and Affordable Care Act of 2010.	100%	N/A

TYPE OF EXPENSE	PRIEST PLAN	
	IN-NETWORK	IN-NETWORK
Mental Health Benefits		
Inpatient Hospital **	90% Subject to deductible Pre-certification required	75% Subject to deductible Pre-certification required
Inpatient Hospital Visits by Physician	90% Subject to deductible	75% Subject to deductible
Outpatient Visits	$20 copay, then 100%	75% Subject to deductible
Substance Abuse Benefits		
Inpatient Hospital **	90% Subject to deductible Pre-certification required	75% Subject to deductible Pre-certification required
Inpatient Hospital Visits by Physician	90% Subject to deductible	75% Subject to deductible
Outpatient Visits	$20 copay, then 100%	75% Subject to deductible

** Pre-certification required with the exception of St. Luke's Institute

Notes:

1. Benefits for services provided by a participating provider are payable as shown in the Schedule of Benefits. For a list of participating providers, please go to ncas.com, click on Provider Search and then click on the PPO network listed on your membership card. Verify the provider participates with the PPO (ask the provider or call the PPO) before you receive services to obtain In-Network benefits.
2. The Office Visit and Outpatient Surgery in the physician's office copays include diagnostic radiology, pathology, laboratory and other services performed in the office and billed by the Physician.
3. Any service applied to a maximum applies toward both the In-Network and the Out-of-Network maximum limits.
4. Emergency care rendered outside the PPO service area will be paid at the In-Network benefit level.
5. Anesthesia, x-rays, laboratory, emergency room services, and other diagnostic services (including consultants) rendered at a PPO facility will be paid at the In-Network benefit level.

COMPREHENSIVE MEDICAL BENEFITS

PLAN PROVISIONS

Individual Deductible - Each Participant's annual Deductible is shown in the Schedule of Benefits. This Deductible must be met once each Calendar Year and applies to Covered Services indicated in the Schedule of Benefits.

Out-of-Pocket Limit - After you have met the Deductible expense, the Plan will pay the amount specified in the Schedule of Benefits. The remaining percentage, for which you are responsible, is called Out-of-Pocket expense. When your out-of-pocket expense reaches the limit shown in the Schedule of Benefits for claims incurred during a Calendar Year, the Plan will pay 100% of the PPO or the Allowed Benefit of that individual's eligible expenses for the remainder of that Calendar Year. Expenses applied to your deductible, penalties for non-certified hospital admissions, non-covered services, In-Network copay amounts, Prescription copays, and charges in excess of the Allowed Benefit do not apply toward the Out-of-Pocket Limit.

Copay - The dollar amount (shown in the Schedule of Benefits) a Participant is required to pay for a covered service. A copay is expressed as a flat dollar amount and does not apply toward the Deductible or Out-of-Pocket limit.

COVERED MEDICAL SERVICES

COVERED SERVICES - A Participant is entitled to the following benefits for Medically Necessary Care only when services are rendered by a certified or Licensed Provider. All benefits are subject to the General Exclusions and Limitations and other provisions of this Plan. Payments to Out-of-Network providers are based on the Allowed Benefit. In-Network payments are based on the allowable amount as contracted between the provider and the PPO Network.

Alcoholism and Substance Abuse Services - Benefits are available for inpatient (including a licensed or certified alcoholism or substance/drug abuse treatment facility) or Outpatient care for alcohol and/or substance abuse disorders including individual and group therapy, medical management, and other expenses related to the diagnosis when rendered by a:

a. Doctor of Medicine (MD);
b. Licensed Clinical Psychologist (PhD);
c. Licensed Clinical Social Worker (LCSW);
d. Licensed Professional Counselor (LPC);
e. Registered Nurse Clinical Specialist (RNCS).

Outpatient day treatment (4 or more hours) is covered as an office visit.

Ambulance Service - Benefits are provided for ground or air ambulance for:

a. Emergency transportation to the nearest Hospital facility equipped to treat the patient's condition;
b. Transportation from one facility to another facility to provide more appropriate care;
c. Transportation to and from a facility to provide appropriate care.

Anesthesia - Benefits are provided for the cost and administration of anesthesia.

Cardiac Rehabilitation Program - The Plan provides benefits for Cardiac Rehabilitation Programs for a heart attack, heart Surgery, or diagnosis of angina pectoris when services are rendered by a Hospital-based Cardiac Rehabilitation Program or a program that is coordinated with a Hospital. Services are limited to a maximum of 90 visits, renewable following an additional Hospitalization for a heart attack, heart Surgery, or diagnosis of angina pectoris.

Care Management - In cases where the patient's condition is expected to be or is of a serious nature, the Claims Administrator may arrange for review and/or care management services from a professional qualified to perform such services, usually the Managed Care Vendor. The Managed Care Vendor or other professional approved by the Claims Administrator shall have the right to alter or waive, in writing, the normal provisions of this Plan to achieve the most efficient use of medical resources and the best patient outcome.

Benefits provided under this provision are subject to all other Plan provisions. Alternative care will be determined on the merits of each individual case and any care or treatment provided will not be considered as setting a precedent or creating any future liability, with respect to that or any other Participant.

Chiropractic Care - Benefits are provided for detecting and correcting structural imbalance, distortion, misalignment or incomplete or partial dislocation of or in the vertebral column. Eligible expenses do not include maintenance and Palliative Treatment.

Cosmetic Surgery - Benefits are **ONLY** provided to correct a condition resulting from non-cosmetic Surgery or an accidental bodily Injury or to correct a congenital anomaly.

Note: Reconstructive Surgery is covered, only if such Surgery is to restore bodily function or correct deformity resulting from non-cosmetic Surgery, an accidental bodily Injury, or a congenital defect.

Dental Services - Benefits for procedures pertaining to the treatment of the teeth and/or support structures of the teeth are not covered with the following exceptions:

a. Services and related supplies resulting from an accidental Injury, including Hospitalization, when the patient's condition warrants such care, will be provided if treatment is received while the individual is a Participant. All treatment must be received within 1 year from the date of accident. An Injury to the natural teeth or damage to a dental appliance as the result of the biting, chewing of a foreign object, or in the course of ingesting food is not considered an accidental Injury;
b. General anesthesia and associated Hospital or Ambulatory Surgical Facility services and related supplies for dental procedures will be covered when such Medically Necessary services are required for a Participant who has a non-dental physical or mental impairment.

Diagnostic Services - Benefits are provided for diagnostic services obtained on an inpatient or Outpatient basis. They are tests or procedures ordered by a Physician or other professional provider because of specific symptoms. Diagnostic services must be directed toward determining a definite condition or disease and can include:

a. X-ray and other radiology services;
b. Laboratory and pathology services;
c. Cardiographic, encephalographic and radioisotope tests.

Durable Medical Equipment (DME) - Any equipment designed for repeated use and which is Medically Necessary for the treatment of an Illness or Injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. DME shall also include wheelchairs, Hospital beds, respirators and other such items as determined by the Claims Administrator:

Benefits for DME are provided for the lesser of the rental charges or the purchase price, up to the PPO or Allowed Benefit, and are paid as specified in the Schedule of Benefits. The DME must be:

a. Primarily and customarily used to serve a medical purpose and generally is not useful to a person in the absence of Illness or Injury;
b. Appropriate for use in the home;
c. Prescribed by a Physician;
d. Consistent with the diagnosis.

Standard DME is equipment including braces, devices or supplies which provides the basic therapeutic or functional purpose necessary for the Participant's condition. Deluxe DME is equipment which has features not necessitated by the patient's medical condition.

Benefits for the initial services or supplies for eyeglasses (or contact lenses), or hearing aids and the fitting thereof, may be provided when such services or supplies are required as a result of accidental bodily Injury occurring while the patient is covered under this Plan.

In addition, benefits may be provided for 1 pair of eyeglasses or contact lenses required as a result of and directly related to intraocular Surgery. Examples of surgeries for which such benefits may be allowed include cataract Surgery, cornea transplant and scleral buckling.

Benefits would not be provided in cases such as strabismus Surgery in which extraocular muscle work is performed.

Extended Care Facility/Skilled Nursing Facility - Any Hospital services and supplies available on an inpatient basis are available for a confinement in an Extended Care Facility or Skilled Nursing Facility for the maximum period of time shown in the Schedule of Benefits.

Home Health Care - To receive Home Health Care benefits, the Participant's condition must necessitate Skilled Care such that he would have required Hospital or Extended Care Facility confinement if Home Health Care benefits had not been available. The patient must be under the direct care of a Physician and the patient's Physician must develop a plan of treatment with a Hospital or Home Health Care agency which defines the services the patient is to receive at home. There is a maximum of 100 visits per plan of treatment.

The Home Health Care agency must be licensed to provide nursing and other therapeutic services. Any single visit up to 4 hours by a member of a Home Health Care Provider team will equal 1 Home Health Care visit.

Covered Home Health Care services provided by the Home Health Care agency include:

a. Part-time or intermittent nursing care, by a Registered Nurse (RN) or a Licensed Practical or Vocational Nurse (LPN/LVN);
b. Part-time or intermittent home health aide or homemaker services for the patient only;
c. Occupational, speech, audiological, physical, and respiratory therapies provided by a Home Health Care agency;
d. Social work, performed by a certified or licensed Social Worker (if licensing is not required by the state in which the work is performed, the Social Worker must have at least a masters degree in social work) to help the patient and family cope with the Illness;
e. Nutrition services by a Registered Dietician.

Home Health Care Exclusions:

a. Custodial care;
b. Services or supplies not included in the Home Health Care plan;
c. Any period during which the Participant is not under the care of a Physician;
d. Those services or supplies listed under the General Exclusions and Limitations section.

Home Infusion Therapy - Medically referred treatment for parenteral infusion of antibiotics, chemotherapy, total parenteral nutrition, and other infusion therapies in the Participant's residence. Covered services include:

a. Medical care for the patient receiving home infusion therapy via central venous line or standard intra-venous route;
b. Nutritional and other infusion therapies, including hydration, antibiotics, chemotherapy, pain management, and certain blood products;
c. Related nursing care and supplies.

Hospice Care - Benefits are available to terminally ill patients with a life expectancy of 6 months or less.

Inpatient Hospice Care - All inpatient services covered while a Participant is confined in a Hospital are also covered under the Hospice Care coverage. All treatment rendered to a Participant admitted to a Hospice Care Program must be under the direction of a Physician.

Outpatient Hospice Care - Benefits will be provided for Hospice Care services rendered in the patient's home by members of the Hospice Care team when the services are billed by a Hospice Provider. The following Outpatient Hospice Care services are covered when rendered by members of a Hospice Care team:

a. Nursing care by a Registered Nurse (RN) or Licensed Practical/Vocational Nurse (LPN/LVN);
b. Patient care provided by home health aides or homemaker services;
c. Visits by Medical Social Workers;
d. Visits by Physical and Respiratory Therapists;
e. Rental of durable medical equipment such as Hospital beds, respirators, oxygen tents, crutches and wheelchairs when billed by the Hospice Provider;
f. Medically necessary surgical and medical supplies;
g. Drugs and medicines billed by the Hospice Provider;
h. Nutritional counseling by a Registered Dietician.

Reserve Hospice Care Days - If a patient survives the 6 month life expectancy period and has exhausted the Hospice Care days allotted, a special reserve of 30 Hospice Care days is available. This special reserve can be used as inpatient or Outpatient (home) Hospice Care. However, if it is used as inpatient Hospice Care, the patient's condition must be such that he would have to be admitted to an acute care facility if Hospice Care were not available.

Hospital Inpatient - Your Plan provides benefits for the following services when a member is admitted to a Hospital:

a. Room and board and general nursing care in a semi-private room (2 or more beds), and a special care unit;
b. Private room accommodations, if Medically Necessary;
c. Use of operating, delivery, and treatment rooms and equipment;
d. Prescribed drugs and medications administered in the Hospital;
e. Charges related to unreplaced blood, blood plasma and expanders including the processing, collection, and storage of blood;
f. Anesthesia and its administration;
g. Oxygen and its administration;
h. Dressings, supplies, casts and splints;
i. Diagnostic services;
j. Therapy services.

Hospital Outpatient - Any Hospital services and supplies available on an inpatient basis are also available on an Outpatient basis for:

a. X-rays, laboratory services and diagnostic tests;
b. Outpatient Surgery and anesthesia;
c. Emergency care.

Medical Services and Supplies - Medical care is the non-surgical treatment a Participant receives from a Physician or other Approved Provider for an Illness or Injury, including:

a. Physician's inpatient visits;
b. Care by a surgeon and, at the same time, care by another Physician, provided the Physicians are treating 2 separate conditions;
c. Consultations, excluding routine staff consultations required by Hospital rules;
d. Home and office visits;

e. Charges related to unreplaced blood, blood plasma and expanders including the processing, collection, and storage of blood;
f. Allergy tests and shots;
g. Second Surgical Opinions;
h. Oxygen;
i. Diabetic equipment and supplies, except supplies covered by the Prescription Drug Plan

Nervous and Mental Disorders - Benefits are available for Inpatient or Outpatient care for nervous or mental conditions including individual and group therapy, psychiatric tests, medical management, and expenses related to the diagnosis when rendered by a:

a. Doctor of Medicine (MD);
b. Licensed Clinical Psychologist (PhD);
c. Licensed Clinical Psychiatric Social Worker (LCSW);
d. Licensed Professional Counselor (LPC);
e. Registered Nurse Clinical Specialist (RNCS).

Outpatient day treatment (4 or more hours) is covered as an office visit.

Oral Surgery - Benefits are provided only for the following procedures:

a. Surgical procedures required to correct injuries of the jaw, cheeks, lips, tongue, roof and floor of the mouth;
b. Surgical reduction of dislocation or excision of temporomandibular joints;
c. Surgery involving accessory sinuses, salivary glands, or ducts;
d. Excision of tumors and cysts of the jaw, cheeks, roof and floor of the mouth when pathological examination is required;
e. Excision of exostosis of the jaw and hard palate when not related to the fitting of dentures;
f. Extraoral incision and drainage of abscesses;
g. Maxillomandibular dysfunction;
h. Extraction of teeth due to a medical diagnosis related to radiation therapy.

Organ Transplants – Covered Services for Participants receiving Medically Necessary human-to-human organ or tissue transplants include all related services and supplies:

a. Charges incurred for selective testing of potential donors from an organ registry. Benefits are not provided for screening of the general population;
b. Charges incurred for organ transplantation;
c. Charges for organ procurement, including donor expenses not covered under the donor's benefit Plan including:

    1) Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ;
    2) Coverage for organ procurement from a live donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant (see Travel Allowance), as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for the follow-up care;
    3) If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogeneic). Coverage will also be provided for treatment and storage costs of the marrow, up to the time of reinfusion;

d. Charges incurred for follow-up care, including immuno-suppressant therapy.

Travel Allowance: While traveling to and from the Transplant Program Provider, and if the Transplant Program Provider is located 50 or more miles from the recipient's home, the following benefits are covered expenses:

a. Transportation is limited to a maximum of the cost of a round-trip coach airfare to the Transplant Program Provider for you and your travel companion;
b. Transportation using a motor vehicle will be paid in accordance with the current IRS allowance per mile for medical travel;
c. Hotel accommodations up to $75 per day at hotels should you be released to an Outpatient facility for Medically Necessary post-surgical care from the Transplant Program Provider;
d. Hotel accommodations up to $75 per day at hotels for your travel companion to remain in the immediate area during all or a portion of the duration of your treatment plan;
e. Daily meals and other reasonable and necessary services or supplies for you and your travel companion up to an allowance of $75 per person per day.

Transplant Program Provider is the Physician performing the transplant and/or the Hospital in which the transplant is performed.

Organ transplant procedures, including complications from any such procedure, services or supplies related to any such procedure, such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, **except** for the following procedures:

a. Heart; combined heart and lung; single lung; double lung; lobar lung; kidney, kidney/pancreas; pancreas; cornea; liver; bone; small bowel in pediatric patients; small bowel/liver; multivisceral; skin (for grafting or for any other Medically Necessary purposes);

b. Autologous bone marrow for:

    1) Non-Hodgkin's lymphoma;
    2) Hodgkin's lymphoma;
    3) Neuroblastoma;
    4) Acute lymphocytic leukemia in first or subsequent remission;
    5) Acute non-lymphocytic leukemia in first or subsequent remission;
    6) Germ cell tumors;
    7) Multiple myeloma;
    8) Medulloblastoma in high risk children.

c. Allogeneic bone marrow for:

    1) Aplastic anemia;
    2) Acute leukemia;
    3) Severe combined immunodeficiency;
    4) Wiskott-Aldrich syndrome;
    5) Infantile malignant osteopetrosis (Albers-Schonberg disease or marble bone disease);
    6) Chronic myelogenous leukemia (CML);
    7) Neuroblastoma Stage III or IV in children over 1 year of age;
    8) Homozygous beta thalassemia (thalassemia major);
    9) Hodgkin's lymphoma;

10) Non-Hodgkin's lymphoma;
11) Myelodysplastic syndromes;
12) Lysosomal storage disorders (mucopolysaccharidosis, Gaucher's disease, Hunter's syndrome, Hurler's syndrome, Sanfilippo syndrome, Maroteaux-Lamy syndrome, mucolipidosis, lipidosis, and metachromatic leukodystrophy);
13) Multiple myeloma.

Clinical Trials - Benefits for High Dose Chemotherapy/Bone Marrow or Stem Cell Transplants (HDC/BMTSCT) for conditions not listed above will be provided if the Participant is properly and lawfully registered in a Plan-Certified Controlled Clinical Trial as defined below. The patient must meet and continue to meet all eligibility requirements for participation in the trial as established by the Plan-Certified Controlled Clinical Trial.

A "Plan-Certified Controlled Clinical Trial" means HDC/BMT/SCT treatment that the Plan has reviewed and determined in advance of the Participant's treatment, is:

a. Approved as a controlled clinical trial by the institutional review board of the institution providing treatment;
b. Conducted for the primary purpose of determining whether or not a particular HDC/BMTSCT treatment is safe and efficacious; and
c. Approved by:
    An Institute or center of the National Institutes of Health;
    U.S. Food and Drug Administration;
    U.S. Department of Veterans Affairs; or
    U.S. Department of Defense.

Coverage requires prior approval by the Plan. You or your provider must notify NCAS when you are first evaluated as a possible recipient of HDC/BMT/SCT for any of the conditions subject to this paragraph, but in any event prior to your registration in the trial. Based on the information you provide NCAS with, and that NCAS obtains from the facility or provider, your eligibility for coverage will be determined, including whether the facility and trial meet the requirements of a Plan-Certified Controlled Clinical Trial.

NOTE:

Participation in a controlled clinical trial, including a Plan-Certified Clinical Trial, does not guarantee that the patient will receive the treatment being evaluated by the trial. In a randomized clinical trial, some patients may be treated under one or more alternative protocols as a control to assess the safety and effectiveness of the treatment that is being evaluated under the study. The Plan does not guarantee that you will be accepted for participation in a Plan-Certified Controlled Clinical Trial or that you will receive HDC/BMTSCT in a Plan-Certified Clinical Trial to which you have been accepted.

Coverage will not be provided if the patient is not participating in a Plan-Certified Controlled Clinical Trial for any reason, including the unavailability of a Plan-Certified Controlled Clinical Trial, the patient's ineligibility for participation in a Plan-Certified Controlled Clinical Trial or the Participant's unwillingness to participate in a Plan-Certified Controlled Clinical Trial or accept the conditions and requirements for participation in a Plan-Certified Controlled Clinical Trial.

Under the Organ Transplant benefit, the following services are not provided:

a. Travel, lodging and other charges for your travel companion other than to accompany you to and from the Transplant Program Provider;

b. Charges in connection with the Travel Allowance that are not related to your travel to and from the Transplant Program Provider except for charges for your treatment while at the Transplant Program Provider;
c. Charges for the repair or maintenance of a motor vehicle;
d. Personal expenses incurred for the maintenance of your or your travel companion's residence. Examples of these are childcare costs, house-sitting costs, or kennel charges;
e. Reimbursement of any wages lost by you or your travel companion;
f. The services and medical expenses incurred by a donor (except as specified above) as a result of such transplant procedure.

Orthotic Device – Benefits are included for the initial purchase and fitting of orthotic devices (rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part). This does not include orthopedic, corrective shoes and shoe inserts, unless they are an integral part of a leg brace.

Pre-admission Testing - The Plan provides benefits for pre-admission x-rays and laboratory tests required in connection with a scheduled Hospital admission or out-patient procedure. Benefits will be provided if the Hospital or Physician postpone or cancel the admission or out-patient procedure but no benefits are payable if the Participant postpones or cancels the Hospital admission or out-patient procedure.

Prescription Drugs - See Chapter III.

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

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

A description of Preventive and Wellness Services can be found at: http://www.healthcare.gov/law/about/provisions/services/lists.html

Private Duty Nursing Services - When recommended by a Physician, coverage is available for the Outpatient services of a private duty nurse (RN, LPN and LVN) for a maximum of one shift per day, per nurse.

Covered expenses do not include charges by:

a. The same nurse for more than one shift during any day;
b. A nurse who is a member of the patient's family or normally resides in the patient's home.

Prosthetic Devices – Benefits are provided for the initial purchase of a prosthesis provided for functional reasons when replacing all or part of a missing body part (or contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ. A charge for the purchase of a prosthesis is considered incurred on the date the prosthesis is received/delivered. Repair or replacement of a prosthesis which is medically necessary due to normal use or physiological change in the patient’s condition will be considered a covered expense.

Second Surgical Opinion - A second opinion on the necessity of a specific surgical procedure. The second opinion is voluntary, but if elected, must be given by a board-certified specialist who, by reason of the Physician's specialty, qualifies the Physician to make such an opinion.

Surgery - Inpatient or Outpatient surgical services are covered for the following procedures:

a. Surgery, when performed by a Physician or other professional provider;
b. Assistant at Surgery;
c. Treatment of fractured or dislocated bones;
d. Reconstructive (non-cosmetic) Surgery

The following guidelines apply to surgical procedures:

Assistant Surgeon Fees – The amount eligible will be based on 20% of the PPO or Allowed Benefit for the covered surgical procedure.
Co-Surgery Fees – If two or more surgeons work together as primary surgeons for the same surgical procedure, benefits for all surgeons will not exceed the PPO or Allowed Benefit for that procedure.
Multiple Surgical Procedures – If two or more surgical procedures are performed through the same incision, benefits for the primary procedure will be based on 100% of the PPO or Allowed Benefit and all other eligible procedures will be based on 50% of the PPO or Allowed Benefit.

Note: Reconstructive Surgery is covered, only if such Surgery is to restore bodily function or correct deformity resulting from non-cosmetic Surgery, an accidental bodily Injury, or a congenital defect.

Temporomandibular Joint Disorder (TMJ) –Diagnostic evaluation/testing is covered. Surgical treatment for a medical diagnosis related to TMJ is payable as any other surgical benefit.

Therapy Services - Services for individual therapy are covered on an inpatient or Outpatient basis. They are services or supplies used for the treatment of an Illness or Injury and include:

a. Chemotherapy;
b. Occupational therapy - to restore bodily function lost due to an Illness, Injury, or surgical procedure. Eligible expenses do not include maintenance and Palliative Treatment;
c. Physical therapy – Eligible expenses do not include maintenance and Palliative Treatment;
d. Speech therapy – to restore speech lost or impaired due to an Illness, Injury, surgical procedure, or major congenital anomalies that affect speech. Speech therapy is not covered for language dysfunctions or articulation errors such as stuttering, lisps or tongue thrust;
e. Radiation therapy;
f. Renal dialysis treatments;
g. Respiratory therapy;
h. Vision therapy.

Urgent Care Centers – A facility licensed to provide medical services for unexpected Illnesses or injuries that require prompt medical attention but are not life-threatening.

GENERAL LIMITATIONS AND EXCLUSIONS

Exclusions: Benefits are not provided under your Medical Plan for:

1. **Acupuncture** – charges for acupuncture;
2. **Blood Processing** – Charges related to the processing, collection and storage of blood billed by an independent laboratory;
3. **Chiropractic Services** – when rendered Out-of-Network;
4. **Commission of a Crime** - Charges resulting from or occurring (a) during the commission of a crime by the Participant, or (b) while engaged in an illegal act, illegal occupation, or aggravated assault. Charges are eligible if they result from a medical condition or domestic violence;
5. **Cosmetic Surgery –** charges for cosmetic Surgery and related services, except as specified under Cosmetic Surgery and Surgery;
6. **Counseling** – charges for personality or emotional testing;
7. **Cranio-mandibular Disorders –** Charges for non-surgical treatment of cranio-mandibular disorders which include temporo-mandibular joint dysfunction, oral rehabilitation, oral splints, orthotics and appliances;
8. **Dental** – charges for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes. However, treatment will be provided for reasons listed under Dental Covered Services.
9. **Diagnostic Inpatient Care** – Inpatient care primarily for diagnostic purposes, speech or occupational therapy, or while the Participant is confined primarily for rest, custodial or domiciliary care. This exclusion does not apply to Hospice Care.
10. **Durable Medical Equipment** – Charges for the difference in cost between the standard and deluxe models of durable medical equipment;
11. **Excess Charges** – Excess of the Allowed Benefit;
12. **Experimental or Investigational** – Services which are determined to be for research or experimental or investigational;
13. **Foot Care** – Charges for routine care of feet, including removal of corns, calluses, toenails (except the partial removal of a nail with removal of part or all of its matrix);
14. **Genetic Testing** - Expenses for, or related to, genetic testing or counseling;
15. **Government Facility** – Treatment in a facility owned or operated by the United States or any state or local government unless the Participant is legally obligated to pay;
16. **Hair Loss** – Charges for care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician;
17. **Hearing** – Hearing aids and their fitting, except as specified under Durable Medical Equipment;
18. **Home Blood Pressure Monitoring** – Home blood pressure monitoring and related services and supplies;
19. **Holistic or Homeopathic Medicine** – Holistic or homeopathic medicine including services or supplies provided in connection with the treatment;
20. **Insurance or Employment** – Charges for or related to examinations for insurance or employment;
21. **Myotherapy** – Charges for myotherapy by a massage therapist;
22. **Non-Covered Services -** Any services, supplies, or drugs related to Non-Covered Services or complications arising from such Non-Covered Services are not eligible for benefits (Examples of Non-Covered services include cosmetic surgery and Experimental/Investigational procedures).
23. **Not Legally Required to Pay** – Charges which the Participant is not legally required to pay or which would not have been made if no coverage had existed. This exclusion does not apply if a claim is from the Veterans Administration under Title 38 of the US Code for treatment of a veteran not having a service connected disability;

24. **Not Medically Necessary or Recommended** – Charges which are determined not to be Medically Necessary for the medical care diagnosis or treatment of an Injury or Illness; or charges for any service, treatment or supply not recommended by a Physician;
25. **Nutritional Counseling** – Charges for nutritional counseling and oral nutritional supplements , except as specified under Home Health Care and Hospice Care;
26. **Obesity** – Charges for the treatment of obesity, including surgical treatment for Morbid Obesity;
27. **Orthopedic shoes** - Charges for orthopedic or corrective shoes or shoe inserts unless attached to a brace;
28. **Personal Hygiene** – Charges for personal hygiene, convenience or personal comfort items, such as, but not limited to, vaporizers, air conditioners, humidifiers, air filters, first aid items, bathing/toilet accessories, elevators, stair and van lifts, whirlpools, and physical fitness equipment or programs, and other non-medical supplies or equipment;
29. **Personal Injury Protection** - Personal Injury Protection, sometimes called No-fault First Party Benefits, is a type of mandatory automobile insurance coverage that is used to pay, among other things, medical bills to individuals who are injured in a motor vehicle accident, regardless of who was at fault. Mandatory personal Injury protection benefit amounts, vary by state. This Plan will deny any claim for medical services or supplies rendered to a Participant, up to the minimum amount of PIP coverage mandated by law in the state of residence, or up to the actual amount of PIP coverage, whichever is greater, whether or not the Participant properly asserts his rights under his automobile insurance coverage.
30. **Private Duty Nursing** – Charges for Private Duty Nursing when rendered on an inpatient basis; when requested by or for the convenience of the patient's family; when such services are rendered by a nurse who resides in the Participant's home or who is related by blood or marriage to the Participant;
31. **Relative Giving Services** – Services or supplies rendered by the Employee, brothers, sisters, parents, or grandparents of the Employee;
32. **Self-help** – Charges for educational services, hypnotism, biofeedback, or any type of self-help or goal oriented or behavior modification therapy, such as to lose weight or quit smoking;
33. **Self-inflicted Injuries –** Services or supplies furnished in connection with intentionally self-inflicted injuries, whether committed while sane or insane; treatment of or related to a drug overdose if such overdose is intentional, the result of illegal drugs, or results from the intentional improper use of drugs and medicines, whether or not the drugs or medicines are prescribed. Charges for self-inflicted injuries are eligible if they result from a medical condition or domestic violence;
34. **Services Before or After Coverage -** Charges incurred prior to the date an Employee becomes a Participant under this Plan; or charges incurred after the date an Employee is no longer a Participant under this Plan;
35. **Smoking Cessation –** Charges for smoking cessation expenses, including smoking deterrents;
36. **Telephone Consultations –** Charges for telephone or electronic consultations, failure to keep scheduled appointments, completion of claim forms, stand-by, set-up or other charges for services not rendered;
37. **Timely Filing -** Charges for services received by the Claims Administrator or the PPO later than 1 year from the date the services were rendered or otherwise provided;
38. **Transportation -** Charges for transportation, except as specified under ambulance and organ transplants;
39. **Vision –** Charges for vision examinations, eyeglasses or contact lenses to correct refractive errors and related services, including Surgery performed to eliminate the need for eyeglasses for refractive errors (i.e. radial keratotomy or LASIK), except as specified under Durable Medical Equipment;

40. **War or Act of War –** Charges for treatment of a condition resulting from war or an act of war, declared or undeclared;
41. **Weekend Admission –** Charges for any inpatient Hospital admission occurring on a Friday or Saturday in conjunction with a surgical procedure scheduled to be performed during the following week. A Sunday admission will be eligible only for procedures scheduled to be performed early Monday morning. This limitation will not apply to necessary medical admissions requiring immediate attention or to emergency surgical admissions;
42. **Workers' Compensation Law -** Illness or Injury charges which arises out of or in the course of any employment for wage or profit for which the covered person is entitled to indemnify under the terms of any Workers' Compensation Law or similar law. This applies whether or not the Participant has declined participation under such law, except if the Participant is a proprietor, partner, or executive corporate officer Employee.

CHAPTER III

PRESCRIPTION DRUG BENEFITS

The administrator of the Prescription Drug Plan is Express Scripts. The Prescription Plan's network of participating pharmacies is nationwide and they display a decal in their window or near the pharmacy department. You may contact Express Scripts for questions regarding your Prescription Plan. Express Scripts' Customer Service can be reached at: 1-866-265-9458 .

The Benefits are provided for brand name and generic prescription drugs. The Prescription Drug Plan co-payment amounts are as follows:

Prescription Drug Plan for Priest Plan	**Co-payment per Prescription**	
	Retail 34 day supply	**Mail Order 90 day supply**
Generic drugs	$15	$30
Preferred Brand Drugs	$30	$60
Non-preferred Brand Drugs	$45	$90
Over-the-Counter (OTC) Drugs related to Preventive and Wellness Services as specified by the Patient Protection and Affordable Care Act of 2010*	No copay	
* A description of these services can be found at: http://www.healthcare.gov/law/about/provisions/services/lists.html		

NOTE: You will be required to pay the generic copay plus the difference between the cost of the brand name and the generic if you purchase the Brand Name drug. You will be required to pay this difference even if your doctor writes "Dispense as Written."

Generic versions of brand name drugs are reviewed and approved by the FDA (Food & Drug Administration). Generic drugs have the same active ingredients and come in the same strength and dosage form as the brand name drug. If you choose the generic drug, you will always pay the lowest copay.

A formulary is a preferred list of drugs. Express Scripts has a panel of Physicians and pharmacists that meets regularly to identify and review prescription drugs that provide the highest therapeutic and economic value. By choosing drugs on this list, your Physician helps keep the cost of prescription drugs affordable. Formulary drugs are subject to change at any time. Your Physician may contact Express Scripts to obtain information on formulary. Using Formulary drugs saves you money, but you are not required to use them.

A brand-name drug is any approved drug a particular pharmaceutical company has the exclusive right to produce and sell. Over time, companies can lose the patents on particular drugs, opening up the market to generic equivalents. Generic drug equivalents may become available at any time.

The patient should discuss the prescription alternatives with his doctor to determine if a lower cost alternative is available and appropriate for his condition. The patient and the doctor should determine the treatment Plan that is most appropriate for the condition. In some cases, this may mean the patient will pay the higher copay.

When you present your prescription drug card to a participating pharmacy, your cost for a prescription or a refill will be the brand name or generic prescription co-payment as indicated in the Schedule of Benefits. For maintenance prescription drugs you can obtain a larger quantity saving you trips to the pharmacy and prescription co-payment expenses by using the Mail Service Prescription Drug Program below.

Over-the-Counter Drugs – The Patient Protection and Affordable Care Act requires that the Plan provide benefits for a comprehensive list of preventive care services. Included in this list are several over-the-counter drugs. If your physician recommends that you take one of the drugs on this list, benefits will be provided under this Plan. You must obtain a prescription from your physician for the OTC drug and present it to the pharmacist. The pharmacist will fill your prescription with no copay. A list of these services and OTC drugs, can be found at: http://www.healthcare.gov/law/about/provisions/services/lists.html

Prior Authorization Program - Certain drugs in the Prescription Drug Plan require Prior Authorization from Express Scripts before they can be considered for benefits. To obtain authorization, your doctor must contact Express Scripts when prescribing one of the following drugs:

1. Drugs that could be used for non-medical purposes – for instance, a drug that treats a skin condition but could also be used for cosmetic purposes;
2. A drug listed on the Prior Authorization List.

Note: The Prior Authorization List is subject to change. To obtain a copy of the current list, go to Express Scripts' website: www.express-scripts.com and sign on as a member.

Please request that your doctor contact Express Scripts before prescribing a drug that is listed on the Prior Authorization List. If the prescription drug is approved by Express Scripts, you will pay the applicable copay. If the drug is not approved, you will be responsible for the full cost. To obtain Prior Authorization, please call Express Scripts Customer Service at 1 (800) 451-6245.

Covered Services - The Prescription Plan pays up to a 34-day supply or 100 unit doses for all the medicine your doctor requests on the original prescription or refill. The Plan also pays for the following:

1. **Compounded medications –** of which at least one ingredient is a prescription drug;
2. **Growth Hormones –** prior authorization is required;
3. **Insulin;**
4. **Insulin supplies -** Disposable needles and syringes, alcohol swabs and lancets, disposable blood/urine glucose/acetone testing agents (e.g. Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips, and Tes-Tape);
5. **Legend Drugs -** A pharmaceutical product that requires a Physician's written prescription and cannot be obtained legally without a Physician's prescription.

Exclusions - In addition to the General Exclusions and Limitations and other provisions of the Plan, benefits are not included for the following:

1. **Administration -** Charges for giving you the drug or giving you an injection and charges for a medication which is taken by or administered to an individual while he is a patient in a rest home, nursing home, sanitarium, Extended Care Facility, Hospital or other similar entity which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;

2. **Anti wrinkle agents –** such as Renova, regardless of intended use.
3. **Educational materials**
4. **Experimental -** Experimental drugs or drugs of questionable therapeutic value, or drugs labeled "Caution: limited by federal law to investigational use;"
5. **Illegal –** drugs or medicines not legally dispensed under federal and/or state law and drugs purchased outside the United States that are not legal inside the U.S.;
6. **Immunizations -** Immunization agents, biological sera, blood, or blood plasma;
7. **Over the counter -** Drugs or medicines that are legally available without a doctor's prescription (Over-the-counter or non-Legend Drugs except insulin);
8. **Minoxidil –** (Rogaine) for the treatment of alopecia;
9. **Refills –** Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.
10. **Stop Smoking –** smoking cessation products;
11. **Therapeutic -** Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical items;
12. **Vitamins –** vitamins.

HOW TO FILE A CLAIM

Member Pharmacies - Many pharmacies participate in the Prescription Plan program. When you go to a participating pharmacy, show your identification card. It provides the pharmacy with important information about your coverage. The pharmacy will collect your co-payment and fill your prescription(s).

Non-Member Pharmacies or Member Pharmacies When the Participant Does Not Use the Prescription Plan Card - You must submit a claim directly to the Prescription Plan when you purchase a prescription from a non-member pharmacy or do not use your card at a member pharmacy. The Prescription Plan will only pay the maximum contracted price for each prescription, less your co-payment. The maximum contracted price used for reimbursement will probably be less than the amount you are charged. Reimbursement will be sent directly to you. To submit a claim, please contact Express Scripts and request a "Prescription Drug Claim Form" and follow the instructions on the claim form.

Mail Service Prescription Drug Program - The Mail Service Prescription Drug Program provides benefits for maintenance drugs which require a prescription by law to purchase, and insulin. The maximum quantity which can be claimed is a 90-day supply which is more than can be obtained under the regular Prescription Drug Plan. Use of the Mail Service Prescription Drug Program will save you trips to the pharmacy and minimizes the prescription co-payments. Please contact Express Scripts for the forms needed to order maintenance drugs via mail order or you can obtain information from Express Scripts' website at: www.express-scripts.com.

CHAPTER IV

Managed Care

The Managed Care provisions of this Plan are administered by the Managed Care Vendor. The staff at the Managed Care Vendor are Physicians and Registered Nurses who monitor the use of your health care benefits to ensure that you:

a. Receive the best medical care possible in the most appropriate health care setting;
b. Avoid unnecessary Surgery and excess Hospital days;
c. Receive answers to questions you have regarding medical care;
d. Receive the maximum benefits from your health care treatment and benefit plan.

Components of the Managed Care program include:

a. Pre-admission and Admission Review of all Hospital admissions, including inpatient psychiatric and obstetrical admissions;
b. Continued Stay Review of all Hospitalizations;
c. Case management of potentially catastrophic cases;

Pre-admission, admission, and continued stay review decisions are based on the medical policy guidelines of MCV. This may include, but is not limited to the following reviews:

a. Cosmetic
b. Investigational/Experimental
c. Outpatient services, e.g. speech therapy, physical therapy, chiropractic services

Otherwise, all medical necessity review will be performed at NCAS utilizing the CareFirst Medical Policy.

HOW THE MANAGED CARE PROGRAM WORKS

PRE-ADMISSION CERTIFICATION:

a. If your Physician recommends that you be Hospitalized, you must contact the Managed Care Vendor for assistance with the certification process. Hospitalizations out of the country or when this Plan is the secondary payer do not require Pre-admission certification. All other Hospitalizations require Pre-admission and Admission Review. Admission certification must occur prior to an elective or planned Hospitalization or the next business day after an urgent or emergency admission. To obtain admission certification, call the telephone number on the back of your identification card.

   When you call, have your identification number, Employer name, patient name, home phone number, Physician name and phone number ready.

   Note: The pre-admission certification requirement does not apply to admissions to St. Luke's Institute.

b. Notification may be initiated by you, a family member, Physician, or representative from the Hospital. The Managed Care Vendor will review your Physician's recommendations based on the medical information supplied and accepted standards and criteria for Hospital admission. In most cases, the Managed Care Vendor will notify you, your doctor, and the Hospital of your certification approval within 24 hours. At that time the Hospital will be advised of the number of approved days.

CONTINUED STAY REVIEW:

a. If necessary, you, a family member, your Physician, or the Hospital representative must call the Managed Care Vendor to request an extension of inpatient days beyond those originally assigned. The Managed Care Vendor will review your admission to determine if additional inpatient Hospital days are Medically Necessary. This type of review is known as Continued Stay Review.

b. If your admission or request for extension is denied; you may appeal the decision to the Managed Care Vendor and they will review your case and render a decision.

NOTE: In order to receive full benefits for a Hospital admission, the admission must be certified by the Managed Care Vendor. If the Managed Care Vendor is not notified of the Hospital admission, covered charges will be reduced by $250, even if the admission is determined to be Medically Necessary. If the admission is not Medically Necessary, no benefits are payable for the entire Hospital stay. If the Participant stays in the Hospital longer than originally certified, and the extended stay is not certified through the Managed Care Vendor, no benefits are payable for the remainder of the Hospital stay.

LARGE CASE MANAGEMENT (CARE MANAGEMENT)

A "Large Case" is one resulting from a catastrophic Illness or accident, which usually results in a lengthy stay or multiple Hospital confinements. Large Case Management is the development of alternative treatment plans for Participants which meet the medical needs of the Participant, and achieve the most efficient use of medical resources.

By fully exploring treatment alternatives and, when appropriate, using a flexible approach to benefit administration, the case manager, Physicians, patients and families are able to work together to provide the patient with quality care which promotes the fullest recovery possible, in the most effective manner.

"A flexible approach to benefit administration" means that the case manager can approve treatment alternatives which usually are not covered under the Plan but will provide quality care to the patient and generate a savings over other covered options.

CHAPTER V

DENTAL BENEFITS

The following is a brief summary of your dental benefits. Please note that the administrator of the Archdiocese of Washington's Dental Plan is Delta Dental. This is a dental PPO Plan with a Point of Service feature. If you have any questions regarding your benefits or the status of a claim, please call Delta Dental at 1 (800) 932-0783. For a list of participating dentists, check their website at www.midatlanticdeltadental.com under "Dentist Directory".

DELTA DENTAL BENEFITS PRIEST PLAN	
Calendar Year Deductible	$50
Calendar Year Maximum Per Individual	$1,500
Diagnostic & Preventive	100%
Basic Restorative, Oral Surgery, Endodontics, Periodontics	100% Subject to deductible
Major Restorative, Prosthodontics	90% Subject to deductible

CHAPTER VI

VISION BENEFITS

The following is a brief summary of your vision benefits. The administrator of your vision benefits is VSP. If you have any questions regarding these services or need assistance finding a VSP provider, please call VSP at 1 (800) 877-7195 or visit their website at: www.vsp.com

Vision Benefits	VSP Network Doctor	Non-VSP Doctor
Eye Exam	Covered in full	Covered up to $52
Lenses including: - Single Vision - Lined bi-focal - Lined tri-focal	$25 copay applies to lenses and a frame, then lenses are covered in full and the frame of your choice is covered up to $120. Plus up to 20% savings on lens extras such as scratch resistant and anti-reflective coatings.	$25 copay applies to lenses and a frame: Covered up to $55 Covered up to $75 Covered up to $95
Frames	$25 copay applies to a frame if lenses are not purchased, then the frame of your choice is covered up to $120. Plus 20% off any out-of-pocket costs. In addition, you'll also receive 20% off on additional prescription glasses and sunglasses.*	Covered up to $45
Contact Lenses - When you choose contacts instead of glasses, your allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your eye exam to ensure proper fit of contacts.	No copay, covered up to $120 Plus 15% off the cost of your contact lens exam (fitting and evaluation).*	No copay, covered up to $105

Benefits are limited to one exam, one pair of lenses and a frame, or contacts every other calendar year.

*Available from the same VSP doctor who provided your eye exam within the last 12 months.

CHAPTER VII

GENERAL INFORMATION

DEFINITIONS

Active Employee - An Employee who performs the regular duties of his/her job in a customary manner, on a day which is a scheduled work day, for at least 30 hours per week on a full-time basis as determined by the Employer, either at his or her customary place of employment or at some location at which that employment requires him or her to travel, or if he is absent from work solely by reason of vacation, Illness, or other excused absence.

Alcoholic Rehabilitation Facility - An institution licensed or certified to provide rehabilitative services for alcoholism, drug addiction, and/or substance abuse.

Allowed Benefit – Plan allowances for treatment, services or supplies, rendered by an Out-of-Network provider, essential to the care of the individual as determined by the Claims Administrator. Charges by a Licensed Provider must be the amount usually charged for similar services and supplies in the absence of a Plan or insurance. Charges for Covered Services that do not exceed the Allowed Benefit will be reimbursed as specified in the Schedule of Benefits. A fee schedule, approved by NCAS, may be used by the Plan in determining the amount of the Allowed Benefit.

Ambulatory Surgical Facility - A licensed or certified institution which:

a Has permanent operating rooms and at least a recovery room, and all necessary equipment for use before, during and after Surgery;
b. Is operated under the supervision of a Licensed Physician with a medical staff including Registered Nurses (RNs) available for care in an operating or recovery room;
c. Is other than a private office or clinic of 1 or more Physicians.

Approved Provider - A person or entity, other than a Hospital or Physician, which is a Licensed Provider. Other providers include:

Institutional	Professional
Alcohol Rehabilitation Facility	Audiologist
Ambulance Service	Certified Registered Nurse Anesthetist
Ambulatory Surgical Facility	Licensed Clinical Social Worker
Extended Care Facility	Licensed Practical or Vocational Nurse
Free-Standing Laboratory Facility	Licensed Professional Counselor
Home Health Care Agency	Nurse Practitioner
Home Infusion Therapy Agency	Occupational Therapist
Hospice	Physical Therapist
Pharmacy	Registered Nurse
Renal Dialysis Facility	Registered Nurse Clinical Specialist
Rehabilitation Facility	Respiratory Therapist
Residential Treatment Facility	Speech Pathologist

Calendar Year - The 12-month period from January 1 through December 31 of each year.

Certificate of Coverage – A written document that reflects certain details about an individual's creditable health coverage. It is intended to establish an individual's prior Creditable Coverage for purposes of reducing the extent to which a Plan offering health coverage can apply a pre-existing exclusion.

Chemical Dependency, Alcoholism, or Substance Abuse - Physical and/or emotional addiction to drugs, narcotics, alcohol or other addictive substances to a debilitating degree. Dependence upon tobacco, nicotine, and caffeine are not included in this definition.

Claims Administrator - The person/organization providing consulting services to the Employer in connection with the operation of this Plan and performing such other functions, including processing and payment of claims, as may be delegated to it. The Claims Administrator is NCAS.

Creditable Coverage - Coverage under almost any other type of medical plan, including group health plans, individual insurance, Medicare, Medicaid, Tricare, Indian Health Service medical care or care through a tribal organization, state health benefits risk pools, the Federal Employees Health Benefits Program, a public plan, the State Children's Health Insurance Program and a Peace Corps Plan. A public Plan includes plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the Plan.

Custodial Care - The care provided primarily for maintenance of the patient. Custodial Care is designed essentially to assist the individual in meeting the activities of daily living and is not provided primarily for its therapeutic value in the treatment of an Illness, accidental Injury or condition. Custodial care includes, but is not limited to, helping in walking, bathing, dressing, feeding, or preparation of special diets.

Deductible - The amount of expenses for Covered Services that a Participant must pay for himself before the Plan will begin its payments.

Effective Date - The date on which coverage for an eligible Employee begins.

Electronic Protected Health Information (EPHI) – The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means Protected Health Information that is transmitted or maintained in any electronic media.

Eligibility Waiting Period – The Eligibility Waiting Period is the period that must pass before an Employee is eligible to enroll under a group health plan. The Eligibility Waiting Period does not count as prior Creditable Coverage nor as days in a break in coverage.

Emergency Care - Emergency service rendered for the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:

a. Permanently placing the patient's health in jeopardy;
b. Serious impairment to bodily functions;
c. Serious and permanent dysfunction of any bodily organ or part;
d. Sudden and unexpected onset of severe pain; or
e. Other serious medical consequences.

Heart attacks, poisoning, loss of consciousness, severe breathing difficulties, convulsions, and other acute conditions may be considered medical emergencies. The symptoms and severity of the attack must require immediate medical care. Medical emergencies do not include less acute medical conditions which your own Physician could treat during his regular hours.

Employer - The employer is any office, agency, school or parish which is a part of the Archdiocese of Washington, or any other organization affiliated with the Archdiocese that participates in this Plan.

Enrollment Date - The Enrollment Date is within the first 30 days of eligibility.

Essential Health Benefits - For purposes of the unlimited dollar Plan Year maximum, has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use 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.

Exhaustion of COBRA Continuation Coverage - An individual's COBRA coverage ends for any reason other than either the failure of the individual to pay premiums on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan).

Experimental or Investigative - The use of any drug, device, supply, medical treatment or procedure not yet recognized by the Plan as acceptable medical practice. The Plan defines a drug, device, medical treatment or procedure as Experimental or Investigative if any of the following criteria apply:

a. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
b. The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval;
c. Reliable Evidence shows the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
d. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

However, a service or supply will not be considered Experimental or Investigative if the Plan determines that:

a. The disease can be expected to cause death within one year, in the absence of effective treatment; and
b. The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination the Plan

will take into account the results of a review of a panel of independent medical professionals.

This exception also applies with respect to drugs that:

a. Have been granted treatment investigational new drug (IND) or Group/treatment IND status; or
b. Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, if the Plan determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

Extended Care Facility/Skilled Nursing Facility - An institution operated pursuant to law and primarily engaged in providing room and board, together with 24-hour-a-day nursing service as needed to provide adequate medical care for persons convalescing from accident or Illness and providing services under the supervision of a Physician or a Registered Nurse devoting full-time to such supervision. An Extended Care or Skilled Nursing Facility must maintain adequate medical records and have available the services of a Physician under an established agreement if not supervised by a Physician. In no event shall such term include any institution which is:

a. A Hospital;
b. Primarily for the care of mental Illness, drug addiction or alcoholism;
c. Primarily engaged in providing domiciliary care, custodial care, educational care, or care for the aged.

Family and Medical Leave Act of 1993 (FMLA) - This applies to employers with 50 or more Employees for at least 20 workweeks in the current or preceding Calendar Year. The following are some definitions identified by the FMLA:

Eligible Employee - An individual who has been employed by the Archdiocese of Washington for at least 12 months, has performed at least 1250 hours of service during the previous 12 month period, and has worked at a location where at least 50 Employees are employed by the Employer within 75 miles.

Family Member - The (a) Employee's biological, step, or foster parent or (b) a natural, adopted, foster, or step child, or a legal ward under 18 years of age, or 18 years and older and incapable of self-care because of a mental or physical disability.

Serious Health Condition - An Illness, Injury, impairment, or physical or mental condition that involves; (a) Inpatient Care in a Hospital, Hospice or residential medical care facility, or (b) continuing treatment by a health provider.

These definitions are listed as a guide and the actual wording of the FMLA, as amended, shall supersede these definitions.

If you are covered under the Plan and you cease active employment because of an Employer-approved absence in accordance with the requirements of the FMLA (or in accordance with any state or local law which provides a more generous medical or family leave and requires continuation of coverage during such leave), coverage under the Plan will be continued under the same terms and conditions which would have been provided had you continued your active service, provided you continue to pay your required contributions. Contributions will remain as the same Employer/Employee percentage level as of the date immediately preceding the date of the leave (unless contribution percentage levels change for other employees in the same classification).

If you are covered under the Plan and are planning to be absent from employment for a FMLA leave, you should contact the Employer to discuss which of the various methods of payment of any required premiums which may be due during the FMLA leave of absence the Employer permits (e.g., to prepay prior to the FMLA leave, to pay as the payments become due during the FMLA leave or to catch-up upon return from the FMLA leave). You should notify the Employer, prior to taking the FMLA leave, of the method by which any required payments will be paid among the methods permitted.

If you do not return to employment with the Employer after the Employer-approved FMLA leave or if, during the leave, you give the Employer notice of your intent not to return to employment, coverage under the Plan could be continued under the Extension of Benefits provision of the Plan, provided benefit coverage has not lapsed and provided you elect to continue coverage. If an election for continued health care coverage is made, you would be the sole party responsible for paying the premiums during the Extension of Benefits period.

If you fail to pay a required premium payment for benefit coverage during a FMLA leave within 30 days after the date such payment becomes due, your coverage would terminate effective as of the date the premium payment had become due. If coverage under the Plan has lapsed, and you elect Extension of Benefits coverage, you would be required to pay all premium payments due since the lapse-in-coverage date.

If coverage under the Plan is terminated during an approved FMLA leave because you fail to pay the required premiums and you return to active employment at the end of the FMLA leave, benefit coverage would be reinstated as of the date you return to employment (i.e., upon completion of the FMLA period). You would not need to satisfy any condition for Plan participation, including any Pre-Existing Waiting Period or open enrollment period requirements, but you would be required to pay any unpaid premium payments that had become due and to enroll for coverage under the Plan within 30 days after the date you return to employment.

Fiduciary - The person or organization that has the authority to control and manage the operation and administration of the Plan. The Fiduciary has discretionary authority to determine eligibility for benefits or to construe the terms of this Plan. The named Fiduciary for this Plan is the Employer.

Home Health Care - Is care rendered to Participants who require active and skilled medical care at home. Home Health Care includes any array of professional, technical, and health related services usually provided by Hospitals to inpatients.

Home Health Care Provider - A Hospital, skilled nursing facility, local or state governmental health department, a community Home Health Care agency or other health organization. A Home Health Care Provider must be licensed by the state or certified by the U.S. Health Care Financing Administration as a provider of Home Health Care services.

Hospice Care - The Provider-directed professional, technical, and related medical, palliative, and personal care services provided under a Hospice Care Program.

Hospice Care Program - A coordinated interdisciplinary program for meeting the special physical, psychological, and social needs of dying individuals and their immediate families; which provides palliative and supportive medical, nursing and other health services through home or Inpatient Care during the Illness to Participants who have no reasonable prospect of a cure and, as estimated by a Physician, have a life expectancy of less than 6 months; and which provides bereavement counseling to the immediate families of such Participant.

Hospice Provider - Any Hospital, Home Health Care agency, Hospice or other facility or unit of such facility, which is licensed or certified (by the state in which services are rendered) to provide Hospice Care.

Hospital - A Licensed Provider, accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program, which is an acute-care institution primarily engaged in providing diagnostic and therapeutic services for surgical or medical treatment by or under the supervision of Physicians and which provides 24-hour-a-day nursing services. An institution specializing in the care and treatment of a mental Illness, which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall nevertheless be deemed a Hospital.

Illness - Sickness or disease, including mental infirmity, which requires treatment by a Physician. A recurrent Illness shall be considered the same Illness. Concurrent Illnesses shall be deemed the same Illness unless such Illnesses are totally unrelated.

Injury - An Injury means a condition caused by accidental means which results in damage to the Participant's body from an external force. All injuries sustained by a Participant in connection with an accident shall be considered 1 Injury.

Inpatient Care - Treatment as a registered bed patient.

Legend Drug - A pharmaceutical product that requires a Physician's written prescription and cannot be obtained legally without a Physician's prescription.

Licensed Provider - An Approved Provider, Hospital or Physician who is licensed or certified by the State in which he practices or the entity is located and provides Covered Services within the scope of their license. The Covered Services must be for Medically Necessary Care of an Illness, Injury or otherwise identified as a covered expense in the Schedule of Benefits.

Lifetime - The inception date in which coverage for you commences and continues throughout the period you meet the definition of a Participant under the Employer's Plan.

Maintenance Care – Any service or activity which seeks to prevent disease, prolong life, or promote health of an asymptomatic person who has reached the maximum level of improvement and whose condition is resolved or stable.

Managed Care Vendor – Firm which provides pre-admission certification.

Medically Necessary – Any health care treatment, service or supply determined by the Plan Administrator to meet each of these requirements:

1. It is ordered by a Physician for the diagnosis or treatment of a Sickness or Injury;
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition; and
3. It is furnished by a provider with appropriate training and experience, acting within the scope of his or her license, and it is provided at the most appropriate level of care needed to treat the particular condition.

The Plan Administrator will determine whether these requirements have been met based on:

1. Published reports in authoritative medical and scientific literature and are not considered experimental and investigational;

2. Regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA) and HCFA;
3. Listings in the compendia, such as: *The American Hospital Formulary Service Drug Information* and the *United States Pharmacopoeia Dispensing Information*; and
4. Other authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

Service or supplies that are for the convenience of a Participant or provider are not considered Medically Necessary. When specifically applied to Inpatient Care, Medically Necessary also means the Participant's condition could not be treated safely on an Outpatient basis.

Off-label drug use is considered medically necessary when all of the following conditions are met:

a. The drug is approved by the FDA.
b. The prescribed drug use is supported by one of the following standard reference sources.
    (1) DRUGDEX;
    (2) The American Hospital Formulary Service Drug Information;
    (3) Medicare approved Compendia; or
    (4) Scientific evidence is supported in well designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.
c. The drug is medically necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

Medicare - The programs established by Title XVIII of Public Law 89-97 (79 Statutes 291), as amended, entitled Health Insurance for the Aged Act.

Morbid Obesity – A diagnosed condition in which an individual's body weight exceeds the normal weight by 100 pounds or has a body mass index (BMI) of 40 or more (35 with certain co-morbid conditions). The excess weight must cause a condition such as physical trauma, pulmonary, and circulatory insufficiency, diabetes, or heart disease.

NCAS - The Claims Administrator which provides claims payment services and customer service. Their telephone number is **(703) 934-6227** or **1 (800) 888-6227**.

Outpatient - Anyone receiving services or supplies while not an inpatient.

Palliative Treatment – Relief of symptoms for a time but does not cure or end the cause of symptoms.

Participant - Any eligible Employee who has elected coverage in this Plan and has fulfilled all requirements to continue participation.

Physician - A properly Licensed Provider holding a degree of Doctor of Medicine (MD), Osteopath (DO), Podiatrist (DPM), Psychologist (PhD), Dentist (DDS or DMD), or Chiropractor (DC).

Plan/This Plan - The Plan of benefits as contained in the Summary Plan Description and Plan Document, and any agreements, schedules and amendments endorsed by the Plan Sponsor.

Plan Administrator - The person/organization responsible for the day-to-day functions and management of this Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. If an Administrator is not appointed in the

instrument which governs the Plan, then the Administrator is the Plan Sponsor. The Plan Administrator is the Archdiocese of Washington.

Plan Sponsor - The Plan Sponsor is the Archdiocese of Washington.

Preferred Provider - A panel of Licensed Providers and/or a group of participating healthcare institutions which provide medical services to contracted groups of Participants. Savings received because of the contracted rates are not the responsibility of the Participant. Some Per-diem and discounted Hospital rates can provide coverage for items usually not covered under the Plan (such as a private room which is not Medically Necessary). Contact NCAS or access the Preferred Provider Organization's (PPO) website, to determine if a provider participates.

Priest Plan – That Schedule of Benefits set for the on page 22.

Private Duty Nursing - Out of Hospital Skilled Care ordered by a Physician and rendered by a Registered Nurse (RN) or Licensed Practical or Vocational Nurse (LPN/LVN).

Protected Health Information (PHI) - Individually identifiable health information which is maintained or transmitted by a health plan .

Rehabilitation Facility - A facility which mainly provides therapeutic and restorative services to sick or injured people to restore bodily function after an inpatient Hospitalization for a debilitating Illness or Injury. Inpatient rehabilitation, provided by a licensed or certified facility in the jurisdiction in which care is rendered, must be Medically Necessary, that is the patient's condition must require supplementary Skilled Care in addition to physical therapy and/or occupational therapy. The expectation is to restore the Participant to enable him/her to live outside of an institution.

Residential Treatment Facility - A facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug or substance abuse disorders or mental Illness.

Security Incidents – According to HIPAA guidelines, the term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Significant Break in Coverage - A break in coverage of 63 days or more. Waiting Periods are not considered breaks in coverage. Under HIPAA, if an individual has a break in coverage of at least 63 days, any Creditable Coverage before that break will be disregarded by the Plan when evaluating whether to impose a pre-existing condition limitation period.

Skilled Care - Care which requires the technical proficiency and scientific skills of a Registered Nurse (RN) or Licensed Practical or Vocational Nurse (LPN/LVN). Skilled nursing services include, but are not limited to, the following:

a. Intravenous or intramuscular injections;
b. Administration of total parenteral nutrition, chemotherapy drugs, blood products, medications, and solutions via intravenous or central venous catheters;
c. Levine tube and gastrostomy feedings (until a maintenance level is reached);
d. Naso-pharyngeal and tracheostomy aspiration (until a maintenance level is reached);
e. Insertion or replacement of catheters and sterile irrigations of catheters;
f. Care of extensive decubitus ulcers, infected wounds or other severe skin disruptions requiring sterile technique and skilled application of dressings, and medications.

Surgery - The performance of generally accepted operative and cutting procedures, as well as the following:

a. Specialized instrumentations, endoscopic examinations and other invasive procedures;
b. Correction of fractures and dislocations;
c. Usual and related pre-operative and post-operative care;
d. Other procedures as reasonably approved by the Claims Administrator.

Total Disability - An Employee is prevented solely because of an Injury, Illness or disease, from engaging in the substantial duties of any business or occupation for which he is qualified by education and experience and from performing any and all work for substantially similar compensation or profit. Certification of Total Disability must be made by a Physician.

CONDITIONS OF COVERAGE - The benefits described are available only when Covered Services are received after a Participant's Effective Date.

All Covered Services must be Medically Necessary, prescribed by a Physician or other professional provider, and rendered by a Physician (see Definitions). Payment will be made for Covered Services according to the benefits in effect on the date the services are received.

A Participant has the right to select the provider of his choice. The Plan Sponsor has no responsibility for a provider's failure or refusal to render services to a Participant. Furthermore, the Plan Sponsor is not liable for anything the provider may or may not do.

COORDINATION OF BENEFITS - This Plan contains a non-profit provision coordinating it with other similar plans under which an individual may be covered so that the total benefits available during the Calendar Year will not exceed the benefits of this Plan that would have been provided in the absence of Coordination of Benefits.

If, in coordinating the benefits of this Plan with those of another plan, the rules set forth in the following Order of Benefit Determination paragraph would require this Plan to be the primary payer and the other plan, according to its rules, is the secondary payer, then the benefits of that other Plan will be ignored for the purpose of determining the benefits of this Plan.

If, in coordinating the benefits of this Plan with those of another plan, the rules set forth in the following Order of Benefit Determination paragraph would require this Plan to be the secondary payer, and the other Plan the primary payer, then benefits will be paid by this Plan to the extent of the difference between the dollar amount the primary Plan will pay and the dollar amount of allowable expenses.

An "allowable expense" is a health care service or expense including Deductibles, coinsurance or copayments that is covered in full or in part by any of the Plans involved.

"Plans" means these types of medical benefits:

a. Group insurance and group subscribed contracts;
b. Uninsured arrangements of group or group-type coverage;
c. Group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans;
d. Group-type contracts (obtained and maintained only because of membership in a particular organization or group);
e. Group, group-type or individual automobile "no fault" and traditional automobile "fault" type policies;
f. Medicare or other government benefits;
g. Group or group-type Hospital indemnity benefits in excess of $200 per day;
h. Medical care portions of group long-term care contracts (such as skilled nursing care).

Order of Benefit Determination: When a claim is made, the primary Plan pays its benefits without regard to any other plans. The secondary plans adjust their benefits so that the total benefits available will not exceed the allowable expenses.

A Plan without a coordination provision similar to this Plan is always the primary Plan . If all plans have such a provision:

a. The Plan covering the patient directly is primary.
b. Active/Inactive Employee: The Plan covering a person as an Employee who is neither laid off nor retired pays benefits first. The Plan covering that person as a laid off or

retired Employee pays benefits second. If both plans do not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

c. If none of the above rules determine the order of benefits, the Plan covering the patient longest is primary. The Plan covering that person for the shorter time pays second.
d. If none of the previously discussed rules apply, then the plans are to share the allowable expenses equally.

This Plan will always be primary for an expense incurred by a disabled Participant age 65 or under, other than a retired Employee, for which Medicare benefits are available. This does not apply to charges incurred for End Stage Renal Disease.

With respect to a Participant's automobile insurance coverage, no fault and otherwise, where permitted by law, that coverage shall be primary to the coverage afforded by this Plan.

The Plan covering the individual as an Employee or retiree will be primary, and the Plan providing continuation coverage (COBRA) will be secondary. There are different rules for Medicare and COBRA. See that section below.

When the above rules reduce the total amount of benefits otherwise payable under this Plan, each benefit charge that would be payable shall be reduced proportionately.

EFFECT OF MEDICARE

Priests and Medicare – If a Priest has Medicare, Primary and Secondary coverage would be determined by the following chart:

Status - Active or Retired?	Primary	Secondary
Active	AOW	Medicare
Retired	Medicare	AOW

Disability Due to End Stage Renal Disease (ESRD) - If a Participant becomes eligible for benefits under Medicare as a result of disability due to End Stage Renal Disease and chooses to remain covered under this Plan, this Plan will pay its benefits first and Medicare will be the secondary payer for the first 30 months of disability, in addition to the 3 month Waiting Period or a maximum of 33 months, when applicable. After the initial 30 or 33 months, Medicare will be the primary payer as determined by the Social Security Act and the Omnibus Reconciliation Acts, as amended.

Disability (other than End Stage Renal Disease) and Medicare - Medicare is the primary payer for individuals entitled to Medicare due to disability (other than End Stage Renal Disease) and under age 65 who have coverage under a Plan covering 100 or more Employees. However, if the coverage under the group health Plan is by virtue of the "current employment status" of the individual then Medicare is the secondary payer.

For purposes of this provision, the term "disabled" will be the definition given by Social Security.

SUBROGATION/REIMBURSEMENT

1. The Plan may elect, but is not required, to advance payment of medical or dental benefits in those situations where an Injury, sickness, disease or disability is caused in whole or in part by, or results from, the acts or omissions of a third party, or from the acts or omissions of a covered person where other insurance (such as auto or homeowners) is available. As a condition of providing benefits in such situations, the Plan and its agents shall have the right to recoup all benefits paid, either:

a. By subrogation directly from the responsible party (whether an unrelated third party or another covered person) or its insurer, without regard to whether the covered person is pursuing a claim against that responsible party, or
b. By reimbursement from the covered person, when the covered person has recovered compensation for such Injury from any source described below.

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or other deductions, without regard to whether the covered person is fully compensated by his/her net recovery from all the sources described in subsection 2, and without regard to allocation or designation of the recovery. ***The Plan explicitly has the right of first recovery, even where a Participant or beneficiary is not made whole.*** If the covered person's net recovery is less than the benefits paid, then the Plan is entitled to be paid all of the net recovery achieved. All funds received by or for any covered person, up to and including the amount of claims paid, are subject to the Plan's equitable lien thereon and are deemed to be held in constructive trust for the benefit of the Plan until such funds are delivered to the Plan or its attorneys. The Plan does not pay for, nor is responsible for the Participant's attorney's fees.

2. The Plan's rights of subrogation and/or reimbursement shall have priority against and shall constitute a first lien against any and all payments, settlements, judgments or awards made by or received from the responsible party, its insurer, or any other source on behalf of that party by:

    a. Any insurance company under an uninsured, underinsured or medical payment provision on behalf of the covered person and
    b. Any other source (such as crime victim restitution funds and Workers' Compensation) whose payment is designed or intended to compensate or reimburse the covered person for the Injury or damages sustained.

3. It is the covered person's obligation to:

    a. Cooperate with the Plan or its agents in defining, verifying and protecting its rights of subrogation and reimbursement
    b. Provide the Plan with pertinent information regarding the Injury or sickness, including various forms of documentation, accident reports, settlement reports and any other requested additional information.
    c. Do nothing to prejudice the Plan's rights of subrogation and reimbursement
    d. Promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
    e. To not settle, without the prior consent of the Plan, any claim that the covered person may have against any legally responsible party or insurance carrier.

    Failure to comply with any of these requirements may result in the withholding of payment by the Plan of further medical, dental or disability benefits and/or shall render the covered person responsible for the attorneys' fees and costs incurred by the Plan in protecting its rights.

4. 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:

    a. The location of the event that led to or caused the applicable sickness, Injury, disease or disability; and
    b. Whether any separate written acknowledgment of these rights is required by the Plan

or its administrator and signed by the Covered person.

RIGHTS OF RECOVERY - Whenever payments have been made by the Claims Administrator with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the Claims Administrator shall have the right to recover such excess payments. If a covered Employee is paid a benefit greater than that allowed by the Plan, the covered Employee will be requested to refund the overpayment. If the refund is not received from the covered Employee, the amount of overpayment will be deducted from future benefits. Similarly, if payment is made on the behalf of a covered Employee to a Hospital, Physician, or other provider of health care, and that payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider.

NO VERBAL MODIFICATIONS - The Participant shall not rely on any oral statement from an Employee of NCAS including, but not limited to, a customer service representative to:

a. Modify or otherwise affect the benefits, General Limitations and Exclusions, or other provisions of this Plan;
b. Increase, reduce, waive or void any coverages or benefits under this Plan.

In addition, such oral statement shall not be used in the prosecution or defense of a claim under this Plan. Any written or oral verification received from NCAS is based upon eligibility information and Plan benefits, which are subject to change. Therefore, any verification should not be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to a Participant.

PLAN MODIFICATION AND AMENDMENT - Amendment/modification of the Plan shall be in writing and signed by an officer of the Plan Sponsor. The Plan Sponsor may modify or amend the Plan from time to time at its sole discretion. The amendments or modifications, which affect the Plan Participants, will be communicated to them. The foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may have been made by the Plan Sponsor with the bargaining representatives of any employees. Participants will be notified of material reductions in services or benefits within 60 days of adoption of the change.

PLAN TERMINATION - The Plan Sponsor may terminate the Plan which shall be accomplished in writing and signed by an officer of the Plan Sponsor pursuant to authorization of the Plan Sponsor's Board of Directors. Upon termination, the rights of Participants to benefits are limited to claims incurred and due up to the date of termination. Any termination of the Plan will be communicated to Participants. In the event of Plan termination, all claims incurred by a Participant must be received by the Claims Administrator within 90 days after the date of termination.

NO GUARANTEE OF EMPLOYMENT - Neither the Plan nor any provisions contained in the Plan shall be construed to be a contract between the Employer and the Employee, or consideration for, or an inducement of, the employment of any Employee by the Employer. Nothing contained in the Plan shall grant any Employee the right to be retained in the service of the Employer nor shall it limit in any way the right of the Employer to discharge or to terminate the service of any Employee at any time.

CONFORMITY WITH THE LAW – This Plan of benefits shall be provided in compliance with HIPAA, FMLA, USERRA, and other group health Plan laws to the extent required by such laws. If any provision of this Plan is contrary to any applicable law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirements.

INTERPRETATION OF THE PLAN – The Plan Administrator has the sole and absolute discretion to construe and interpret the provisions and terms of the Plan, to resolve any disputes which may arise under the Plan and otherwise determine the operation and administration of the Plan. In making such interpretations and determinations, the Plan Administrator shall take into account the interpretation of the provisions and terms of the Plan by the Plan's reinsurance carrier and any other relevant information.

Any and all such decisions and determinations made by the Plan shall be final and binding upon all parties.

CLAIM PROVISIONS

ASSIGNMENT - It is recommended that payment of Covered Services for Participants be assigned and paid directly to providers of medical services and/or supplies. There is an assignment of benefits statement on the front of the claim form. NCAS will make payment to the provider when the statement is signed by the Participant as long as the provider has completed all requested information. NCAS may override the Assignment of Benefits if the provider was issued a Form W-9 and B-Notice letter of instruction requesting IRS reporting information and the provider did not respond within the time frame noted on the letter.

PROOF OF LOSS - A completed claim form, corresponding itemized bills, and other information necessary to process the claim, which represent proof of loss related to a Covered Service incurred by a Participant must be received by the Claims Administrator or PPO no later than 1 year from the date the service was rendered or otherwise provided.

The Plan reserves the right at its discretion to accept or to require verification of any alleged fact or assertion pertaining to any claim. In the event of Plan termination, all claims incurred by a Participant must be received by the Claims Administrator within 90 days of the date of termination of the Plan.

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

EXAMINATION - The Plan, at its own expense, shall have the right and opportunity to have the Participant examined whose Injury or sickness is the basis of a claim when and as often as it may reasonably require during the processing of the claim. The Claims Administrator shall also have the right and opportunity to have an autopsy performed where it is not forbidden by law.

FACILITY OF PAYMENT - If a Participant is a minor, or physically or mentally incapable of giving a valid release for payment, the Claims Administrator, at its option, may make payment to a party who has assumed responsibility for the care of such person. Such payments will be made until claim is made by a guardian. If a Participant dies while benefits remain unpaid, benefits will be paid, at the Claims Administrator's option to:

a. the provider of services; or
b. beneficiary.

Such payment will release the Plan of all further liability to the extent of payment.

CLAIM APPEAL PROCEDURE - If a claim is denied or partially denied, the Plan Supervisor will furnish notice to the Participant which will specify the reason or describe the additional information required. Upon written request by the Participant within 60 days after notice is received, the Plan Supervisor will review the claim in question and give final written decision. If such decision is not received within 90 days, the Participant may assume that the claim has been denied, unless he or she has been notified of special circumstances necessitating an extension of time for consideration of the claim (up to 90 additional days).

Within 60 days after an appealed claim has been denied by the Plan Supervisor, the Participant may appeal the denial by filing a written request for a review by the Plan Administrator. The Participant may have access to pertinent Plan documents, which will be made available during normal business hours or any other reasonable times designated by the Employer. He or she also has the right to provide the Plan Administrator with written statements relating to the merits of his or her claim. As soon as is possible (but in no event longer than 120 days), the Plan Administrator will render a written, final and binding decision. This decision will also be delivered in writing setting forth specific reasons for the decision and specific references to the pertinent Plan provisions upon which the decision is based. If the decision on review is not furnished within the prescribed time, the claim shall be deemed denied on review.

Statute of Limitations

Notwithstanding any otherwise applicable statutory statute of limitations, no legal action may be commenced or maintained to recover benefits under this Plan more than 12 months after the final review decision by the Plan Supervisor has been rendered (or deemed rendered).

PRIVACY OF PROTECTED HEALTH INFORMATION

1. Plan Sponsor's Certification of Compliance.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Employer (Plan Sponsor) unless the Employer (Plan Sponsor) certifies that the Plan Documents have been amended to incorporate this section and agrees to abide by this section.

2. Purpose of Disclosure to Employer (Plan Sponsor).

(a) Except to the extent permitted under paragraphs 3 and 4 of this section, the Plan will disclose Plan Participants' Protected Health Information to the Employer (Plan Sponsor) only to permit the Employer (Plan Sponsor) to carry out Plan administration functions for the Plan only if the disclosure is consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by the Employer (Plan Sponsor) of Plan Participants' Protected Health Information will be subject to and consistent with the provisions of paragraphs 5 and 6 of this section.

(b) Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Employer (Plan Sponsor) except to the extent that the disclosures are permitted under the Notice of Privacy Practices distributed to the Plan Participants.

(c) Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Employer (Plan Sponsor) for the purpose of employment-related actions or decisions or in connection with any other benefit or Employee benefit Plan of the Employer (Plan Sponsor).

3. Summary Health Information.

The Plan or any health insurance issuer or business associate servicing the Plan, may disclose Protected Health Information that is summary health information (as defined in 45 C.F.R 164.504(a)) to the Employer if the Employer requests the summary health information for the purpose of:

(a) Obtaining premium bids from insurance issuers for providing health insurance coverage under the Plan; or

(b) Modifying, amending or terminating the Plan. The Plan may disclose Protected Health Information to the Employer and may permit the disclosure of Protected Health Information to the Employer by a health insurance issuer or HMO with respect to the Plan.

4. Enrollment Information.

The Plan or any health insurance issuer or business associate servicing the Plan, may disclose to the Employer information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health option or HMO offered by the Plan.

5. Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information.

(a) The Employer (Plan Sponsor) will not use or disclose Participants' Protected Health Information, except as permitted or required by the Plan Documents, as amended, or required by law.

(b) The Employer (Plan Sponsor) will ensure that any agent, including any subcontractor, to whom it provides Plan Participants' Protected Health Information agrees to the restrictions and conditions of the Plan Documents, including this section, with respect to Plan Participants' Protected Health Information.

(c) The Employer (Plan Sponsor) will not use or disclose Plan Participants' Protected Health Information for employment-related actions or decisions or in connection with any other benefit or Employee benefit Plan of the Employer (Plan Sponsor).

(d) The Employer (Plan Sponsor) will report to the Plan any use or disclosure of Plan Participants' Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

(e) The Employer (Plan Sponsor) will make Protected Health Information available to the Plan Participant who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524.

(f) The Employer (Plan Sponsor) will make Plan Participants' Protected Health Information available for amendment, will consider any requested amendment and will incorporate any accepted amendment of Plan Participants' Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526.

(g) The Employer (Plan Sponsor) will track certain disclosures it may make of Plan Participants' Protected Health Information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.

(h) The Employer (Plan Sponsor) will make its internal practices, books, and records, relating to its use and disclosure of Plan Participants' Protected Health Information available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.

(i) The Employer (Plan Sponsor) will, if feasible, return or destroy all Plan Participant Protected Health Information, in whatever form or medium (including in any electronic medium under the Employer's (Plan Sponsor's) custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the Protected Health Information, when the Plan Participants' Protected Health Information is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Plan Participant Protected Health Information, the Employer (Plan Sponsor) will limit the use or disclosure of any Plan Participant Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

6. Adequate Separation Between the Employer (Plan Sponsor) and the Plan.

(a) The following workforce members under the control of the Employer (Plan Sponsor) may be given access to Plan Participants' Protected Health Information received from the Plan or a health insurance issuer or business associate servicing the Plan:

Human Resources Director

Moderator of the Curia

Assistant Director of Human Resources

The following classes of employees or other workforce members under the control of the Employer (Plan Sponsor) may be given access to record information for the purpose of reports, only and cannot have access to Plan Participants' Protected Health Information other than their own:

Chief Financial Officer

Controller

Director of Budget and Financial Reporting

This list includes every employee or class of employees or other workforce members under the control of the Employee (Plan Sponsor) who may receive Plan Participants' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

(b) The Employees, classes of Employees or other workforce members identified in paragraph 6(a) of this section will have access to Plan Participants' Protected Health Information only to perform the Plan administration functions that the Employer (Plan Sponsor) provides for the Plan.

(c) The Employees, classes of Employees or other workforce members identified in paragraph 6(a) of this section will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer (Plan Sponsor), for any use or disclosure of Plan Participants' Protected Health Information in breach or violation of or noncompliance with the provisions of this section to the Plan Documents. Employer (Plan Sponsor) will promptly report such breach, violation or noncompliance to the Plan, as required by paragraph 5(d) of this section, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each Employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

HIPAA SECURITY STANDARDS

Plan Sponsor Obligations - Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

a. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
b. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
c. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
d. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
    1. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
    2. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter or more frequently upon the Plan's request.

PLAN INFORMATION

Name and Type of Administration of the Plan:

Archdiocese of Washington Health Care Plan. The Plan is a group health Plan providing medical benefits to covered Employees through contract administration by a third party administrator referred to as the Claims Administrator.

Plan Sponsor:

Archdiocese of Washington
c/o Human Resources
P.O. Box 29260
Washington, D.C. 20017

Plan Sponsor's Federal Employer Identification Number: 53-0196550

Plan Administrator:

Archdiocese of Washington
c/o Human Resources
P.O. Box 29260
Washington, D.C. 20017

Claims Administrator:

NCAS
P. O. Box 981610
El Paso, Texas 79998
(703) 934-6200

Plan's Fiscal Year: January 1st- December 31st

Source of Financing of the Plan:

The Plan's benefits are funded by a combination of Employer and Employee contributions through a bank account established to pay benefits. The Employer contributes for the cost of the group coverage partially from its funds. The Employee's contribution is a fixed rate as determined from time to time. The total contributions are based on the cost of claims paid under the Plan plus administrative expenses. This is not an insurance policy, however, the Employer has purchased excess risk insurance to insure its liability for catastrophic losses under the Plan. NCAS processes the claims in accordance with the Employer's Plan Document.

Service of process may be made upon the Plan Administrator.

CLAIMS FILING INSTRUCTIONS

(For further information, refer to the section on Claim Appeal Procedure)

In-Network Providers

Before you use a provider listed in the PPO directory, call the provider or PPO network to verify that the provider is still a member. Simply present your NCAS Identification Card at the time you receive services. The provider will file a claim with the PPO network and will be directly reimbursed for the services you receive.

Out-of-Network Providers

MEDICAL SERVICES - Reimbursement of medical expenses provided by Out-of-Network providers is handled by NCAS. Claims for benefits may be filed by a Hospital or Physician's office, or by the Participant. Payment will be made by NCAS either to the provider or the Participant.

You do not need a claim form to file your claims. You should mail your itemized bill from the provider and be sure to include the following information on the bill:

a. Employee Name
b. Employee's Identification Number
c. Patient Name
d. Employer Name or Group Number
e. Provider's Tax ID Number (TIN)
f. Procedure Code
g. Diagnosis Code
h. Date of Service
i. Charge for Each Service.

Balance due bills are not acceptable. The bill for processing claims must include all the information described above. All claims and written inquiries should be sent to:

Medical	RX	Dental	Vision
NCAS P.O. Box 981610 El Paso, TX 79998 (703) 934-6227 1 (800) 888-6227	**Express Scripts** www.express-scripts.com or 1 (866) 265-9458	**Delta Dental** One Delta Drive Mechanicsburg, PA 17055 1 (800) 932-0783	**VSP** www.vsp.com or 1 (800) 877-7195

NOTE ON HOSPITAL CHARGES - Claims for inpatient admissions are usually filed by the Hospital. Most Hospitals will verify that your health coverage is in effect and will then take care of the paperwork on behalf of the patient. If you do receive a bill for inpatient services, do not pay it until you are certain that your claim has been settled. In some instances, the Participant is responsible for balances. When you are unsure, ask the Hospital or NCAS for guidance.

Remember - Authorization is required from the Managed Care Vendor prior to all non-emergency Hospital admissions and the next business day following an emergency admission. Failure to call the Managed Care Vendor may reduce your benefits (Refer to Chapter IV).
Call the telephone number found on the back of your identification card.

DENTAL SERVICES Please contact Delta Dental if you have questions on how to file a dental claim. They can be reached at:

Delta Dental
One Delta Drive
Mechanicsburg, PA 17055

1 (800) 932-0783

VISION SERVICES For questions on how to file a claim for vision services, please contact VSP at the following:

1 (800) 877-7195
or
www.vsp.com