EASTERN CATHOLIC BENEFIT PLAN

Restated effective as of October 1, 2024

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EASTERN CATHOLIC BENEFIT PLAN

ARTICLE I

RESTATEMENT AND PURPOSE OF PLAN

Section 1.01. Preliminary Information.

(a) The Metropolitan Archdiocese of Pittsburgh, Byzantine Rite a/k/a the Metropolitan Archeparchy of Pittsburgh, Byzantine Rite ("Archeparchy") is a nonprofit corporation organized under the laws of Pennsylvania. In accordance with its mission, the Archeparchy established the Eastern Catholic Benefit Plan ("Plan") effective June 1, 2012, for the purpose of providing health and welfare benefits to eligible employees of participating Catholic eparchies, and the parishes within those eparchies, and their eligible dependents.

(b) The Plan was established and has been maintained to be a "church plan" within the meaning of Section 414(e) of the Internal Revenue Code of 1986, as amended ("Code"), and Section 3(33) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and shall at all times be construed, interpreted, and administered so as to maintain its status as a church plan. The Plan is exempt from ERISA and entitled to protection from state laws and regulations pursuant to the Church Plan Parity and Entanglement Prevention Act, P.L. 106-244.

(c) The Plan operates within the framework of the tenets of the Catholic Church and does not provide benefits for services inconsistent with the position of the Catholic Church.

(d) The Plan has been amended from time to time and was most recently restated in its entirely effective January 1, 2019.

Section 1.02. Plan Restatement. The Archeparchy, as Plan Sponsor, has amended the Plan from time to time to make certain desired changes. The Archeparchy now desires to amend and restate the Plan effective as of October 1, 2024.

Section 1.03. Plan Funding. The Plan is funded exclusively through the Eastern Catholic Benefit Trust ("Trust"), either through the purchase of insurance or directly on a self-funded basis, as set forth herein. The Archeparchy is the Grantor of the Trust.

ARTICLE II

DEFINITIONS AND CONSTRUCTION

Section 2.01. Construction and Governing Law.

(a) The Plan and any Benefit Program under the Plan shall be interpreted, enforced, and administered in accordance with Code Sections 105 and 106, and when not inconsistent with the Code, or expressly provided otherwise herein, with the laws of the Commonwealth of Pennsylvania without regard to conflict of law principles. The nondiscrimination requirements under Code Section 105(h) shall separately apply to the plan for Eligible Employees in Class 1 and the plan for Eligible Employees in Class 2.

(b) Words used herein in the masculine gender shall be construed to include the feminine gender where appropriate, and *vice versa*, and words used herein in the singular or plural shall be construed as being in the plural or singular where appropriate, and *vice versa*.

(c) The headings and subheadings in the Plan are inserted for convenience and are not to be considered in the construction of any provision of the Plan.

(d) If any provision of the Plan or Benefit Program shall be held to violate the Code or be illegal or invalid for any other reason, that provision shall be deemed null and void, but the invalidation of that provision shall not otherwise impair or affect the Plan or Benefit Program.

(e) In resolving any conflict between provisions of the Plan or Benefit Program and in resolving any other uncertainty as to the meaning or intention of any provision of the Plan or Benefit Program, the interpretation that causes the Plan or Benefit Program to (i) be a church plan as defined in ERISA Section 3(33) and Code Section 414(e), and (ii) comply with all applicable requirements of the Code, shall prevail over any different interpretation.

Section 2.02. Definitions. When the initial letter of a word or phrase is capitalized herein the meaning of such word or phrase shall be as follows:

(a) "**Administrator**" means the Administration Committee of the Eastern Catholic Benefit Plan, the members of which are designated by (and can be removed and replaced by) the Plan Sponsor from time to time.

(b) "**Affordable Care Act**" means the Patient Protection and Affordable Care Act of 2010, as amended from time to time.

(c) "**Appeal**" means review by the Claims Administrator of a Denial.

(d) "**Archeparchy**" means the Metropolitan Archdiocese of Pittsburgh, Byzantine Rite a/k/a the Metropolitan Archeparchy of Pittsburgh, Byzantine Rite, a nonprofit corporation organized under the laws of Pennsylvania.

(e) "**Benefit Program**" means, as applicable, the Medical Benefit Program, Dental Benefit Program, and/or Vision Benefit Program, as defined herein.

(f) "**Child**" means an Eligible Employee's son or daughter, stepson or stepdaughter, legally adopted child (or a child placed with the Eligible Employee in anticipation of adoption), or a child who is placed under the legal guardianship of an Eligible Employee by a court of competent jurisdiction.

(g) "**Claimant**" means an individual who makes a claim for benefits under Article XI. For purposes of Article XI, references to a Claimant include a Claimant's authorized representative.

(h) "**Claims Administrator**" means a person, firm, or company, including an insurance company or other benefit provider, which has agreed to provide technical or administrative services and advice in connection with the operation of all or a part of a Benefit Program, and to perform such other functions, including processing and payment of claims, as may be delegated to it under such contract. The Claims Administrator with respect to each Benefit Program is set forth in Schedule A.

(i) "**COBRA**" means the Consolidated Omnibus Reconciliation Act of 1986, as amended from time to time.

(j) "**Code**" means the Internal Revenue Code of 1986, as amended from time to time. All citations to sections of the Code are to such sections as they may from time to time be amended or renumbered.

(k) "**Denial"** or **"Denied**" means, with respect to the Medical Benefit Program, any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including based on utilization review or a failure to cover a benefit because it is determined to be experimental or investigational or not medically necessary. A Denial includes any denial based on a determination that an individual is not eligible for coverage and also means a Rescission of coverage whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time.

(l) "**Dental Benefit Program**" means an employee benefit program offered under the Plan that provides dental benefits to Eligible Employees and Dependents, and which is funded by the Trust directly on a self-insured basis.

(m) "**Dependent**" means:

(1) a Spouse and

(2) a Child of the Eligible Employee until the end of the month in which he or she attains age 26; provided, however a Child shall continue to be a Dependent after the end of the month in which he or she attains age 26 if the Child is a Dependent under the Plan immediately prior to attaining age 26 and is permanently and totally disabled. A Child is permanently and totally disabled if he or she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. The Child must be unmarried and primarily dependent on the Eligible Employee for support. Proof of permanent and total disability must be provided to the Claims Administrator prior to the Child's 26th birthday and proof of continued permanent and total disability may be required by the Claims Administrator on an annual basis thereafter.

Notwithstanding the foregoing, for any Benefit Programs that are fully-insured, Dependent shall have the meaning set forth in that Benefit Program.

(n) "**Effective Date**" means, for the Plan, June 1, 2012, and for this restatement, October 1, 2024.

(o) "**Electronic Protected Health Information**" or "**EPHI**" means "electronic protected health information" as defined at 45 CFR § 160.103, which, generally, means Protected Health Information that is transmitted by, or maintained in, electronic media. For these purposes, "electronic media" means: (i) electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or (ii) transmission media used to exchange information already in electronic storage media (e.g., the internet, extranet, leased lines, dial up

lines, private networks, and the physical movement of removable/transportable electronic storage media).

(p) "**Eligible Employee**" means, as designated by the Participating Eparchy in its Participation Agreement, the following two classes of employees:

(1) Class 1: A priest who provides services to a Participating Employer and who is in a classification that has been designated by the Participating Eparchy as eligible to participate in the Plan, which may include inactive and/or retired priests. A priest who is incardinated (enrolled) in a Participating Eparchy will remain eligible to participate in the Plan through that Participating Eparchy even if the priest transfers to a Parish of another Participating Eparchy (or a non-participating eparchy), provided that all contributions continue to be paid on behalf of the priest.

(2) Class 2: A common law employee of a Participating Employer who is regularly scheduled to work at least 30 hours per week.

Class 1 Eligible Employees and Class 2 Eligible Employees are each covered under a separate plan under the Plan.

The term "Eligible Employee" shall not include: (a) a part-time, seasonal, or temporary employee; (b) a leased employee as defined under Code Section 414(n); (c) an individual designated in good faith by his or her Participating Employer as an independent contractor, regardless of whether the Internal Revenue Service or a court of law later determines such individual to be a common law employee; or (d) an employee covered by a collective bargaining agreement that does not provide for participation in the Plan. In addition, any employee who is eligible to participate in another health benefit plan sponsored by a Participating Employer is not eligible for participation in this Plan.

(q) "**Eligible for Medicare Coverage**" means that a person is covered under Medicare Parts A, B, and/or D or would have been covered under Medicare Parts A, B, and/or D, if such person had timely applied for Medicare Coverage and paid all required premiums for such Medicare Coverage; provided, however, a person is not considered Eligible for Medicare Coverage during a period to the extent that the Medicare Secondary Payer Act requires the Plan to be primary to Medicare during such period. This may occur, for example, if an Eligible Employee becomes covered under Medicare due to end-stage renal disease.

(r) "**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

(s) "**External Review**" means a review of a Denial (including a Final Denial) of benefits under the Medical Benefit Program conducted pursuant to either a State External Review process or the Federal External Review process, which are described in Article XI.

(t) "**Final Denial**" means a Denial of benefits under the Medical Benefit Program that has been upheld by the Claims Administrator at the completion of the internal appeals process conducted pursuant to Section 11.06, or a Denial of benefits under the Medical Benefit Program with respect to which the internal appeals process has been deemed exhausted as described under Section 11.12 (a "deemed Final Denial").

(u) "**Final External Review Decision**" means a determination by an Independent Review Organization at the conclusion of External Review.

(v) "**Health Care Operations**" means "health care operations" as defined by 45 CFR § 164.501, as amended. Generally, Health Care Operations include, but are not limited to, the following activities taken by or on behalf of the Plan:

(1) Quality assessment;

(2) Population based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(3) Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

(4) Underwriting, premium rating and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to health care claims (including stop loss insurance and excess loss insurance);

(5) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(6) Business planning and development, such as conducting cost management and planning related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(7) Business management and general administrative activities of the Plan, including, but not limited to:

(A) Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

(B) Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

(C) Resolution of internal grievances;

(D) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity; and

(E) Any other activity considered to be a "health care operation" activity pursuant to 45 CFR § 164.501.

(w) "**Health Care Professional**" means a physician or other health care professional licensed, accredited, or certified to perform health services consistent with State law.

(x) "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

(y) "**Independent Review Organization**" or "**IRO**" means an entity that conducts independent External Reviews of Denials and Final Denials.

(z) "**Individual**" means any person who is the subject of Protected Health Information.

(aa) "**Medical Benefit Program**" means an employee benefit program offered under the Plan that provides medical and prescription drug benefits to Eligible Employees and Dependents and comprises three distinct benefits:

(1) The "*Under 65 Medical Benefit*" is a benefit for Members who are not Eligible for Medicare Coverage. This benefit is funded by the Trust directly on a self-insured basis.

(2) The "*Supplemental Medicare Benefit*" is a benefit for Members who are Eligible for Medicare Coverage. This benefit is funded by the Trust through the purchase of a fully insured group policy.

(3) The "*Specialty Pharmacy Medical Expense Reimbursement Plan*" or "*Special Pharmacy MERP*" is a health reimbursement arrangement that is integrated with the Under 65 Medical Benefit. This benefit is funded by the Trust directly on a self-insured basis and automatically applies to all Members enrolled in the Under 65 Medical Benefit.

(bb) "**Medicare**" means the Health Insurance for the Aged Act, which includes Part A-Hospital Benefits for the Aged, Part B-Supplementary Medical Insurance Benefits for the Aged, Part C-Medicare Advantage Benefits, and Part D–Voluntary Prescription Drug Benefit Program.

(cc) "**Member**" means an Eligible Employee or Dependent who has enrolled in and is covered under the applicable Benefit Program.

(dd) "**NAIC Uniform Model Act**" means the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners in place on July 23, 2010.

(ee) "**Parish**" means a parish that operates as a separate legal entity within a Participating Eparchy.

(ff) "**Participating Employer**" means a Participating Eparchy or a Parish within a Participating Eparchy; provided, however, that a Participating Eparchy or Parish is eligible to participate in the Plan with respect to its Eligible Employees only if it has less than 20 employees and is exempt from the working aged rules under the Medicare Secondary Payer Act.

(gg) "**Participating Eparchy**" means a Catholic eparchy which, on behalf of itself and each Parish within the eparchy, has elected to participate in the Plan, has entered into a Participation Agreement pursuant to which it has agreed to all of the terms of participation, and whose participation has been accepted by the Plan Sponsor. As of the Effective Date of this restatement, the Participating Eparchies are as follows:

(1) The Archeparchy;

(2) Byzantine Catholic Eparchy of Parma;

(3) Byzantine Catholic Eparchy of Passaic;

(4) Diocese of Newton for the Melkites; and

(5) Eparchy of Our Lady of Lebanon of Los Angeles.

(hh) "**Participation Agreement**" means the written agreement between the Archeparchy and each Participating Eparchy which governs the terms of participation in the Plan for the Participating Eparchy and its Parishes, including the classification of Eligible Employees, coverage of Dependents, and applicable Benefit Programs offered with respect to the Participating Eparchy and its Parishes. The applicable terms of the Participation Agreement are incorporated herein by reference and made a part hereof.

(ii) "**Payment**" means "payment" as defined by 45 CFR § 164.501, as amended. Generally, Payment activities include, but are not limited to, activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an Individual to whom health care is provided (except as may be prohibited under 45 CFR § 164.502(a)(5)(i)). These activities include, but are not limited to, the following:

(1) Determination of eligibility, coverage, and cost sharing amounts (for example, cost of a benefit, Plan maximums and copayments as determined for an Individual's claim);

(2) Coordination of benefits;

(3) Adjudication of health benefit claims (including Appeals and other payment disputes);

(4) Subrogation of health benefit claims;

(5) Establishing Eligible Employee contributions;

(6) Risk adjusting amounts due based on an Eligible Employee's health status and demographic characteristics;

(7) Billing, collection activities and related health care data processing;

(8) Claims management and related health care data processing, including auditing payments, investigating, and resolving payment disputes and responding to an Eligible Employee's inquiries about payments;

(9) Obtaining payment under a contract for reinsurance (including stop loss and excess loss insurance);

(10) Medical necessity reviews or reviews of appropriateness of care or justification of charges;

(11) Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

(12) Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following Protected Health Information may be disclosed for Payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan);

(13) Reimbursement to the Plan; and

(14) Any other activity considered to be a "payment" activity pursuant to 45 CFR § 164.501.

(jj) "**Plan**" means the Plan embodied herein known as the Eastern Catholic Benefit Plan, as amended from time to time; provided, however, that the Plan shall at all times consist of two separate plans, one plan for Eligible Employees in Class 1 and one plan for Eligible Employees in Class 2.

(kk) "**Plan Sponsor**" means the Archeparchy and its successors and assigns. The Archbishop has complete authority to act on behalf of the Archeparchy.

(ll) "**Plan Year**" means the calendar year.

(mm) "**Post-Service Claim**" means any medical claim that is not an Urgent Care Claim or a Pre-Service Claim.

(nn) "**Pre-Service Claim**" means any medical claim that needs to be approved, in whole or in part, before the Member obtains medical care.

(oo) "**Privacy Regulations**" mean the regulations under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164, as amended).

(pp) "**Protected Health Information**" means "protected health information" as defined at 45 CFR § 164.501, which generally means information (including demographic information) that (i) identifies an Individual (or with respect to which there is a reasonable basis to believe the information can be used to identify an Individual), (ii) is created or received by a health care provider, a health plan, or a health care clearinghouse, and (iii) relates to the past, present, or future physical or mental health or condition of an Individual; the provision of health care to an Individual; or the past, present, or future Payment for the provision of health care to an Individual.

(qq) "**Rescission**" or "**Rescind**" means a cancellation or discontinuance of coverage under the Medical Benefit Program that has retroactive effect. A Rescission does not include the cancellation or discontinuance of such coverage that (i) has only a prospective effect, or (ii) is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of such coverage.

(rr) "**Security Incident**" means "security incident" as defined at 45 CFR § 164.304, which, generally, means the attempted or successful unauthorized access, use, disclosure,

modification, or destruction of information or interference with system operations in an information system.

(ss) "**Separation from Service**" means permanent severance from employment with all Participating Employers.

(tt) "**Service in the Uniformed Services**" means (i) the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, and National Guard duty under Federal law, (ii) a period for which an Eligible Employee is absent from a position of employment for the purpose of an examination to determine the fitness of the Eligible Employee to perform any such duty, (iii) a period for which the Eligible Employee is absent from employment to perform funeral honors duty as authorized by law, and (iv) service as an intermittent disaster-response appointee upon activation of the National Disaster Medical System or as a participant in an authorized training program.

(uu) "**Spouse**" means a person of the opposite sex to whom an Eligible Employee is married where the marriage is legally recognized under the law of any state. A Spouse shall not include a common law spouse or a same-sex spouse, whether or not permitted under state law.

(vv) "**Summary Health Information**" means "summary health information" as defined at 45 CFR § 164.504(a), which generally means information that may be individually identifiable health information, and:

(1) that summarizes the claims history, claims expenses, or type of claims experienced by Individuals for whom the Administrator has provided health benefits under a group health plan, and

(2) from which the information described at 45 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

(ww) "**Trust**" means the Eastern Catholic Benefit Trust, as amended from time to time.

(xx) "**Uniformed Service**" means the Armed Forces, the Army National Guard, the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commission corps of the Public Health Service, and any other category of persons designated by the President of the United States of America in time of war or emergency. For purposes of USERRA coverage only, services as an intermittent disaster response appointee of the NDMS when federally activated or attending authorized training in support of their Federal mission is deemed Service in the Uniformed Services, although such appointee is not a member of the "uniformed services" as defined by USERRA.

(yy) "**Urgent Care Claim**" means any claim for medical care or treatment where the failure to make a non-urgent care determination quickly (i) could seriously jeopardize the Member's life, health, or ability to regain maximum function, or (ii) in the opinion of a physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without such care or treatment.

(zz) "**USERRA**" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

(aaa) "**Vision Benefit Program**" means an employee benefit program offered under the Plan that provides vision benefits to Eligible Employees and Dependents, and which is funded by the Trust directly on a self-insured basis.

ARTICLE III

BENEFITS

Section 3.01. Member Benefits. Each Participating Eparchy shall designate in its Participation Agreement the applicable Benefit Programs in which the Eligible Employees and their Dependents of the Participating Eparchy and its Parishes may participate. Coverage will be provided pursuant to the Plan, the applicable Benefit Programs, and in accordance with each Participating Eparchy's Participation Agreement, which the Participating Eparchy may modify from time to time. No Member shall have any vested interest in any Benefit Program under the Plan.

Section 3.02. Insured Policies and Benefit Contracts Providing Employee Benefits.

(a) The Plan Sponsor may, but is not obligated to, enter into insurance contracts issued by any insurance company qualified to do business in the United States or enter into contracts with any other benefit provider, including but not limited to a preferred provider organization, to provide Benefit Programs under the Plan. Any such benefit contracts or policies may be changed by mutual agreement between the Plan Sponsor and the insurance company or benefit provider at any time and from time to time. The Plan Sponsor shall be the owner and policyholder of any such benefit contracts or policies.

(b) Any fully insured Benefit Program shall be limited to the benefits provided under any benefit contract or policy, as amended from time to time. Except as may be otherwise specifically provided in the Plan, the rights, duties, obligations, and responsibilities of the Plan Sponsor, the Participating Eparchies, the Parishes, the Administrator, and the Members concerning the benefits shall be limited to such rights, duties, obligations, and responsibilities as may be set forth in any such benefit contract or policy, as amended from time to time.

Section 3.03. Uninsured Benefit Programs.

(a) From time to time, the Plan Sponsor may provide Benefit Programs to Members which are not fully insured. With respect to each such benefit, there shall be set forth in writing:

(1) the extent of such benefit, including periods during which benefits are provided;

(2) the procedures governing elections, if any, for such benefits;

(3) the eligibility requirements for such benefits;

(4) required contributions for such benefits;

(5) the conditions and limitations on such benefits, including conditions precedent and subsequent with regard to qualification for benefits;

(6) the claims procedures; and

(7) such other matters as required by law or as the Plan Sponsor in its sole discretion may deem relevant or appropriate.

Such writing shall be kept on file with the Administrator and shall be made available to any Member upon written request. Any such writing is incorporated herein by reference and made a part hereof.

(b) No benefit shall be paid or made available to any Member under the Plan, except as may be specifically provided by the Administrator.

Section 3.04. Incorporation of All Relevant Benefit Program Documents. All written documents relating to the Benefit Programs are set forth in Schedule A, which documents are incorporated herein by reference and made a part hereof. Unless otherwise stated herein, in the event of a conflict between the terms of the Plan and the written documents relating to the Benefit Programs, the terms of the Plan shall govern.

Section 3.05. Termination, Addition, and Modification of Benefit Programs. The Plan Sponsor may terminate, add, or modify any Benefit Program under the Plan and Schedule A by adopting a revised Schedule, Plan amendments or policy riders, as the case may be, and adding or deleting (as applicable) such additional benefits or modifications thereto. Such revised Schedule, amendments, and riders shall become a part hereof. Any such additional benefit shall be subject to all of the terms and conditions of this Plan.

ARTICLE IV

ELIGIBILITY FOR COVERAGE

Section 4.01. Eligibility.

(a) An Eligible Employee shall be eligible for coverage under an applicable Benefit Program on his or her first day of service for a Participating Employer or, if later, the day he or she first becomes an Eligible Employee.

(b) A Dependent shall be eligible for coverage under an applicable Benefit Program on the same date as the Eligible Employee, or, if later, the date on which the individual first becomes a Dependent of the Eligible Employee.

(c) If two Eligible Employees are the Spouse of one another, one Eligible Employee may enroll the other as his or her Dependent; provided, however, an individual may not be covered as both an Eligible Employee and a Dependent.

(d) Except as otherwise provided in the Plan, an Eligible Employee must be enrolled (or contemporaneously enrolling) in the applicable Benefit Program in order to enroll his or her Dependents in such Benefit Program.

(e) Notwithstanding paragraph (d), with respect to the Medical Benefit Program, an Eligible Employee and his or her Dependents will be eligible for the Under 65 Medical Benefit (which is integrated with the Specialty Pharmacy MERP) or the Supplemental Medicare Benefit, as applicable, based on whether or not each are Eligible for Medicare Coverage. Therefore, an Eligible Employee may be covered by a different component of the Medical Benefit Program than his or her Dependents.

Section 4.02. Initial Coverage Date.

(a) An Eligible Employee and his or her Dependents shall become covered under an applicable Benefit Program (and, therefore, become a Member) effective as of their eligibility date defined in Section 4.01, provided that (i) the Eligible Employee timely submits a completed enrollment form to the Administrator and (ii) the Eligible Employee (and/or the Participating Eparchy on behalf of itself and its Parishes) make all required contributions for coverage to the Administrator. The deadline to submit an enrollment form is 31 days from the Eligible Employee's or Dependent's eligibility date, as applicable, unless a different deadline is set forth in the applicable Benefit Program.

(b) If an Eligible Employee does not timely enroll himself or herself (or his or her Dependents) under an applicable Benefit Program when initially eligible, he or she must wait until the next annual enrollment period to enroll in the Benefit Program. Notwithstanding the foregoing, an Eligible Employee may enroll or otherwise make changes to benefit elections if he or she either (i) is entitled to a special enrollment pursuant to HIPAA, as outlined under Section 7.02, or (ii) has experienced a change in status and timely submits a new election to the Administrator that is consistent with such status change, as permitted under the applicable Benefit Program.

(c) Notwithstanding paragraph (a) or (b), a Member who is covered by the Under 65 Medical Benefit at such time that he or she becomes Eligible for Medicare Coverage will continue to be covered by the Under 65 Medical Benefit until the earlier of (i) the initial date of coverage under the Supplemental Medicare Benefit or (ii) ninety (90) days after the Member becomes Eligible for Medicare Coverage. Therefore, a Member who does not complete all enrollment requirements for the Supplemental Medicare Benefit within ninety (90) days of becoming Eligible for Medicare Coverage could have a gap in coverage under the Plan.

Section 4.03. Annual Open Enrollment. Each Eligible Employee will have an opportunity once each Plan Year to enroll himself or herself (or his or her Dependents) in any of the applicable Benefit Programs or to make changes to existing benefit elections. The annual open enrollment period will be designated by the Administrator and communicated to Eligible Employees prior to such period. Provided that the Eligible Employee completes the applicable enrollment form and submits it to the Administrator within the annual open enrollment period, elections made during open enrollment will take effect as of the first day of the following Plan Year.

Section 4.04. Change in Status. Each Member shall notify the Administrator in writing of: (i) a change in address; (ii) entrance into the military by the Eligible Employee; (iii) marriage by the Eligible Employee; (iv) death of a Spouse; (v) divorce or legal separation from a Spouse; (vi) loss of eligibility or entitlement to Medicare; or (vii) any other change in status which might affect the coverage of the Eligible Employee or a Dependent under any Benefit Program and the Plan. The Participating Eparchy shall notify, in writing, the Administrator of (a) termination of

the Member's employment with the Participating Eparchy or a Parish and (b) loss of eligibility of the Member for coverage under the Plan or any Benefit Program. Notice and any required certification must be provided within 31 days of the change in status. A failure to notify the Administrator that an individual ceases to be classified as an Eligible Employee or a Dependent, and thus is no longer eligible for coverage under a Benefit Program or the Plan, will be deemed by the Administrator to be an act that constitutes fraud or an intentional misrepresentation of material fact prohibited by the Plan that could result in a Rescission of coverage. The Administrator may request whatever documentation it deems necessary to substantiate a claimed change in status.

Section 4.05. Termination of Coverage.

(a) Subject to the USERRA provisions in Article V, and unless otherwise provided under a Benefit Program, coverage for an Eligible Employee under a Benefit Program and the Plan shall terminate on the earliest of:

(1) the date of termination of the Benefit Program or the Plan or the date of amendments to the Benefit Program or the Plan that result in cessation of coverage;

(2) the date the Eligible Employee ceases to be classified as an Eligible Employee;

(3) the date that the Participating Eparchy or Parish through which the Eligible Employee is covered is no longer exempt from the working aged rules under the Medicare Secondary Payer Act;

(4) the date of the Eligible Employee's death;

(5) the date an Eligible Employee becomes a full-time member of the Armed Forces of any country, unless coverage is continued pursuant to Article V;

(6) the date the Participating Eparchy (on behalf of itself and its Parishes) or Member fails to pay the required contribution on behalf of the Member;

(7) the date coverage under the Plan is terminated for a particular employment classification of an Eligible Employee; or

(8) the date of the Eligible Employee's Separation from Service, except as otherwise provided under the Plan or the Participation Agreement.

(b) Subject to USERRA provisions in Article V, and unless otherwise provided under a Benefit Program, coverage for a Dependent under a Benefit Program and the Plan shall terminate on the earliest of:

(1) the last day of the month in which an individual ceases to be classified as a Dependent;

(2) the date of the Dependent's death; or

(3) the date that the Eligible Employee's coverage terminates for any reason, except that if coverage terminates on account of the Eligible Employee's death, his or her

covered Dependents shall continue to be eligible for benefits under the Plan until the earlier of (i) 90 days after the end of the month in which the Employee's death occurs or (ii) the date on which the Dependent would otherwise lose coverage under the Plan for any reason other than the death of the Eligible Employee.

ARTICLE V

CONTINUATION OF COVERAGE

Section 5.01. COBRA Continuation Coverage. The Plan does not offer continuation coverage under COBRA. As a church plan, the Plan is exempt from COBRA under federal law.

Section 5.02. USERRA Continuation Coverage.

(a) A Member who is an Eligible Employee and actively employed with a Participating Employer may be entitled to reemployment and other rights during and after a period of Service in the Uniformed Services under USERRA, including certain contributions and service credits under the Plan.

(b) To be eligible for such USERRA benefits, before leaving for military service, the Eligible Employee is generally required to give the Participating Employer advance notice that such Eligible Employee is leaving employment for Services in the Uniformed Services. When such Eligible Employee returns from military service, he or she must timely submit an application for reemployment with the Participating Employer and request information regarding such Eligible Employee's reemployment rights. Time limits for returning to work shall depend on the length of time of such military service.

(c) If an Eligible Employee is absent from a position of employment with the Participating Employer by reason of Service in the Uniformed Services and was covered under the Plan immediately prior to his or her absence due to Service in the Uniformed Services, such Eligible Employee shall then be entitled to elect to continue health care coverage for the Eligible Employee and the Eligible Employee's covered Dependents for a period equal to the lesser of (i) 24-month period beginning on the date on which such Eligible Employee is absent from employment with the Participating Employer by reason of Service in the Uniformed Services or (ii) the period beginning on the date of the Eligible Employee's absence for Service in the Uniformed Services begins, and ending on the day following the date on which the Eligible Employee fails to apply for or return to a position of employment with the Participating Employer as determined pursuant to USERRA Section 4312(e). An Eligible Employee may elect to discontinue coverage under the Plan during Service in the Uniformed Services by submitting the applicable forms to the Administrator.

Section 5.03. Election of USERRA Continuation Coverage.

(a) An Eligible Employee may elect to continue coverage described in Section 5.02 by reason of Service in the Uniformed Services for himself or herself and his or her covered Dependents. Dependents do not have an independent right to elect USERRA continuation coverage. The election period for continued coverage shall begin on the date the Eligible Employee gives the Participating Employer advance notice that he or she is required to report for

Uniformed Service (whether such service is voluntary or involuntary) and shall end 60 days after the date the Eligible Employee would lose coverage.

(b) If the Eligible Employee is unable to give advance notice of Uniformed Service, the Eligible Employee may still be able to elect continuation coverage under this Article if the failure to give advance notice was because giving such notice was impossible, unreasonable, or precluded by military necessity. In such a case, the election period shall begin on the date the Eligible Employee leaves for Uniformed Service and shall end on the earlier of (i) the last day of the 24-month period beginning on the date on which the Eligible Employee's absence for the Uniformed Service begins, or (ii) the date on which the Eligible Employee fails to return from Uniformed Service or apply for a position of employment as provided under 20 CFR §§ 1002.115-123. For these purposes, "military necessity" occurs only when deemed to be so by a designated military authority as described in 20 CFR § 1002.86 and may include situations where a mission, operation, exercise, or requirement is classified, or could be compromised or otherwise adversely affected by public knowledge. It may be impossible or unreasonable to give advance notice under certain circumstances such as when the Participating Employer is unavailable, or the Eligible Employee is required to report for Uniformed Service in an extremely short period of time.

(c) The election of USERRA continuation coverage must be made on a form provided by the Administrator and made within the 60-day period described herein. An election is considered to be made on the date it is sent to the Administrator or its designee. If timely elected pursuant to this Section, coverage shall be reinstated as of the date the Eligible Employee lost coverage due to absence for Service in the Uniformed Service and shall last for the period set forth in paragraph (b); provided that the Eligible Employee pays all unpaid costs for the coverage pursuant to Section 5.04.

Section 5.04. Cost of USERRA Continuation Coverage.

(a) If an Eligible Employee elects continuation coverage pursuant to Section 5.03, the Eligible Employee will be required to pay 102% of the full premium cost for such coverage; provided, however, if the Eligible Employee's Service in the Uniformed Services is for a period of fewer than 31 days, the Eligible Employee will not be required to pay more for such coverage than is otherwise required for other eligible persons.

(b) Premiums are due on the first day of each month for which continuation coverage is desired. Failure to pay premiums on a timely basis shall result in termination of coverage as of the date the premium is due. Payment of any premium, other than the initial premium, shall only be considered to be timely if made within 30 days after the date due. An initial premium must be paid for the time period between the date that continuation coverage commences and the date continuation coverage is elected. This initial premium payment must be made within 45 days after the date of election. Failure to pay the initial premium by the date due shall result in cancellation of coverage back to the initial date coverage would have terminated.

Section 5.05. Waiting Period and Exclusions Upon Reemployment. Notwithstanding any other provision herein, an Eligible Employee and his or her Dependents whose benefit coverage is terminated by reason of Service in the Uniformed Services shall not be subject to any exclusion or waiting period upon reinstatement of such coverage following Service in the Uniformed Services; provided, however, the above shall not apply to any

condition determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during the performance of Service in the Uniformed Services.

Section 5.06. Rights, Benefits, and Obligations of Employees Absent from Employment By Reason of Service in the Uniformed Services. An Eligible Employee who is absent from employment with the Participating Employer by reason of Service in the Uniformed Services shall be considered on furlough or leave of absence while performing such service and shall be entitled to such other rights and benefits as are generally provided by the Participating Employer to Eligible Employees having similar status and pay who are on furlough or leave of absence; provided, however, an Eligible Employee who knowingly provides written notice of intent not to return to employment with the Participating Employer shall cease to be entitled to such rights and benefits. Furthermore, an Eligible Employee who is absent from employment with a Participating Employer by reason of Service in the Uniformed Services shall be permitted to apply any accrued paid vacation, annual or similar leave while on such leave by reason of Service in the Uniformed Services.

Section 5.07. USERRA Continuation Health Benefits Provided. The continuation coverage provided to an Eligible Employee serving in the Uniformed Services who elects continued coverage (and his or her covered Dependents) shall be identical to the coverage provided under the Plan to similarly situated persons covered by the Plan who are active. If coverage is modified under the Plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are covered under USERRA continuation coverage. Continuation coverage may not be conditioned on evidence of good health. During the open enrollment period, if similarly situated active employees may choose to be covered under another Benefit Program or option under the Plan, or to add or eliminate coverage of a family member, the Plan shall provide the same opportunity to individuals who have elected USERRA continuation coverage.

Section 5.08. Reinstatement of Coverage Upon Re-employment. The Administrator shall promptly reinstate Plan coverage when an Eligible Employee is re-employed after Service in the Uniformed Service

ARTICLE VI

COORDINATION

Section 6.01. Secondary Coverage to Medicare. The Plan covers Members who are Eligible for Medicare Coverage and for whom Medicare coverage is primary. Coverage under the Plan for a Member who is Eligible for Medicare Coverage shall be secondary to coverage under Medicare. If such a Member incurs a claim, after benefits have been paid under Medicare with respect to such claim, the Plan shall pay for covered services as described in the applicable Benefit Program.

Section 6.02. Coordination of Medical Benefit Program.

(a) Eligibility for coverage under the Medical Benefit Program is based on whether the Member is Eligible for Medicare Coverage, such that (i) a Member who is not Eligible for Medicare Coverage is eligible only for the Under 65 Medical Benefit and (ii) a Member who is Eligible for Medicare Coverage is eligible only for the Supplemental Medicare Benefit.

(b) A Member who is covered under the Under 65 Medical Benefit shall automatically be covered under the Specialty Pharmacy MERP. To the extent a Member is eligible to receive reimbursements for medical expenses under the Specialty Pharmacy MERP (or would be eligible to receive such reimbursements if the Member provided information required to determine eligibility for coverage), such coverage shall be provided under the Specialty Pharmacy MERP and shall be excluded from the Under 65 Medical Benefit.

Section 6.03. Coordination with Other Plans. Unless otherwise provided by the applicable Benefit Program, this Plan shall be coordinated with all other plans under which an individual is covered for benefits, which benefits are also covered under this Plan so that the total benefits available under both plans shall not exceed 100% of the allowable expenses. Coordination shall be as described in the applicable Benefit Program.

ARTICLE VII

LAWS AFFECTING BENEFIT PROGRAMS

Section 7.01. Scope of Article. This Article applies to the Medical Benefit Program, to the extent that the Medical Benefit Program and its individual components are subject to the federal requirements outlined herein. The Dental Benefit Program and the Vision Benefit Program constitute "excepted benefits" under the Code Section 9832(c), and, therefore, are generally exempt from the federal requirements outlined in this Article, except to the extent of their voluntary compliance pursuant to the terms of the applicable Benefit Program.

Section 7.02. Health Insurance Portability and Accountability Act of 1996.

(a) The Medical Benefit Program shall comply with HIPAA, as amended from time to time, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing the Medical Benefit Program. As part of such compliance, and notwithstanding any other provisions in this Plan or in the Medical Benefit Program to the contrary, the Medical Benefit Program shall be administered consistently with this Section 7.02.

(b) A Member shall be entitled to enroll in the Medical Benefit Program during special enrollment periods upon the loss of other coverage or upon the acquisition of a new Dependent, to the extent required under HIPAA. A Member shall also be entitled to enroll himself or herself or his or her Dependent(s) in the Medical Benefit Program during special enrollment periods in either of the following circumstances:

(1) The eligible individual is covered under a Medicaid plan under Title XIX of the Social Security Act, or a state children's health plan under Title XXI of the Social Security Act, and coverage under such plans is lost due to a loss of eligibility for such coverage; or

(2) The eligible individual becomes eligible for premium assistance, with respect to the Medical Benefit Program, under such Medicaid plan or a state children's health plan (including any waiver or demonstration project conducted under or in relation to such plan), to the extent required by HIPAA.

(c) No pre-existing conditions shall be excluded from coverage under the Medical Benefit Program to the extent such exclusion would violate HIPAA or the Affordable Care Act.

(d) No person shall be discriminated against in terms of eligibility, continued eligibility, or level of required Member contributions based on the following health status-related factors: (i) health status; (ii) medical condition (including both physical and mental illnesses); (iii) claims experience; (iv) receipt of health care; (v) medical history; (vi) genetic information, as that term is defined in HIPAA; (vii) evidence of insurability (including conditions arising out of acts of domestic violence); or (viii) disability.

Section 7.03. Parity in Mental Health and Substance Use Disorder Benefits. The Medical Benefit Program shall comply with the Mental Health Parity Act of 1996, as amended by the Mental Health Parity and Addiction Equity Act of 2008, as amended from time to time thereafter, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing the Plan.

Section 7.04. Newborns' and Mothers' Health Protection Act of 1996. The Medical Benefit Program shall comply with the Newborns' and Mothers' Health Protection Act of 1996, as amended from time to time, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing the Plan. As part of such compliance, neither the Medical Benefit Program, nor any health insurance funding the Medical Benefit Program, may restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following normal vaginal delivery, or less than 96 hours following a caesarean section, or require that a provider obtain authorization from the Plan, the Medical Benefit Program, or insurance issuer for prescribing a length of stay not in excess of the above periods.

Section 7.05. Women's Health and Cancer Rights Act of 1998. The Medical Benefit Program shall comply with the Women's Health and Cancer Rights Act of 1998, as amended from time to time, and any regulations issued thereunder, and to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulation governing the Plan.

Section 7.06. Genetic Information and Nondiscrimination Act of 2008. The Medical Benefit Program shall comply with the Genetic Information Nondiscrimination Act of 2008 ("GINA"), as amended from time to time, and any regulations issued thereunder, and to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing the Plan. As part of such compliance, the Plan may not adjust premium or contribution amounts for the group covered under the Medical Benefit Program on the basis of genetic information and shall not request or require an individual or a family member of such individual to undergo a genetic test. The Plan also shall not request, require, or purchase genetic information for underwriting purposes or with respect to any individual prior to such individual's enrollment in the Plan or in connection with such enrollment. Pursuant to GINA, the term "genetic information" includes genetic tests, the genetic tests of family members, and family medical history.

Section 7.07. Eligibility for Medicaid Benefits. Benefits shall be paid in accordance with any assignment of rights made by or on behalf of any Member as required by a State plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act. For purposes of enrollment and entitlement to benefits, a Member's eligibility for or receipt

of medical benefits under a State plan for medical assistance approved under Title XIX of the Social Security Act shall not be taken into account. The State shall have a right to any payment made under a State plan for medical assistance approved under Title XIX of the Social Security Act when the Plan has a legal liability to make such payment.

Section 7.08. Patient Protection and Affordable Care Act.

(a) The Plan shall administer the Medical Benefit Program in compliance with the Affordable Care Act, as amended from time to time, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing the Plan.

(b) The Plan Sponsor shall be responsible for paying and reporting the annual Patient-Centered Outcomes Research Institute fee ("PCORI fee") on behalf of the Under 65 Medical Benefit and the integrated Specialty Pharmacy MERP. The insurers who provide fully insured group policies under the Plan that are subject to the PCORI fee shall be responsible for paying and reporting the fee with respect to those policies.

(c) The Plan shall comply with the prohibition on Rescissions with respect to the Medical Benefit Program. Specifically, the Plan shall not Rescind coverage with respect to a Member, except in the case where the Member (or a person seeking coverage on behalf of the Member) has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan. The Plan shall provide 30 days advance written notice to each such Member who would be affected before coverage is Rescinded. Notwithstanding the foregoing, the Plan may still cancel or discontinue coverage effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Nothing in this paragraph (c) shall prohibit the Plan from cancelling or discontinuing coverage prospectively for any reason provided under the Plan.

Section 7.09. Consolidated Appropriations Act, 2021. The Plan shall administer the Medical Benefit Program in compliance with the Consolidated Appropriations Act, 2021 ("CAA"), and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing the Plan. The Plan may rely on any enforcement delays announced by federal agencies with respect to compliance deadlines under the CAA, and in the absence of regulations, the Medical Benefits under the Plan shall implement provisions in accordance with a good faith, reasonable interpretation of the statute.

ARTICLE VIII

PROTECTED HEALTH INFORMATION

Section 8.01. Scope of Article. This Article reflects certain provisions of HIPAA as it relates to the privacy and security of Protected Health Information. It is intended as good faith compliance with the requirements of HIPAA and is to be construed in accordance with HIPAA and guidance issued thereunder. This Article applies to the Plan with respect to all Benefit Programs that are group health plans as defined in 45 CFR § 160.103.

Section 8.02. Supersession of Inconsistent Provisions. This Article shall supersede the provisions of the Plan (and any applicable Benefit Program) to the extent those provisions are inconsistent with the provisions of this Article.

Section 8.03. Use and Disclosure of Protected Health Information. The Plan shall use Protected Health Information to the extent of and in accordance with the uses and disclosures permitted by HIPAA, as set forth in the Privacy Regulations. Specifically, the Plan shall use and disclose Protected Health Information for purposes related to health care treatment, Payment for health care, and Health Care Operations.

Section 8.04. Plan Documents. In order for the Plan to disclose Protected Health Information to the Plan Sponsor and/or any Participating Employer, or to provide for or permit the disclosure of Protected Health Information to the Plan Sponsor and/or a Participating Employer by a health insurance issuer with respect to the Plan, the Plan must ensure that the Plan documents restrict uses and disclosures of such information by the Plan Sponsor and each Participating Employer consistent with the requirements of HIPAA. For purposes of this Article, if a Participating Employer is a Parish, the term "Participating Employer" shall also refer to the Participating Eparchy on behalf of the Parish.

Section 8.05. Disclosures by Plan to the Plan Sponsor or Participating Employers. The Plan may:

(a) Disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of:

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

(2) Modifying, amending, or terminating the Plan.

(b) Disclose to the Plan Sponsor or a Participating Employer (with respect to its employees only) information on whether an Individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer offered by the Plan.

(c) Disclose Protected Health Information to the Plan Sponsor to carry out Plan administration functions that the Plan Sponsor may perform, consistent with the provisions of Sections 8.06 to 8.08 of this Article.

(d) With an authorization from the Eligible Employee, disclose Protected Health Information to a Participating Employer for purposes related to the administration of other employee benefit plans and fringe benefits sponsored by the Participating Employer.

(e) Not permit a health insurance issuer with respect to the Plan to disclose Protected Health Information to the Plan Sponsor or a Participating Employer except as permitted by this Section.

(f) Not disclose (and may not permit a health insurance issuer to disclose) Protected Health Information to the Plan Sponsor or a Participating Employer as otherwise permitted by this Section unless a statement is included in the Plan's notice of privacy practices that the Plan (or a health insurance issuer with respect to the Plan) may disclose Protected Health Information to the Plan Sponsor or the Participating Employer.

(g) Not disclose Protected Health Information to a Participating Employer for the purpose of employment related actions or decisions or in connection with any other benefit or employee benefit plan of the Participating Employer.

(h) Not disclose (and may not permit a health insurance issuer to disclose) Protected Health Information that is genetic information about an individual for underwriting purposes as defined in Section 1180(b)(4) of the Social Security Act and underlying regulations.

Section 8.06. Uses and Disclosures by the Plan Sponsor and Participating Employers. The Plan Sponsor and each Participating Employer may only use and disclose Protected Health Information as permitted and required by the Plan, as set forth within this Article. Such permitted and required uses and disclosures may not be inconsistent with the provisions of HIPAA. The Plan Sponsor may use and disclose Protected Health Information without an authorization from an Eligible Employee for Plan administrative functions including Payment activities and Health Care Operations. In addition, the Plan Sponsor and each Participating Employer may also use and disclose Protected Health Information to accomplish the purpose for which any disclosure is properly made pursuant to Section 8.05.

Section 8.07. Certification. The Plan may disclose Protected Health Information to the Plan Sponsor or a Participating Employer only upon receipt of a certification from the Administrator that the Plan documents have been amended to incorporate the provisions provided for in this Section and that the Plan Sponsor and each Participating Employer so agrees to the provisions set forth therein.

Section 8.08. Conditions Agreed to by the Plan Sponsor and Participating Employers. The Plan Sponsor and each Participating Employer agrees to:

(a) Not use or further disclose Protected Health Information other than as permitted or required by the Plan document or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor or Participating Employer provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor and Participating Employer with respect to such Protected Health Information, and that any such agents or subcontractors agree to implement reasonable and appropriate security measures to protect any Electronic Protected Health Information belonging to the Plan that is provided by the Plan Sponsor or Participating Employer;

(c) Not use or disclose Protected Health Information for employment related actions and decisions unless authorized by an Individual;

(d) Not use or disclose Protected Health Information in connection with any other benefit or employee benefit plan of the Participating Employer unless authorized by an Individual;

(e) Report to the Plan any Protected Health Information use or disclosure that is inconsistent with the uses or disclosures provided for by this Article, or any Security Incident, of which it becomes aware;

(f) Make Protected Health Information available to an Individual in accordance with HIPAA's access requirements pursuant to 45 CFR § 164.524;

(g) Make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR § 164.526;

(h) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

(i) Make internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA;

(j) If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor or Participating Employer still maintains in any form, and retain no copies of such Protected Health Information when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible);

(k) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates receives, maintains, or transmits on behalf of the Plan; and

(l) Ensure that the separation and requirements of Sections 8.09, 8.10, and 8.11 of the Plan are supported by reasonable and appropriate security measures.

Section 8.09. Adequate Separation Between the Plan and the Plan Sponsor and each Participating Employer. In accordance with HIPAA, only the following employees or classes of employees may be given access to Protected Health Information:

(a) Privacy Officer: Any Protected Health Information necessary to enforce the Plan's privacy policies and procedures or as necessary to perform any plan administrative functions, including, but not limited to, adjudicating Appeals for claims denials and addressing claims questions.

(b) Human Resources: Any Protected Health Information necessary to perform any Plan administrative functions, including, but not limited to, adjudicating Appeals for claims denials and addressing claims questions.

(c) Accounting/Payroll: Only the minimum necessary amount of Protected Health Information necessary to ensure that funds are available to pay for claims made under the Plan and to coordinate payroll deduction for plan premiums. In most circumstances, unless otherwise approved by the Privacy Officer, information provided to Accounting/Payroll will include only information that does not identify the identity of an Individual or an Individual's medical condition or treatment.

(d) Senior Management: Only aggregated non identifiable information, unless minimally necessary to perform a Plan administrative function such as determining final Appeals of claims.

(e) Others: In his or her discretion, the Privacy Officer may, from time to time, designate other individuals or classes of individuals to use Protected Health Information. The Privacy Officer will identify such individuals and define the Protected Health Information they may use. Individuals performing services on behalf of the Plan will not access the Protected Health Information of any Member that is not relevant to the particular job they are performing for the Plan. All such individuals will be trained in the use and disclosure of Protected Health Information.

Section 8.10. Limitations of Access and Disclosure. The persons described in Section 8.09 of this Article may only have access to and use and disclose Protected Health Information for Plan administration functions that the Plan Sponsor or (in very limited circumstances, such as payroll functions) the Participating Employer may perform for the Plan.

Section 8.11. Noncompliance. If the persons or classes of persons described in Section 8.09 of this Article do not comply with this Plan document, then the Plan and the Administrator, in cooperation with the Plan Sponsor, shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

ARTICLE IX

FUNDING POLICY AND CONTRIBUTIONS TO THE PLAN

The Administrator shall be responsible for establishing and carrying out the funding policy of the Trust for the provision of benefits consistent with the objectives of the Plan and as set forth in the Participation Agreement. Benefit Program contributions may consist of contributions made by the Member or by the Participating Eparchy (on behalf of itself and its Parishes) for the Member, and shall be deposited into the Trust. The Administrator shall determine the amount of required contributions to be made with respect to each Benefit Program in accordance with the terms of the Participation Agreement. Required contributions for Benefit Programs shall be communicated to Members.

ARTICLE X

ADMINISTRATION OF THE PLAN AND DISCRETIONARY AUTHORITY

Section 10.01. Administrator. The Administration Committee shall be the Administrator of the Plan; however, the Administration Committee may from time to time designate a person, committee, or organization to perform certain administrative functions of the Administrator. Any such individual, committee, or organization shall perform the delegated functions as directed by the Administrator. The Administrator or its designee may provide rules and regulations, not inconsistent with the provisions hereof, for the operation and management of the Plan, and may from time to time amend or rescind such rules or regulations. The Administrator shall have the full discretion, power, and duty to take all action necessary or proper to administer the Plan. The Administrator is authorized to accept service of legal process for the Plan.

Section 10.02. Claims Administrator. The Administrator may appoint or remove a Claims Administrator with respect to any Benefit Program under the Plan.

Section 10.03. Discretionary Authority of Administrator. Except as may be otherwise specifically provided in the Plan or in any Benefit Program, the Administrator or its designee, shall have full, discretionary authority to control and manage the operation and administration of the Plan and to enable it to carry out its duties under the Plan, including, but not limited to, the authority to determine eligibility under the Plan, to construe the terms of the Plan, and to determine all questions of fact or law arising hereunder. The Administrator or its designee shall have all power necessary or convenient to enable the Administrator to exercise such authority. Subject to Article XII, all such determinations and interpretations shall be final, conclusive, and binding on all persons affected thereby. The Administrator or its designee shall have full, discretionary authority to correct any defect, supply any omission or reconcile any inconsistency and resolve ambiguities in the Plan in such manner and to such extent as it may deem expedient and the Administrator or its designee shall be the sole and final judge of such expediency. Benefits under the Plan shall be paid only if the Administrator and/or its designee decide in its discretion that the Member is entitled to such benefits.

ARTICLE XI

CLAIMS PROCEDURES

Section 11.01. Scope of Article. The claims procedures set forth in this Article XI, except for Section 11.17, shall apply to the Medical Benefit Program (or any component thereof), but only to the extent that the written claims procedures set forth in the applicable Benefit Program documents do not comply with the requirements under the Affordable Care Act, but such compliance is legally required. The claims procedures set forth in Section 11.17 shall apply to the Dental Benefit Program and the Vision Benefit Program, but only in the absence of written claims procedures in the applicable Benefit Programs documents. All notifications by any Claims Administrator to a Claimant for claim review, Denial, approval, and Appeal may be done in writing or electronically, unless otherwise designated.

Section 11.02. Initial Claim for Medical Benefit Program Benefits.

(a) Any claim to receive a benefit under the Medical Benefit Program must be filed with the Claims Administrator within the designated time period on the designated form and will be deemed filed upon receipt. If a Claimant fails to follow the claims procedures outlined herein for filing an Urgent Care Claim or a Pre-Service Claim, the Claimant will be notified orally (unless the Claimant requests written notice) of the proper procedures to follow, not later than 24 hours for Urgent Care Claims and five days for Pre-Service Claims. This special timing rule applies only to Urgent Care Claims and Pre-Service Claims that (i) are received by the person or unit customarily responsible for handling benefit matters, and (ii) specify a Claimant, a medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

(b) The Claimant must submit any required physician statements on the appropriate form (as required under the Medical Benefit Program). If the Claims Administrator disagrees with the physician statement, the terms of the Medical Benefit Program will be followed in resolving any such dispute.

Section 11.03. Initial Review of Medical Benefit Program Claims. When a claim under the Medical Benefit Program has been properly filed, the Claimant will be notified of the approval or Denial within the time periods set forth in the chart under Section 11.08 below. For

Urgent Care Claims, the Claims Administrator will defer to the attending provider with respect to the decision as to whether a claim is an Urgent Care Claim for purposes of determining the applicable time period.

Section 11.04. Initial Denial of Medical Benefit Program Claims. If any claim under the Medical Benefit Program is partially or wholly Denied, the Claimant will be given notice which will contain the following items:

(a) the specific reasons for the Denial;

(b) references to Medical Benefit Program provisions upon which the Denial is based;

(c) a description of any additional material or information needed and why such material or information is necessary;

(d) a description of the review procedures and time limits; including information regarding how to initiate an Appeal and information on the External Review process;

(e) the specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the Denial, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request;

(f) if the Denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request;

(g) for Urgent Care Claims, a description of the expedited review process applicable to such claims; and

(h) (1) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning), (2) the Denial code and its corresponding meaning, as well as a description of the Claims Administrator's standard, if any, that was used in the Denial of the claim, and (3) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and Appeals and External Review processes.

For Urgent Care Claims, the information in the notice may be provided orally if the Claimant is given notification within three days after the oral notification.

Section 11.05. Appeal of Medical Benefit Program Claim Denial. A Claimant may Appeal the Denial of a claim by filing a written claim Appeal with the Claims Administrator within the time period set forth in the chart in Section 11.08 below, which will be deemed filed upon receipt. If the request is not timely, the decision of the Claims Administrator will be the final decision of the Medical Benefit Program, and will be final, conclusive, and binding on all persons. For Urgent Care Claims, a Claimant may make a request for an expedited Appeal orally or in writing, and all necessary information will be transmitted by telephone, facsimile, or other similarly expeditious method.

Section 11.06. Decision on Appeal of Medical Benefit Program Claim Denial.

(a) The Claimant will receive notice of the Claims Administrator's decision on Appeal within the time periods shown in Section 11.08 below. If the claim is Denied on Appeal, the Claims Administrator will provide notice to the Claimant containing the information set forth in paragraph (c). The decision on Appeal will serve as the Final Denial.

(b) The Claims Administrator will provide the Claimant with the following information free of charge as soon as possible and sufficiently in advance of the date on which the notice of Final Denial is required under Section 11.08, such that the Claimant has a reasonable opportunity to respond prior to that date: (1) any new or additional evidence considered, relied upon, or generated by the Claims Administrator (or at the direction of the Claims Administrator) in connection with the claim, and (2) any new or additional rationale that forms the basis of the Claims Administrator's Final Denial, if any.

(c) In addition, if the claim is denied on Appeal (including a Final Denial), the Claimant will be given notice with a statement that the Claimant is entitled to receive, free of charge, access to and copies of all documents, records, and other information that apply to the claim. The notice will also contain:

(1) the specific reasons for the Denial;

(2) references to Medical Benefit Program provisions upon which the Denial is based;

(3) a description of the review procedures and time limits, including information regarding how to initiate an Appeal, information on the External Review process;

(4) the specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the Denial, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request;

(5) if the Denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request;

(6) (i) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning), (ii) the Denial code and its corresponding meaning, as well as a description of the Claims Administrator's standard, if any, that was used in the Denial of the claim, and (iii) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and Appeals and External Review process; and

(7) A discussion of the decision.

Except as provided in Section 11.09 or Section 11.14 below, the decision on review will be final, conclusive, and binding on all persons.

Section 11.07. Ongoing Treatments.

(a) If the Claims Administrator under the Plan has approved an ongoing course of treatment to be provided to a Claimant over a certain period of time or for a certain number of treatments, any reduction or termination of such course of treatment before the approved period of time or number of treatments end will constitute a Denial. The Claimant will be notified of the Denial, in accordance with Section 11.04, before the reduction or termination occurs to allow the Claimant a reasonable time to file an Appeal and obtain a determination on the Appeal. Coverage for the ongoing course of treatment that is the subject of the Appeal will continue pending the outcome of such Appeal.

(b) For an Urgent Care Claim, any request by a Claimant to extend the ongoing treatment beyond the previously approved period of time or number of treatments will be decided no later than 24 hours after receipt of the Urgent Care Claim, provided the claim is filed at least 24 hours before the treatment expires.

Section 11.08. Chart of Time Limits.

	MAXIMUM TIME LIMITS FOR:							
TYPE OF CLAIM	**Claims Administrator to decide initial claim (if no additional information is needed) (whether adverse or not)**	**Extension of time by Plan for determining initial claim**	**Claims Administrator to notify Claimant of information needed from Claimant to decide initial claim, if not provided by Claimant**	**Claims Administrator to notify Claimant of Claimant's failure to follow proper procedures**	**Claimant to then provide needed information (if extension allowed by Plan)**	**Claims Administrator to decide claim after requesting additional information and notifying Claimant (if applicable)**	**Claimant to file Appeal**	**Claims Administrator to decide Appeal**
Urgent Care Claims	No later than 72 hours after receipt of the claim by the Claims Administrator.	None	No later than 24 hours after receipt of incomplete claim by Claims Administrator	No later than 24 hours after receipt of improper claim by Claims Administrator	Not less than 48 hours after receipt of notice from Claims Administrator	No later than 48 hours after earlier of (i) Claims Administrator 's receipt of additional information from Claimant, or (ii) end of time period given to Claimant to provide additional information (48 hours)	180 days after receipt of Denial by Claimant	72 hours after receipt of Appeal by Claims Administrator
Pre-Service Claims	No later than 15 days after receipt of claim by the Claims Administrator	One time 15-day extension allowed if (i) due to matters beyond Claims Administrator's control and (ii) Claims Administrator notifies Claimant before end of initial 15-day time period of the circumstances requiring such extension and the date Claims Administrator expects to render decision. If extension is due to Claimant's failure to submit information, notice will describe required information. ***Note:*** Claims Administrator may or may not allow extension due to Claimant's failure to provide needed information.	N/A	No later than 5 days after receipt of improper claim by Claims Administrator	At least 45 days after receipt of notice from Claims Administrator ***Note***: Claims Administrator may or may not request needed information from Claimant.	No later than 15 days after earlier of (i) Claims Administrator 's receipt of additional information from Claimant, if requested, or (ii) end of time period given to Claimant to provide additional information (45 days)	180 days after receipt of Denial by Claimant	30 days after receipt of Appeal by Claims Administrator

	MAXIMUM TIME LIMITS FOR:							
TYPE OF CLAIM	**Claims Administrator to decide initial claim (if no additional information is needed) (whether adverse or not)**	**Extension of time by Plan for determining initial claim**	**Claims Administrator to notify Claimant of information needed from Claimant to decide initial claim, if not provided by Claimant**	**Claims Administrator to notify Claimant of Claimant's failure to follow proper procedures**	**Claimant to then provide needed information (if extension allowed by Plan)**	**Claims Administrator to decide claim after requesting additional information and notifying Claimant (if applicable)**	**Claimant to file Appeal**	**Claims Administrator to decide Appeal**
Post-Service Claims	No later than 30 days after receipt of claim by the Claims Administrator	One time 15-day extension allowed if (i) due to matters beyond Claims Administrator's control and (ii) Claims Administrator notifies Claimant before end of initial 30-day time period of the circumstances requiring such extension and the date Claims Administrator expects to render decision. If extension is due to Claimant's failure to submit information, notice will describe required information. ***Note:*** Claims Administrator may or may not allow extension due to Claimant's failure to provide needed information.	N/A	N/A	At least 45 days after receipt of notice from Claims Administrator ***Note*:** Claims Administrator may or may not request needed information from Claimant.	No later than 15 days after earlier of (i) Claims Administrator 's receipt of additional information from Claimant, if requested, or (ii) end of time period given to Claimant to provide additional information (45 days)	180 days after receipt of Denial by Claimant	60 days after receipt of Appeal by Claims Administrator

Section 11.09. Authorized Representative. The Plan and Medical Benefit Program shall not prevent an authorized representative of a Claimant from acting on behalf of the Claimant in pursuing a benefit claim or Appeal, pursuant to reasonable procedures. In the case of an Urgent Care Claim, a health care professional with knowledge of a Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant.

Section 11.10. Calculating Time Periods. The period of time within which an initial benefit determination or a determination on an Appeal is required to be made will begin when a claim or Appeal is filed regardless of whether the information necessary to make a determination accompanies the filing. Solely for purposes of initial Pre-Service Claims and Post-Service Claims, if the time period for making the initial benefit determination is extended (in the Claims Administrator's discretion) because the Claimant failed to submit information necessary to decide the claim, the time period for making the determination will be suspended from the date notification of the extension is sent to the Claimant until the earlier of (1) the date on which response from the Claimant is received, or (2) the end of the time period given to the Claimant to provide the additional information (at least 45 days).

Section 11.11. Full and Fair Review.

(a) Upon request and free of charge, the Claimant or his or her duly authorized representative will be given reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim, or may submit to the appropriate person or entity written comments, documents, records, and other information relating to the claim. If timely requested, review of a Denied claim will take into account all comments, documents, records, and other information submitted by the Claimant or his or her duly authorized representative relating to his or her claim without regard to whether such information was submitted or considered in the initial benefit determination.

(b) Appeals will be reviewed by an appropriate named fiduciary of the Plan who is neither the individual nor subordinate of the individual who made the initial determination. The Claims Administrator will not give any weight to the initial determination, and, if the Appeal is based, in whole or in part, on a medical judgment, the Claims Administrator will consult with an appropriate health care professional who is neither the individual nor subordinate of the individual who was consulted in connection with the initial determination. The Claims Administrator will identify any medical or vocational experts whose advice was obtained without regard to whether the advice was relied upon in making the benefit determination.

(c) Claimants and this Plan may have other voluntary alternative dispute resolution options, such as mediation. For available options, Claimants could contact their State insurance regulatory agency.

Section 11.12. Exhaustion of Remedies.

(a) If a Claimant fails to file a request for review of a Denial, in whole or in part, of benefits in accordance with the procedures herein outlined, such Claimant will have no right to review and no right to bring action, at law or in equity, in any court and the Denial of the claim will become final and binding on all persons for all purposes.

(b) Unless the exception provided under paragraph (c) applies, if the Claims Administrator fails to strictly adhere to all the requirements with respect to a claim under Sections 11.02 through Section 11.11, the Claimant is deemed to have exhausted the internal claims and Appeals process with respect to such claims. Accordingly, the Claimant may initiate an External Review with respect to such claims as outlined in Sections 11.14 or 11.15 below, as applicable. The Claimant also is entitled to pursue any available remedies under State law with respect to such claims.

(c) Notwithstanding paragraph (b), the internal claims and Appeals process described in Sections 11.02 through 11.08 will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Claims Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Claims Administrator and that the violation occurred in the context of an ongoing, good faith exchange of information between the Claims Administrator and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Claims Administrator. The Claimant may request a written explanation of the violation from the Claims Administrator, and the Claims Administrator shall provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the process outlined in Sections 11.02 through 11.08 to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review due to deemed exhaustion on the basis that the Claims Administrator met the standards for the exception described in this paragraph, the Claimant shall have the right to resubmit and pursue the internal Appeal of the claim. In such case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Claims Administrator shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal Appeal of the claim. Time periods for re-filing the claim shall begin to run upon the Claimant's receipt of such notice.

Section 11.13. Application and Scope of External Review Process. Upon receipt of a Final Denial (including a deemed Final Denial), the Claimant may request External Review under the applicable process described under this Section 11.13. Upon receipt of a Denial that is not a Final Denial, the Claimant may only apply for External Review as permitted by the State external review process, if applicable, or, if the claim is subject to the Federal external review process, as provided under Section 11.15 regarding expedited External Review for Urgent Care Claims.

(a) A Claimant may apply for External Review under a State external review process if:

(1) the Medical Benefit Program is subject to a State external review process that applies to and is binding on the Benefit Program; and

(2) the State external review process includes at a minimum the consumer protections in the NAIC Uniform Model Act, as set forth in Temporary Treasury Regulation Section 54.9815-2719T, as amended and as may be superseded and/or further modified.

(b) Subject to paragraph (c) below, a Claimant may apply for External Review under the Federal external review process as provided in Section 11.14 or Section 11.15 below, as applicable, only if a State external review process described under paragraph (a) above does not apply to the Medical Benefit Program.

(c) A Claimant may request External Review for any Final Denial or eligible Denial, except that if the Federal external review process applies with respect to the Medical Benefit Program, then it will only apply to:

(1) a Final Denial or eligible Denial that involves medical judgment, as determined by the IRO, including but not limited to, those based on the Medical Benefit Program's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is experimental or investigational); its determination as to whether a Member is entitled to a reasonable alternative standard for a reward under a wellness program; or its determination as to whether it is complying with the nonquantitative treatment limitation provisions of Public Health Service Act Section 2726 and 45 CFR §§ 146.136 and 147.160, which generally require, among other things, parity in the application of medical management techniques;

(2) a Final Denial or eligible Denial that involves consideration of whether the Medical Benefit Program is complying with the surprise billing cost-sharing protections set forth in Public Health Service Act Sections 2799A-1 and 2799A-2 and 45 CFR §§ 149.110 through 149.130; and

(3) a Rescission of coverage (whether or not the Rescission has any effect on any particular benefit at that time).

Section 11.14. Standard External Review Process for Claims Subject to Federal Process.

(a) Timing of Request for External Review. The Claimant must file a request for External Review of a claim with the Claims Administrator no later than the date which is four months following the date of receipt of a notice of Final Denial. If there is no corresponding date four months after the date of receipt of such notice, then the request must be filed by the first day of the fifth month following receipt of the notice (*e.g.*, if a Final Denial is received on October 30, request must be made by the following March 1). If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(b) Preliminary Review. The Claims Administrator shall complete a preliminary review of the request for External Review within five business days to determine whether:

(1) the Claimant is or was covered under the applicable Benefit Program at the time the Covered Service was requested or provided, as applicable;

(2) the type of claim is eligible for External Review;

(3) the Claimant has exhausted (or is deemed to have exhausted) the Plan's internal claims and Appeals process under Sections 11.02 through Section 11.08; and

(4) the Claimant has provided all the information and forms required to process an External Review. The Claims Administrator shall issue a notification to the Claimant within one business day of completing the preliminary review.

If the request is complete, but ineligible for External Review, the notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification shall describe the information or materials needed to make the request complete, and the Claimant shall be allowed to perfect the request for External Review by the later of the four-month filing period described in paragraph (a) above, or within the 48-hour period following the receipt of the notification.

(c) Referral to Independent Review Organization (IRO). The Claims Administrator shall assign an IRO to the Claimant's request for External Review. Upon assignment, the IRO will undertake the following tasks with respect to the request for External Review:

(1) Timely notify the Claimant in writing of the request's eligibility and acceptance for External Review. This notice will include a statement that the Claimant may submit in writing to the IRO, within 10 business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

(2) Review all documents and any information considered in making a Final Denial received by the Claims Administrator. The Claims Administrator shall provide the IRO with such documents and information within five business days after the date of assignment of the IRO. Failure by the Claims Administrator to timely provide the documents and information shall not delay the conduct of the External Review. If the Claims Administrator fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Final Denial. In such case, the IRO shall notify the Claimant and the Claims Administrator of its decision within one business day.

(3) Forward any information submitted by the Claimant to the Claims Administrator within one business day of receipt. Upon receipt of any such information, the Claims Administrator may reconsider its Final Denial that is the subject of the External Review. Reconsideration by the Claims Administrator must not delay the External Review. The External Review may be terminated as a result of reconsideration only if the Claims Administrator decides to reverse its Final Denial and provide coverage or payment. In such case, the Claims Administrator must provide written notice of its decision to the Claimant and IRO within one business day, and the IRO shall then terminate the External Review.

(4) Review all information and documents timely received under a *de novo* standard. The IRO shall not be bound by any decisions or conclusions reached during the

Claims Administrator's internal claims and Appeals process. In addition to the information and documents provided, the IRO, to the extent the information and documents are available and the IRO considers them appropriate, shall further consider the following in reaching a decision: (i) the Claimant's medical records; (ii) the attending health care professional's recommendation; (iii) reports from appropriate health care professionals and other documents submitted by the Claims Administrator, the Claimant, or the Claimant's physician; (iv) the terms of the Medical Benefit Program to ensure that the IRO's decision is not contrary to the terms of the Medical Benefit Program, unless the terms are inconsistent with applicable law; (v) appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations; (vi) any applicable clinical review criteria developed and used by the Medical Benefit Program, unless the criteria are inconsistent with the terms of the Medical Benefit Program or with applicable law; and (vii) the opinion of the IRO's clinical reviewer(s) after considering the information described in this paragraph to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

(d) Notice of Final External Review Decision. The IRO shall provide written notice of Final External Review Decision within 45 days after the IRO receives the request for External Review. Such notice shall be delivered to the Claimant and the Claims Administrator and shall contain the following:

(1) A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous Denial);

(2) The date the IRO received the assignment to conduct External Review and the date of the Final External Review Decision;

(3) References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching the decision;

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied upon in making its decision;

(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Medical Benefit Program or the Claimant;

(6) A statement that judicial review may be available to the Claimant; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

(e) Reversal of Plan's Decision. If the Final Denial of the Claims Administrator is reversed by the Final External Review Decision, the applicable Benefit Program shall immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for a claim, upon receipt of notice of such reversal.

(f) Maintenance of Records. The IROs shall maintain records of all claims and notices associated with an External Review for six years. An IRO must make such records available for examination by the Claimant, the Claims Administrator, or a State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Section 11.15. Expedited External Review Process for Claims Subject to Federal Process.

(a) Application of Expedited External Review. The Plan shall allow the Claimant to make a request for expedited External Review at the time the Claimant receives either:

(1) A Denial if the Denial involves a medical condition of the Claimant for which the timeframe for completion of an internal Appeal of an Urgent Care Claim would seriously jeopardize the Claimant's life or health or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an Appeal of an Urgent Care Claim; or

(2) A Final Denial if the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the Claimant's life or health or would jeopardize the Claimant's ability to regain maximum function, or if the Final Denial concerns admission, availability of care, continued stay, or a health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

(b) Preliminary Review. Immediately upon receipt of a request for expedited External Review, the Claims Administrator must determine whether the request meets the reviewability requirements set forth in paragraph (a) above. The Claims Administrator shall immediately send a notice that meets the requirements set forth in Section 11.14(b) above for standard External Review of the Claimant for its eligibility determination.

(c) Referral to Independent Review Organization (IRO). Upon a determination that a request is eligible for expedited External Review following the preliminary review, the Claims Administrator shall assign an IRO pursuant to the requirements set forth in Section 11.14(c) above for standard External Review. The Claims Administrator must provide or transmit all necessary documents and information considered in making the Denial or Final Denial determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, shall consider the information or documents described under Section 11.14(c)(3) above under the procedures for standard External Review. In reaching a decision, the assigned IRO shall review the claim *de novo* and is not bound by any

decisions or conclusions reached during the Claims Administrator's internal claims and Appeals process.

(d) Notice of Final External Review Decision. The IRO shall provide notice of Final External Review Decision, in accordance with the requirements set forth in Section 11.14(c)(4) above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to the Claimant and the Claims Administrator.

Section 11.16. Form and Manner of Notices Pertaining to Benefit Program Claims. Notices provided pursuant to this Article with respect to internal claims and Appeals and External Reviews shall be provided in a culturally and linguistically appropriate manner pursuant to Department of Labor regulations. Accordingly, with respect to an address in any United States county to which a notice is sent, if 10 percent or more of the population residing in the county is literate only in the same non-English language (the "applicable non-English language"), the Claims Administrator shall: (1) provide oral language services (such as a telephone customer assistance hotline) that include answering questions in the applicable non-English language; (2) provide notices sent under this Article in the applicable non-English language upon request; and (3) include a statement in the English versions of all notices sent under this Article, prominently displayed in the applicable non-English language, clearly indicating how to access the language services provided by the Plan.

Section 11.17. Claims for All Other Welfare Benefits.

(a) Claims Other Than Medical Benefit Program Claims. This Section 11.17 shall apply to all claims for welfare benefits under the Plan not governed by Section 11.02 through Section 11.16, but only to the extent that the Benefit Program has no written claims provisions. All notifications by any Claims Administration or the Administrator to a Claimant for claim review, denial, approval, and appeal may be done in writing or electronically, unless otherwise designated.

(b) Requests for Information. Requests for information concerning eligibility, participation, contributions, benefits, or other aspects of the operation of the Plan, and service of legal process, should be in writing and directed to the Administrator.

(c) Denials. If a written request is denied, the Administrator may, within a reasonable time, provide a written denial to the Member. If the Administrator does not provide a written response within a reasonable time, the claim shall be deemed denied.

(d) Claims and Appeals. If a written denial is provided by the Administrator, it shall include the specific reasons for denial, the provisions of the Plan on which the denial is based, and how to apply for a review of the denied claim. Where appropriate, it shall also include a description of any material which is needed to complete or perfect a claim and why such material is necessary. Within a reasonable period of time after the Member receives notification of the denial, a Member may request in writing a review of a claim denied by the Administrator and

review any pertinent documents and submit issues and comments in writing to the Administrator. The Administrator shall provide in writing to the Member a decision upon such request for review of a denied claim within a reasonable period of time following receipt of the request. The decisions of the Administrator shall be binding on all parties and shall be afforded the maximum deference permitted by law.

ARTICLE XII

SUBROGATION AND REIMBURSEMENT RIGHTS

Section 12.01. Right of Subrogation and Reimbursement. In addition to any subrogation and reimbursement rights under a Benefit Program, the following provisions shall apply to and supplement such Benefit Program. For purposes of this Article, "Plan" shall refer to the Plan and includes any underlying Benefit Program. The Plan has the right to full subrogation and reimbursement of any and all amounts paid by the Plan to, or on behalf of, a Member under the Plan, for which a third party is allegedly responsible. The Plan shall have an equitable lien against such funds, and the right to impose a constructive trust upon such funds and shall have the right to be reimbursed therefrom.

Section 12.02. Funds To Which Subrogation and Reimbursement Rights Apply. The Plan's subrogation and reimbursement rights apply if the Member receives, or has a right to receive, any sum of money, regardless of whether it is characterized as amounts paid for medical expenses or otherwise, paid or payable from any person, plan or legal entity that is legally obligated to make payments as a result of a judgment, settlement or otherwise, arising out of any act or omission of any third party (whether a third party or another Member under the Plan), (a) who is allegedly wholly or partially liable for costs or expenses incurred by the Member, in connection for which the Plan provided benefits to, or on behalf of, such Member, or (b) whose act or omission allegedly caused injury or illness to the Member, in connection for which the Plan provided benefits to, or on behalf of, such Member.

Section 12.03. Agreement to Hold Recovery in Trust. If a payment is made under this Plan, and the person to or for whom it is made recovers monies from a third party described in Section 12.02 as a result of settlement, judgment, or otherwise, that person acknowledges the Plan's equitable lien hereunder and shall hold in trust for the Plan the proceeds of such recovery and reimburse the Plan to the extent of its payments.

Section 12.04. Disclaimer of Make Whole Doctrine. The Plan has the right to be paid first and in full from any settlement or judgment, regardless of whether the Member has been "made whole." The Plan's right is a first priority lien. The Plan's right shall continue until the Member's obligations hereunder to the Plan are fully discharged, even though the Member does not receive full compensation or recovery for his or her injuries, damages, loss, or debt. This right to subrogation pro tanto shall exist in all cases.

Section 12.05. Disclaimer of Common Fund Doctrine. The Member shall be responsible for all expenses of recovery from such third parties or other persons, including but not limited to, all attorneys' fees incurred in collection of such third-party payments, or payments

by other persons. Any attorneys' fees and/or expenses owed by the Member shall not reduce the amount of reimbursement due to the Plan.

Section 12.06. Obligations of the Member. The Member shall furnish any and all information and assistance requested by the Administrator. If requested, the Member shall execute and deliver to the Administrator a subrogation and reimbursement agreement before or after any payment of benefits by the Plan. The Member shall not discharge or release any party from any alleged obligation to the Member or take any other action that could impair the Plan's rights to subrogation and reimbursement without the written authorization of the Administrator.

Section 12.07. Plan's Right To Subrogation. If the Member or anyone acting on his or her behalf has not taken action to pursue his or her rights against a third party described in Section 12.01 above or any other persons to obtain a judgment, settlement or other recovery, the Administrator or its designee, upon giving 30 days' written notice to the Member, shall have the right to take such action in the name of the Member to recover that amount of benefits paid under the Plan; provided, however, that any action taken without the consent of the Member shall be without prejudice to such Member.

Section 12.08. Enforcement of Plan's Right to Reimbursement. If a Member fails or refuses to comply with these provisions by reimbursing the Plan as required herein, the Plan has the right to impose and enforce a constructive trust and/or an equitable lien over any and all funds received by the Member, or as to which the Member has the right to receive. The Plan, through the Administrator, has the authority to pursue any and all legal and equitable relief available to enforce the rights contained in this Article, against any and all appropriate parties who may be in possession of the funds described herein.

Section 12.09. Withholding of Payments for Benefits. The Plan may withhold payment of benefits when a party other than the Member or the Plan may be liable for expenses until liability is legally determined. In the event that any payment is made under the Plan for which any party other than the Member or the Plan may be liable, the Plan shall be subrogated to all rights of recovery of the Member to the extent of payments by the Plan and shall have the right to be reimbursed as set forth in this Article.

Section 12.10. Failure to Comply. If a Member fails to comply with these requirements, the Member shall not be eligible to receive any benefits, services, or payments under the Plan until there is compliance regardless of whether such benefits are related to the act or omission of such third party or other persons.

Section 12.11. Future Claims Excluded. If the Member receives any sum of money described in Section 12.02 above, the Plan shall have no further obligation to pay benefits relating in any way to future claims for the same or related injuries, including but not limited to any complications thereof, for which the Member received such sum of money, and charges incurred for such services shall be excluded.

Section 12.12. Discretionary Authority of Administrator. The Plan, through the Administrator, shall have full discretionary authority to interpret the provisions of this Article, and to administer and pursue the Plan's subrogation and reimbursement rights. It shall be within

the discretionary authority of the Administrator to resolve, settle, or otherwise compromise its subrogation and reimbursement rights when appropriate. The Administrator is under no legal obligation to reduce its lien or reimbursement rights unless, in its sole discretion, it determines that doing so is appropriate.

ARTICLE XIII

AMENDMENT AND TERMINATION

Section 13.01. Right to Amend. The Administrator shall have the right, in its sole discretion, to amend or modify the Plan, any Benefit Program, and any provisions thereof, at any time and from time to time and to any extent it may deem advisable. Such modification or amendment shall be duly incorporated in writing. Such amendment or modification may include increases, modifications, reductions, or elimination of certain benefits. Any amendment or modification of the Plan shall be effective as of such date as the Administrator may determine in connection therewith. To the extent allowed by law, any such amendment may be effective retroactively.

Section 13.02. Right to Terminate. The Plan Sponsor, in consultation with the Administrator, shall have the right, in its sole discretion, to terminate the Plan or any Benefit Program under the Plan at any time, effective as of such date as the Plan Sponsor may determine in connection herewith. To the extent allowed by law any such termination may be effective retroactively. In the event of such termination, each Participating Eparchy, on behalf of itself and its Parishes, shall be obligated to pay the difference between the claims incurred (even though later filed) and expenses of the Plan due up to the date of termination, and the funds available in the Trust to pay such claims and expenses, or from insurance policies purchased by the Trust, if applicable. Such claims and expenses shall be paid from the funds in the Trust available for such claims and expenses. In the event there shall be excess funds in the Trust left after the payment of such claims and expenses, then the Trust shall, in its sole discretion, provide extended benefits or apply such funds as provided in the Trust Agreement.

ARTICLE XIV

ENTRY AND WITHDRAWAL OF PARTICIPATING EPARCHIES

Section 14.01. Entry of Participating Eparchies. Any organization classified by the Archeparchy as an eparchy may become a Participating Eparchy in the Plan on behalf of itself and its Parishes by delivering to the Plan Sponsor an appropriate request and completing a Participation Agreement. Such eparchy shall become a Participating Eparchy hereunder as of the date approved by the Plan Sponsor and shall be subject to the terms and provisions of the Plan as then in effect and thereafter amended. Such approval may be issued retroactively by the Plan Sponsor as of any effective date.

Section 14.02. Withdrawal from Plan.

(a) A Participating Eparchy may withdraw from the Plan on behalf of itself and its Parishes by delivering to the Plan Sponsor a request to withdraw as a Participating Eparchy

hereunder and meeting such other terms and conditions as set forth in its Participation Agreement. Notice of withdrawal must be submitted to the Plan Sponsor prior to the date withdrawal is to be effective, unless such requirement is waived by the Plan Sponsor.

(b) A Participating Eparchy may be involuntarily withdrawn from the Plan on behalf of itself and its Parishes for any reason set forth in the Participation Agreement, by notice of the Administrator.

(c) If the Archeparchy wishes to withdraw from the Plan on behalf of itself and its Parishes, then the Plan shall terminate as provided in Section 13.02 unless another Participating Eparchy agrees to assume the role of Plan Sponsor of the Plan and Grantor of the Trust.

Section 14.03. Obligations of Withdrawing Entity. A withdrawing Participating Eparchy is required to reimburse the Plan for certain costs as set forth in the Participation Agreement and may be assessed on behalf of itself and its Parishes for incurred but unreported Member claims as of the date of withdrawal, as determined by the Administrator in its sole discretion. A withdrawing Participating Eparchy agrees to comply with all requirements relating to such withdrawal set forth in the Participation Agreement, regardless of the reason of the withdrawal.

ARTICLE XV

MISCELLANEOUS PROVISIONS

The following provisions shall apply only to the extent such provisions are not set forth in a similar provision of the applicable Benefit Program documents, provided such provisions are not inconsistent with the provisions thereof.

Section 15.01. Nonalienation and Nonassignment. Except as otherwise required pursuant to a qualified medical child support order, no benefit under the Plan prior to actual receipt thereof by a Member or beneficiary shall be subject to any debt, liability, contract, engagement, or tort of any Member or his or her beneficiary, nor subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation, or any other voluntarily or involuntarily alienation or other legal or equitable process, nor transferable by operation of law except as may be provided in the Benefit Program. The prohibition on assignment is not waived merely because a Benefit Program pays a provider directly. A claim for benefits is expressly non-assignable and non-transferable in whole or in part to any person or entity at any time.

Section 15.02. Employment of Consultants. The Administrator may employ one or more persons to render advice with regard to their respective responsibilities under the Plan.

Section 15.03. Limitation of Rights and Obligations. Neither the establishment nor maintenance of the Plan nor any amendment thereof, nor the purchase of any Benefit Program, including any benefit contract or insurance policy, nor any act or omission under the Plan or resulting from the operation of the Plan shall be construed:

(a) as conferring upon any Member, beneficiary, or any other person any right or claim against the Plan Sponsor, a Participating Eparchy, a Parish, the Claims Administrator, or the Administrator, except to the extent that such right or claim shall be specifically expressed and provided in the Plan or required by law;

(b) as creating any responsibility or liability of the Plan Sponsor, a Participating Eparchy, a Parish, the Administrator, or the Claims Administrator for the validity or effect of the Plan;

(c) as a contract or agreement between a Participating Employer and any Eligible Employee or other person;

(d) as being consideration for, or an inducement or condition of, employment of any Eligible Employee or other person, or as affecting or restricting in any manner or to any extent whatsoever the rights or obligations of a Participating Employer or any Eligible Employee or other person to continue or terminate the employment relationship at any time; or

(e) as giving any Eligible Employee or any other person the right to be retained in the service of a Participating Employer or to interfere with the right of a Participating Employer to discharge any Eligible Employee at any time.

Section 15.04. Notice. Any notice given under the Plan shall be sufficient (i) if given to the Administrator, when addressed to its office, (ii) if given to a Claims Administrator, when addressed to its office, or (iii) if given to a Member, when addressed to the Member at his or her address as it appears in the records of the Administrator or the Claims Administrator.

Section 15.05. Disclaimer of Liability. Nothing contained herein shall confer upon a Member any claim, right, or cause of action, either at law or at equity, against the Plan, the Plan Sponsor, the Administrator, a Participating Eparchy, a Parish, or the Claims Administrator for the acts or omissions or any provider of services or supplies for any benefits provided under the Plan.

Section 15.06. Right of Recovery. If the Plan Sponsor, Participating Eparchy, Parish, Administrator, or Claims Administrator makes any payment that, according to the terms of the Plan and the Benefit Program should not have been made, the Plan Sponsor, Participating Eparchy, Parish, Administrator, or Claims Administrator may recover that incorrect payment, whether or not it was made due to the error of the Plan Sponsor, Participating Eparchy, Parish, Administrator, or Claims Administrator, from the person to whom it was made, or from any other appropriate party. If any such incorrect payment is made directly to a Member, then the Plan Sponsor, Participating Eparchy, Parish, Administrator, or Claims Administrator may deduct it when making future payments directly to that Member.

Section 15.07. Legal Counsel. The Administrator, and/or its designee, may from time to time consult with counsel, who may be counsel for the Plan Sponsor, and shall be fully protected in acting upon the advice of such counsel.

Section 15.08. Evidence of Action. All orders, requests, and instructions to the Administrator or the Claims Administrator by a Participating Eparchy or Parish, or by any duly

authorized representative of either, shall be in writing and the Administrator and the Claims Administrator shall act and shall be fully protected in acting in accordance with such orders, requests, and instructions.

Section 15.09. Audit. If an audit of the Plan is required by law for any Plan Year, the Administrator shall engage an independent qualified public accountant.

Section 15.10. Facility of Payment. If, in the opinion of the Administrator, a valid release cannot be rendered by a Member for the payment of any benefit payable, such payment may be made directly to a health care provider, or to the guardian or conservator, or the parents of a minor child, or to an individual or individuals who have custody or provide care and principal support of the Member. In the event of the death of a Member, payment shall be made by the Administrator to the duly qualified and acting personal representative of that Member's estate (or, if there is no such personal representative, to the person or persons entitled to such payments). Any payment made by the Administrator in good faith pursuant to this provision shall fully discharge all liability to the extent of such payment.

Section 15.11. Protective Clause. Neither the Plan Sponsor, a Participating Eparchy, a Parish, nor the Administrator shall be responsible for the validity of any contract of insurance or other benefit contract or policy by any benefit provider issued to the Plan Sponsor, or for the failure on the part of any insurance company or other benefit provider to make payments thereunder.

Section 15.12. Receipt and Release. Any payments to any Member shall, to the extent thereof, be in full satisfaction of the claim of such Member being paid thereby, and the Administrator may condition payment thereof on the delivery by the Member of the duly executed receipt and release in such form as may be determined by the Administrator.

Section 15.13. Legal Actions. If the Administrator is made a party to any legal action regarding the Plan, except for a breach of fiduciary responsibility of such person or persons, any and all costs and expenses, including reasonable attorneys' fees, incurred by the Administrator in connection with such proceeding shall be paid from the assets of the Plan.

Section 15.14. Reliance. The Administrator shall not incur any liability in acting upon any notice, request, signed letter, telegram, or other paper or document believed by the Administrator to be genuine or to be executed or sent by an authorized person.

Section 15.15. Eligibility for Medicaid Benefits. Benefits shall be paid in accordance with any assignment of rights made by or on behalf of any Member as required by a state plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act. For purposes of enrollment and entitlement to benefits, a Member's eligibility for or receipt of medical benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act shall not be taken into account. The state shall have a right to any payment made under a state plan for medical assistance approved under Title XIX of the Social Security Act when the Plan has a legal liability to make such payment.

Section 15.16. Counterparts. This Plan may be executed in any number of counterparts, each of which shall be deemed to be an original. All counterparts shall constitute but one and the same instrument and shall be evidenced by any one counterpart.

Section 15.17. Entire Plan. This Plan document and Schedule A and documents incorporated by reference herein shall constitute the only legally governing documents for the Plan. No oral statement or other communication shall amend or modify any provision of the Plan as set forth herein.

IN WITNESS WHEREOF, the Plan Sponsor has caused the Plan to be executed as of this date set forth below, to be effective as of the Effective Date.

"PLAN SPONSOR"

METROPOLITAN ARCHDIOCESE OF PITTSBURGH, BYZANTINE RITE

By: William C Skurla

Print: Archbishop William C. Skurla

Title: Archbishop & President

Date: September 24, 2024

SCHEDULE A

BENEFIT PROGRAMS UNDER THE EASTERN CATHOLIC BENEFIT PLAN

BENEFIT PROGRAM	CLAIMS ADMINISTRATOR	BENEFIT DOCUMENTS
MEDICAL BENEFIT PROGRAM		
1. Under 65 Medical Benefit	For medical claims: Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581 https://www.healthplansinc.com (800) 532-7575 For prescription drug claims (other than MERP-covered claims): Liviniti 407 Bienville Street Natchitoches, LA 71457 (800) 710-9341	Eastern Catholic Benefit Plan Employee Group Medical Plan Summary Plan Description, effective January 1, 2021, as amended. Group No. 001WC7
2. Specialty Pharmacy MERP	Grenz & Co., Inc. 516 Gibson Drive, Suite 250 Roseville, CA 95678 (916) 846-6292	Eastern Catholic Benefit Plan Specialty Pharmacy Medical Expense Reimbursement Plan.
3. Supplemental Medicare Benefit	Benistar Administrative Services, Inc. (BASI) 10 Tower Lane, First Floor Avon, CT 06001 Florida residents: (860) 408-7000 All other residents: (800) 236-4782	Eastern Catholic Benefit Plan Supplemental Medicare Policy, issued by The Hartford. Policy # AGP-3216 (Residents of ID, IN, LA, KS, MD, MT, NJ, and SD) Policy # AGP-3996 (All other residents)
4. Medicare Part D Prescription Drug Benefit	Express Scripts Medicare PDP c/o Benistar Administrative Services, Inc. (BASI) 10 Tower Lane, First Floor Avon, CT 06001 (888) 497-9500	Eastern Catholic Benefit Plan Medicare Part D Prescription Drug Policy, issued by Express Scripts.

DENTAL BENEFIT PROGRAM		
5. Dental Benefit Program	Guardian Life Guardian Claims P.O. Box 981572 El Paso, TX 79998-1572 (800) 541-7846	Eastern Catholic Benefit Plan Dental Insurance Plan, administered by Guardian Life. Group No. 550529
VISION BENEFIT PROGRAM		
6. Vision Benefit Program	Guardian Life Guardian Claims P.O. Box 981572 El Paso, TX 79998-1572 (877) 814-8970	Eastern Catholic Benefit Plan Vision Insurance Plan, administered by Guardian Life. Group No. 550529

IN WITNESS WHEREOF, the Plan Sponsor has caused Schedule A to be executed as of this date set forth below, to be effective as of the Effective Date.

"PLAN SPONSOR"

METROPOLITAN ARCHDIOCESE OF PITTSBURGH, BYZANTINE RITE

By: William C. Skurla

Print: Archbishop William C. Skurla

Title: Archbishop & President

Date: September 24, 2024