

PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR ACCEPTANCE OF RESPONSIBILITY
FOR THE CONTENTS OF THIS DOCUMENT.

We, the Plan Sponsor, recognize that we have full responsibility for the contents of the document and that, while others may have assisted in the preparation of the document, we are responsible for the final text and meaning. We further certify that the document has been fully read, understood, and describes our intent with regard to our flexible benefit Plan.

IMPORTANT: This document is not intended to be legal or tax advice. Laws regarding Section 125 plans are detailed and complex and include many exception and special rules. Legal advice may be necessary when special circumstances occur that are not addressed or cannot be resolved via this document.

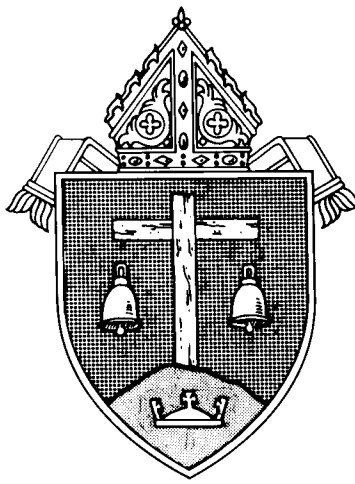
Plan Sponsor: Diocese of Monterey

Signed (authorized representative of Plan Sponsor)

Date

RETURN THIS SIGNED FORM TO:

**Delta Health Systems
1234 W. Oak Street
Stockton, CA 95201**



DIOCESE OF MONTEREY

PLAN DOCUMENT & SUMMARY PLAN DESCRIPTION

OF THE

FLEXIBLE SPENDING ACCOUNT BENEFITS

EFFECTIVE: JANUARY 1, 2006

**Delta Health Systems
1234 W. Oak Street
Stockton, CA 95201**

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INTRODUCTION

The purpose of the benefits described herein is to provide each participating Employee with a means of:

selecting from a "benefit cafeteria" those benefits which are best suited to his/her family's needs; and

paying for certain types of expenses with pre-tax income dollars, thus reducing his taxable income and increasing his net take-home pay.

In accordance with the requirements of Section 125 of the Internal Revenue Code, a "cafeteria plan" must offer at least one benefit option that is taxable (i.e., cash or a "cash equivalent") and at least one qualifying nontaxable benefit. The benefits being offered under this Plan include:

Taxable Benefits - The taxable benefit offered is the cash equivalent of the Plan's nontaxable benefits. That is, an Employee may choose not to participate in one or more nontaxable benefits offered and receive his compensation on an after-tax basis in accordance with the regular payroll practices of the Employer.

Nontaxable Benefits - Subject to the **Benefits and Election Maximums**, an Employee will be allowed to choose among the following nontaxable benefits:

- **Health Care Expense Reimbursement** - within the meaning of IRC § 105(b) & 213. This benefit allows an Employee to allocate Flexible Dollars to a Reserve Account for reimbursement of health plan deductibles, his coinsurance share and certain other health-related expenses.
- **Dependent Care Assistance** - within the meaning of IRC § 129. This benefit allows an Employee to allocate Flexible Dollars to a Reserve Account for reimbursement of certain dependent care expenses that enable him to be gainfully employed.

NOTE: For these purposes, "pre-tax" means "before federal income and Social Security taxes (as well as most state and local income taxes) are deducted from the Employee's income."

IMPORTANT NOTICES

Mid-Year Election Restrictions & Forfeitures – An Employee's annual benefit elections should be made carefully. Pre-tax contribution elections cannot be changed during a Plan Year unless an Employee experiences a "qualified change" as defined by the Internal Revenue Service. Also, Flexible Dollars that are contributed to Reserve Accounts during a Plan Year and that are not utilized for benefits during the year, must be forfeited by the Employee to the Plan and cannot be carried forward by the Employee, in any manner, to a subsequent Plan Year.

Social Security - Because Plan benefits are paid for with pre-tax dollars, Social Security contributions and benefits may be reduced. Other benefits which are based upon taxable compensation could also be affected - such as worker's compensation, unemployment, etc. The Plan Sponsor or a tax professional may be able to provide additional information as to the impact of these reductions in an individual situation.

Dependent Care Credit Under Federal Income Tax - An Employee cannot claim a federal income tax credit for any dependent care expenses that are reimbursed hereunder.

Tax Treatment Not Guaranteed - It is the Plan Sponsor's intent that nontaxable benefits will be eligible for exclusion from the gross income of the Employee. However, neither the Plan Sponsor, the Employer, nor the Fiduciaries in any way: (1) guarantee or ensure that any of the benefits provided will not be subject to income or other taxes, or (2) accept any liability for any income or other taxes imposed upon an Employee, spouse, dependent, or any other person by reason of benefits received.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility

To participate as an "Employee" in the benefits described herein, an individual must be classified on the Employer's payroll system as a common law employee and must be regularly scheduled to work at least twenty (20) hours per week. Other individuals do not retroactively become eligible even if a court, law, regulation, or other government ruling subsequently deems that such individuals were misclassified and actually were common law employees.

An eligible Employee also includes an employee who is otherwise eligible but who is not regularly scheduled to work the required number of hours per week because he is on leave of absence under: (1) the Family and Medical Leave Act (FMLA), or similar state law that requires that he be eligible, or (2) another Employer-approved paid leave of absence. See the "Extension of Participation..." provisions in the **Termination of Participation** provision for details.

Initial Election to Participate

An eligible Employee may initially elect to participate in the Plan benefits by completing a Salary Reduction Agreement and election of benefits form(s). Enrollment must be made within thirty-one (31) days of Employee's becoming eligible. In no instance can enrollment occur after an Employee begins to participate.

If an Employee fails to enroll or elects not to enroll when initially eligible, he may not participate until the beginning of a new Plan Year unless he experiences a qualified change (see "Qualified Changes" below).

Effective Date

An Employee's participation in the benefits of the Plan will be effective on the first day of the month following ninety (90) days of employment, subject to Employee's completion of the necessary enrollment forms and not earlier than the effective date of the Plan.

Qualified Changes

If an Employee has a qualified change in coverage, status or costs (e.g., due to his spouse losing or gaining employment, acquiring or losing a dependent, divorce, marriage or legal separation of the Employee, or such other events as may be permitted by the Plan Sponsor and under regulations issued by the IRS), he may change his Salary Reduction Agreement with respect to the Plan Year. See "Mid-Year Changes in Elections" in the **Election of Benefits** section for additional information.

Annual Re-Enrollment

To continue to participate in the benefit(s) of the Plan, an eligible Employee must complete a new enrollment form prior to the beginning of each new Plan Year. If an Employee fails to re-enroll, he will be considered to have elected not to participate but to receive his full compensation in cash (taxable) for the Plan Year.

TERMINATION OF PARTICIPATION

An Employee will cease to participate on the earliest of the following dates:

the date the Plan is terminated or with respect to any particular benefit, the date the benefit is terminated; or

the date the eligibility requirements are no longer met, except as participation may be extended (see the "Extension of Participation..." provisions below).

With regard to the Dependent Care Assistance benefit, an Employee's Reserve Account will remain open for the remainder of the Plan Year in which termination occurs. Any eligible expenses which are incurred prior to the end of the Plan Year may be submitted for reimbursement from the appropriate account.

With regard to the Health Care Expense Reimbursement benefit, an Employee's Reserve Account will remain open for the remainder of the Plan Year in which termination occurs but ONLY for reimbursement of expenses incurred prior to Employee's termination date, unless the Employee continues his participation as a COBRA enrollee.

If participation terminates due to Employee's death, his beneficiaries or his estate may submit claims for expenses for the remainder of the Plan Year or until the Flexible Dollars in a Reserve Account are exhausted.

Extension of Participation During an FMLA (or USERRA) Leave of Absence

An Employee who wishes to continue participation during an FMLA leave (i.e., a leave taken in accordance with the Family and Medical Leave Act) or similar state law that requires that he be eligible, may do so by signing a written agreement to have the contributions withheld from his or her pay upon return to work.

The above allowance will also apply to military leave under the Uniform Service Employment and Reemployment Act (USERRA).

Extension of Participation During a Non-FMLA Leave of Absence

During a non-FMLA leave, an Employee cannot continue participation.

Rehired Employees

An Employee who terminates employment and is rehired within the same Plan Year will be subject to the following:

if the date of rehire is within thirty (30) days of termination, then Employee must reinstate participation as of the date of rehire and must reinstate the same elections he had prior to his break in service. Such rehired Employee will not be required to affirmatively reinstate his prior elections. Such reinstatement is automatic;

if the date of rehire is more than thirty (30) days after termination, then Employee will be treated in the same manner as a new employee for all purposes.

The Employer or Plan Sponsor will treat rehired Employees in a consistent and non-discriminatory manner.

COBRA CONTINUATION COVERAGE

If an Employee (or a dependent, if required by law) loses eligibility under the Health Care Expense Reimbursement benefit due to a COBRA “qualifying event,” such individual may elect COBRA continuation under the Health Care Expense Reimbursement benefit, to the minimum extent required by applicable law.

An eligible Employee who loses eligibility for the Health Care Expense Reimbursement benefit and who elects COBRA continuation may continue to submit requests for reimbursement of qualifying expenses through the end of the Plan Year, provided such expenses are incurred while the Employee is covered. However, all salary reductions (i.e., pre-tax contributions) will cease once the Employee loses active status. Any further contributions must be made on an after-tax basis.

In general, COBRA continuation must be offered with respect to a participant’s Health Care Expense Reimbursement Account if the participant has a positive balance in such Account at the time of the qualifying event, such as termination of employment (other than by reason of gross misconduct) or reduction in work hours. A “positive balance” for this purpose generally means that the contributions made to the Account prior to the qualifying event exceed the eligible claims for reimbursement submitted prior to the qualifying event. If COBRA continuation is available to a participant who experiences a qualifying event and COBRA continuation is elected by the participant, such coverage will cease at the end of the Plan Year in which the qualifying event occurs and cannot be continued into the next Plan Year.

ELECTION OF BENEFITS

Benefits and Benefit Maximums

The benefits available under the Plan are determined at the discretion of the Plan Sponsor and are adopted on a "Benefits and Election Maximums" statement. Such amounts are uniformly applicable to all Employees. All such amounts are subject to review and final approval by the Plan Sponsor's Human Resources Department.

Each Employee who elects to participate completes his elections on a Salary Reduction Agreement form. The Employer reserves the right to reduce the amount of the Employee's Salary Reduction Agreement in order to assure compliance with the requirements of the Internal Revenue Code for favorable tax treatment. If an Employee enrolls other than at the beginning of a new Plan Year, his Salary Reduction Agreement election maximums will be prorated based on the number of months he actually participates.

Mid-Year Changes in Elections

Employee elections for a Plan Year are irrevocable and must be made before the benefits become currently available. However, an election may be revoked or changed during a Plan Year if there is a qualified change in coverage, status or costs as permitted under federal law (herein a "qualified change"). Any revocation or change must be consistent with the qualified change. "Consistent" means:

the event causes a gain or loss of eligibility for a coverage option or for the cafeteria plan. If eligibility for only one coverage option is affected, an Employee can only change salary reduction elections for that coverage option, not also for others;

the change must be "on account of" and "correspond with" the change event;

if coverage is dropped because coverage is gained under a spouse's plan, the Employee must actually have the other coverage, or be enrolled to begin the other coverage, in order to drop coverage.

An Employee who wishes to change his elections mid-year on account of a qualified change, must notify the Plan Administrator within thirty-one (31) days of the event. Election changes will be effective as follows:

if the qualified event is marriage, the election change is effective as of the first day of the month after receipt of the election change request;

if the qualified event is birth, adoption or placement for adoption of a new dependent child, the election change is effective as of the date of the birth, adoption or placement for adoption;

for any other qualified event, the election change is effective as of the first of the month after the Plan's receipt of notice.

The following is a summary of changes generally permitted under federal law. It is the Plan's intent to allow mid-year changes to the full extent of the law. Each Employee's individual situation, however, will be evaluated in terms of: (1) the Employee's existing benefit elections, (2) the Employee's status, cost or coverage changes, (3) the actual benefits included in the Plan, and (4) the law.

Change in Status - If an Employee (or an Employee's dependent as noted below) experiences a change in status during a Plan Year, the Employee may be permitted to make new elections for the remaining portion of the Plan Year. A "change in status" is a change in an Employee's (or dependent's) eligibility for coverage under a qualified benefit plan sponsored by the Employer or another employer's plan due to at least one of the following:

- an employee's gain or loss of a dependent by birth, death, adoption or placement for adoption, or where a court has issued a judgment, decree or order requiring that an employee's dependent child or foster child be provided with health coverage or that another group health plan provide coverage;
- a change in marital status (e.g., marriage, divorce, legal separation or annulment, or the death of the Employee's spouse);

ELECTION OF BENEFITS, continued

- a change in the Employee's employment status or the employment status of the Employee's spouse or a dependent (e.g., commencement or termination of employment, beginning or returning from FMLA leave, reduction or increase in work hours, change from salaried to hourly, a strike or lock-out, commencement of or return from an unpaid leave of absence, change in worksite, etc.);
- a change in an Employee's residency or the residency of an Employee's spouse or a dependent. (Note that it is unlikely that a change is permitted for the Health Care Expense Reimbursement benefit and it is unlikely that a change is permitted for the Dependent Care Assistance benefit unless the child care provider changes);
- a change in the status of the Employee or one of his dependents under a plan's eligibility criteria (e.g., marriage, attainment of a specified maximum age, enrollment in or graduation from school or any similar circumstances);
- a dependent ceases to be a "qualifying child" or a "qualifying relative" as that term applies to the Dependent Care Assistance benefit;
- status changes which would permit an Employee to make mid-year changes in his Employer-sponsored health coverages in accordance with the special enrollment rights of the Health Insurance Portability and Accountability Act (HIPAA: P.L. 104-191). A change in election status can be made under the Plan only on a prospective, and not a retrospective, basis (except for the retroactive enrollment right under Code Sec. 9801(f) that applies to an election made within 30 days of a birth, adoption, or placement of a child for adoption); or
- such other changes as may be determined to be qualified in accordance with applicable Internal Revenue Service regulations as amended from time to time and which are approved and allowed by the Plan Sponsor.

Change in Costs – Mid-year election changes due to cost changes are allowed as follows:

- an election change with respect to the Dependent Care Expense Reimbursement benefit may be permitted due to a cost change imposed by or afforded to (i.e., in the form of a raise) a dependent care provider who is not an Employee's close relative (by blood, marriage or adoption).

NOTE: The "Change in Cost" rules do not apply to Health Care Expense Reimbursement elections.

Change in Coverage - If the coverage under a health plan should be significantly curtailed for all plan participants or terminated during a Plan Year and another health plan with similar coverage is available under the Plan, an Employee may elect to revoke his election and enroll under the alternative health plan.

If benefits or coverages are added to this Plan, an affected Employee may elect the new option or a replacement for a cancelled option and make corresponding election changes with respect to other options providing similar coverage.

If coverages change under a cafeteria plan or an underlying medical plan sponsored by the employer of an Employee's spouse, former spouse or dependent that results from such family member's - (1) permissible election change, or (2) new election during an open enrollment period - the Employee may change his Plan elections consistent with such changes.

If there is a change in Medicare or Medicaid entitlement by an Employee (or by the Employee's spouse or dependent), an Employee may change his Plan elections consistent with such change.

NOTE: The "Change in Coverage" rules do not apply to Health Care Expense Reimbursement elections.

BENEFITS

To the extent allowed by the Plan Sponsor's **Benefits and Election Maximums** for a Plan Year, an Employee may apply his Flexible Dollars toward the benefits described below.

Health Care Expense Reimbursement

Flexible Dollars may be used for reimbursement of those expenses of the Employee or an eligible Dependent which would be reimbursed under the Employer's health care coverage(s) but for the effect of a deductible amount requirement, a coinsurance provision, or a dollar limitation on the amount of the reimbursement allowable. In addition, other health-related expenses (generally as defined in IRC § 213) may be reimbursed to the extent that they are not otherwise reimbursable. To be eligible for reimbursement, the expenses must be incurred (but not necessarily billed or paid) during the Plan Year and the period of Employee's participation in the Plan.

The following (not a complete listing), illustrates examples of expenses which may be claimed for reimbursement from an Employee's Health Care Expense Reimbursement Account:

- Acupuncture
- Alcoholism treatment
- Ambulance hire
- Artificial limbs
- Braces
- Braille - books and magazines
- Chemical dependency therapy
- Chiropractors
- Christian Science practitioner's fees
- Co-Insurance
- Crutches
- Deductible(s)
- Dental fees
- Dentures
- Diagnostic fees
- Doctors' fees:
 - anesthesiologists
 - chiropractors
 - chiropractors
 - dermatologists
 - gynecologists
 - neurologists
 - obstetricians
 - ophthalmologists
 - osteopaths
 - pediatricians
 - podiatrists
 - psychiatrists
 - surgeons
- Drugs - prescription drugs and insulin and other non-prescription drugs to alleviate or treat personal injury or sickness (e.g., antacids, allergy medicines, pain relievers or cold medicines). See the **OTC Products Addendum** for lists of over-the-counter items which may be eligible for reimbursement
- Eyeglasses, contacts, including examination fee (when medically necessary)
- Guide dog for a blind or deaf person
- Handicapped person's special schools
- Hair transplants
- Hearing devices and batteries
- Home improvements motivated by medical considerations
- Hospital bills
- Laboratory fees
- Lead base paint removal (for children with lead poisoning)
- Life fee to a retirement home for medical care
- Medical information plan
- Nurses' fees (including a nurse's board and Social Security tax where paid by taxpayer)
- Nursing home care (when medically necessary)
- Obstetrical expenses

Operations
Oxygen
Psychiatric care
Psychologist fees
Routine physicals and other non-diagnostic services or treatments
Smoking cessation programs
Special communication equipment for the deaf
Therapy treatments
Transplant donor expenses
Transportation expenses primarily for rendition of medical services (i.e., railroad fare to hospital or to recuperation home, cab fare in obstetrical cases)
Tuition at a special school for the handicapped
Tuition fee (part), if college or private school furnishes breakdown of medical charges
Wheelchair
X-rays

NOTE: Any expense which is claimed as a federal income tax deduction is NOT eligible for reimbursement with Flexible Dollars.

Dependent Care Assistance

Flexible Dollars may be used for the reimbursement of Dependent Care Assistance Expenses which are actually incurred during the Plan Year to care for a Qualifying Child or a Qualifying Relative and which enable the Employee to be gainfully employed. If the Employee is married, the spouse must also work, must be a full-time student at a qualified educational institution during each of five (5) calendar months during the taxable year, or must be physically or mentally handicapped (i.e., unable to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder which has been diagnosed by a physician as a permanent and continuing condition).

If dependent care expenses are incurred for services provided outside the Employee's household by a Dependent Care Center (as defined in IRC § 21(b)(2)(D)), they will be deemed to be eligible only if the care is provided to a Qualifying Child or a Qualifying Relative who regularly spends at least eight (8) hours a day in the Employee's home and such center meets all applicable laws and regulations of the appropriate state or unit of local government.

Amounts paid or incurred by an Employee will not be Dependent Care Assistance Expenses within the meaning of this subsection if such amounts are paid to an individual with respect to whom, for the Plan Year, a Federal Income Tax deduction is allowable to such Employee or the spouse of such Employee, or a person who is a child of such Employee and who is under the age of 19 at the close of the Calendar Year.

In the case of an Employee who is married, the Plan Sponsor reserves the right to require that the Employee provide a statement of his/her spouse's Earned Income in order to participate in the Dependent Care Assistance benefit or at the time of any claim. The Plan Sponsor may also require Employees to submit such other information which the Plan Sponsor deems necessary or desirable to implement the Dependent Care Assistance program.

On or before January 31 of each year, the Plan Sponsor will furnish each Employee with a written statement showing the amounts reimbursed from his/her Dependent Care Assistance Reserve Account during the preceding Calendar Year.

NOTES: An Employee may not receive Dependent Care Assistance in any Plan Year in excess of the lesser of: (i) Employee's Earned Income for the Plan Year, or (ii) the Earned Income of Employee's spouse for the Plan Year, with marital status determined at the close of the taxable year. For purposes of this subsection, an Employee's spouse who is either a Student or incapable of caring for himself, will be deemed to have Earned Income as provided for in IRC § 21(d)(2).

For the purposes of this benefit, the following terms will have the meanings shown below:

Dependent Care Assistance - The provisions of the Plan which constitute a dependent care assistance program within the meaning of IRC § 129.

Dependent Care Assistance Expenses - Household services and expenses for the care of a Qualifying Relative within the meaning of IRC § 21(b)(1) which are performed to enable an Employee to remain gainfully employed and which are performed: (i) in the home of the Employee; (ii) outside the home of the Employee for the care of a Dependent of the Employee under the age of 13, (iii) outside the home of the Employee for a Qualifying Relative who regularly spends at least eight (8) hours a day in the Employee's home, or (iv) outside the home of an Employee for the care of a Qualifying Relative in a Dependent Care Center.

Services may not be rendered by: (i) a dependent of the Employee or (ii) a dependent of Employee's spouse or (iii) a child, within the meaning of IRC § 151(c)(3), who is under the age of 19 at the close of the taxable year.

Dependent Care Center - As provided by IRC § 21(b)(2)(C) and (D): a facility which: (i) complies with all applicable laws and regulations of the state and town, city or village in which it is located, (ii) provides care for more than six (6) individuals (other than individuals who reside at the facility), and (iii) receives a fee, payment or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit).

Earned Income - As provided in IRC § 32(c)(2), all income derived from wages, salaries, tips, other employee compensation and earnings from self-employment (within the meaning of IRC § 1402(a)); but not including any amounts paid or incurred: (i) as a pension or annuity, or (ii) by the Employer for Dependent Care Assistance to the Employee or under any other employer's dependent care assistance program.

Qualifying Child - A dependent of the Employee who is under age 13 and who:

has the same principal place of residence as the Employee for more than half of the taxable year. The residency test replaces the previous support test and applies even if another person provides more than 50% of the child's support;

has a specified relationship with the Employee: (1) a natural, adopted, foster, and/or step child – and a descendant of such child, or (2) a brother or sister, including a step sibling - and a descendant of such brother or sister;

has not provided over half of his own support for the Calendar Year in which the Employee's taxable year begins.

Qualifying Relative - An individual:

who bears a defined familial-type relationship to the Employee: (1) a natural, adopted, foster, and/or step child - and a descendent of such child, (2) a brother or sister, including a step sibling, (3) a parent or ancestor, or (4) a step-parent, aunt, uncle, niece, nephew, in-law or any other person who has the same principal residence as the Employee - i.e., the individual lives with the Employee;

who received over 50% of his support from the Employee during the tax year;

who is physically or mentally incapable of self-support; and

who is not a Qualifying Child of the Employee or any other taxpayer.

Student - As provided in IRC § 21(e)(7), an individual who, during each of five (5) calendar months during the taxable year, is a full-time student at an educational institution which normally maintains a regular facility and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on, as provided in IRC § 21(e)(8) and 170(b)(1)(A)(ii).

CLAIMS PROCEDURES FOR DEPENDENT CARE ASSISTANCE

SUBMITTING A CLAIM

To file a claim for reimbursement of Dependent Care Assistance expenses, an Employee must complete a claim form and include the name, address and taxpayer identification number of the person (or facility) providing the dependent care services as well as a dated receipt for services provided. Claims forms are available from the Employer, Plan Sponsor or claims office. The Employee will also be required to furnish his cancelled check or other proof of payment as the Plan Sponsor or claims office considers necessary.

Claims for expenses related to a Plan Year must be incurred during the Plan Year or within thirty (30) days (the grace period) following the end of the Plan Year. Claims must be submitted for reimbursement not later than twelve (12) months after the end of grace period.

Claims should be forwarded to the following claims office which is responsible for handling benefit matters on behalf of the Plan:

**Delta Health Systems
1234 W. Oak Street
Stockton, CA 95201**

Failure to submit claims during the established period will deprive an Employee of reimbursements to which he might otherwise be entitled.

PAYMENT OF CLAIMS

Reimbursement of eligible expenses will be made directly to the Employee or in accordance with Plan provisions in the event of the Employee's incapacity or death. All Plan reimbursements will be subject to the following limitations:

the maximum amount of reimbursement will not exceed the lesser of: (i) the benefit allowed by the appropriate section of the Code, (ii) the amount elected by the Employee on the election of benefits and Salary Reduction Agreement form(s), or (iii) the amount available in the Employee's Reserve Account at the time of reimbursement;

reimbursement will be made only in the event and to the extent that such reimbursement or payment: (i) is not reimbursable under any other plan or policy, and (ii) will not be claimed by the Employee as a deduction for federal income tax purposes.

APPEAL PROCEDURES

If a claim is wholly or partially denied, the Employee will be given written notification of such denial. This notice will include:

the reason(s) for the denial;

specific reference to the Plan provision(s) on which the denial is based;

a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

appropriate information as to the steps to be taken if the Employee wishes to submit the claim for review.

CLAIMS PROCEDURES FOR DEPENDENT CARE ASSISTANCE, continued

An Employee may request a review of his claim, provided such request is filed in writing to the Contract Administrator (at the address shown above) within sixty (60) days after the date his claim is denied.

At such time as the Employee requests a review of the denied claim, he may review any pertinent documents and should submit issues and comments in writing.

The Plan Sponsor will make a decision with regard to the appeal not later than sixty (60) days after the receipt of the request for review, unless special circumstances require an extension of time. If an extension is required, written notice of the extension will be furnished to the Employee prior to the termination of the initial 60-day period. The extension notice will explain the special circumstances requiring an extension and the date the Plan Sponsor expects to render the final decision.

The decision on review will be in writing, will include the specific reason(s) for the decision and will reference the pertinent provisions on which the decision is based.

CLAIMS PROCEDURES FOR HEALTH CARE EXPENSE REIMBURSEMENT

SUBMITTING A CLAIM

To file a claim for reimbursement of health care expenses, an Employee must complete a claim form. Claims forms are available from the Employer, Plan Sponsor or claims office.

The Employee will also be required to furnish such documents, evidence, data or information in support of his claim as the Plan Sponsor or claims office considers necessary, including a written statement from an independent third party clearly indicating that the health care expense was incurred within the Plan Year, its amount (e.g. the provider's itemized bill) and that it has been paid. Additionally, the Employee must provide a written statement that the expense has not been reimbursed and is not reimbursable under any other health plan and will not be claimed as a federal income tax deduction.

Claims for expenses related to a Plan Year must be incurred during the Plan Year or within thirty (30) days (the grace period) following the end of the Plan Year. Claims must be submitted for reimbursement not later than twelve (12) months after the end of grace period.

Claims should be forwarded to the following claims office which is responsible for handling benefit matters on behalf of the Plan:

**Delta Health Systems
1234 W. Oak Street
Stockton, CA 95201**

Failure to submit claims during the established period will deprive an Employee of reimbursements to which he might otherwise be entitled.

CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances which apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (i.e., how quickly the Plan will respond to claims notices, filings and claims appeals and how much time is allowed for Claimants to respond, etc.).

Important: These claims procedures address the periods within which benefit determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval.

CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Claimant Makes Initial <u>Incomplete</u> Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of material needed to complete the claim request. Claimant has at least 45 days to provide required information.
Plan Receives Completing Information	Within 30 days, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial <u>Complete</u> Claim Request	Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeals Procedures" subsection.

CLAIMS PROCEDURES FOR HEALTH CARE EXPENSE REIMBURSEMENT, continued

Plan Responds to Appeal

Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).

"Full notice" means describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan.

Authorized Representative May Act for Claimant

Any of the above actions which can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization.

Written or Electronic Notices

The Plan shall provide a Employee/Claimant with written or electronic notification of any benefit reduction or denial.

PAYMENT OF CLAIMS

Claims payments will be made directly to the Employee, or to the designated beneficiary in the case of the Employee's death.

All Plan reimbursements will be subject to the following limitations:

the maximum amount of reimbursement will not exceed the lesser of: (1) the amount of benefit allowed by the appropriate section of the Code, or (2) the amount elected by the Employee on the election of benefits and Salary Reduction Agreement form;

reimbursement will be made only in the event and to the extent that such reimbursement or payment: (i) is not provided for under any insurance policy, whether the premium on such policy is paid by the Employer or the individual Employee, (ii) is not provided for or reimbursable under any other plan or policy, and (iii) will not be claimed as a deduction for Federal income tax purposes.

CLAIMS DENIALS

If a claim is wholly or partially denied (see NOTE), the Claimant will be given written or electronic notification of such denial - see "Claims Time Limits and Allowances." The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

the specific reason(s) for the decision to reduce or deny benefits:

specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols which were relied upon in making the decision;

a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to the Claimant's claim for benefits;

the identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice, or a statement that the identity of the expert(s) will be provided upon request;

a description of any additional information needed to change the decision and an explanation of why it is needed;

a description of the Plan's procedures and time limits for appealed claims.

APPEAL PROCEDURES

Filing an Appeal

Within 180 days of receiving notice of a claim reduction or denial, a Claimant may appeal his claim, in writing, to a new decision-maker and he may submit new information (comments, documents, records, etc.) in support of his appeal. A Claimant may not take legal action on a denied claim until he has exhausted the Plan's mandatory (i.e., non-voluntary) appeal procedures.

In response to his appeal, the Claimant is entitled to a full and fair review of the claim and a new decision. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

At such time as the Claimant appeals a denied claim, he will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to his claim for benefits. The Plan will also disclose the names of any medical or health professionals consulted as part of the claim process.

Decision on Appeal

A decision with regard to the claim appeal will be made within the stated time frame - see "Claims Time Limits and Allowances."

The decision on appeal will be in writing or by electronic notification. The decision may be provided by phone, facsimile or other available and similarly expeditious method. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

the specific reason(s) for the decision;

reference to the pertinent Plan provisions on which the decision is based;

a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;

identification of any medical or vocational experts whose advice was obtained in connection with the claim denial;

identification of and access to any guidelines, rules, protocols which were relied upon in making the decision;

a statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures.

DEFINITIONS

When capitalized within, the following items will have the meanings shown below.

Calendar Year - The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1. Each succeeding like period will be considered a new Calendar Year.

Claimant - Any person who submits a claim or on whose behalf a claim is submitted for benefits under the Plan.

Code - The Internal Revenue Code of 1986, as amended, and the regulations thereunder.

Contract Administrator - A company which performs all functions reasonably related to the general management, supervision and administration of the Plan in accordance with the terms and conditions of an administration agreement between the Contract Administrator and the Plan Sponsor.

Covered Person - A covered Employee or a Qualified Beneficiary under COBRA. See the **Eligibility and Effective Dates** and **Continuation of Coverage Option (COBRA)** sections for further information.

Dependent - Any individual who is a tax dependent of the Employee as defined in Code § 152, with the following exceptions:

for purposes of: (1) the Health Care Expense Reimbursement benefit:

- a dependent is as defined in Code § 152, determined without regard to subsection (b)(1), (b)(2), and (d)(1)(B) thereof; and
- any child to whom Code § 152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents; and

for purposes of the Dependent Care Assistance benefit, a dependent means a Qualifying Individual as defined in Code Section 9.3(c).

Notwithstanding the foregoing, Health Care Expense Reimbursement benefits will be provided in accordance with the applicable requirements of any Qualified Medical Child Support Order, even if the child does not meet the definition of a "Dependent."

Employee - see **Eligibility and Effective Dates** section

Employer(s) - The Employer or Employers participating in the Plan as stated in the **General Plan Information** section.

Fiduciary - Any person who has binding power to make decisions regarding Plan policies, interpretations, practices or procedures. A Fiduciary will thus include, but not be limited to, the Plan Administrator, officers and directors of the Plan Sponsor, investment committee members and Plan trustees, if any.

Flexible Dollars - Those dollar amounts which an Employee may allocate to obtain benefits.

Highly Compensated Participant - Except as noted, an individual meeting any of the following definitions:

an officer of the Employer;

a shareholder owning more than 5% of the voting power or value of all classes of the Employer's stock;

a highly compensated employee as may be determined based on the facts and circumstances;

a spouse or dependent of one of the above.

DEFINITIONS, continued

NOTE: Final determination of a Highly-Compensated Participant will be based on the applicable sections of the Code (e.g., IRC § 125(e)) and as the Code may be amended from time to time.

Human Resources Department - The Human Resources Department of the Plan Sponsor.

Key Employee - An Employee who, at any time during a current Plan Year or any of the four (4) preceding Plan Years, meets any of the following descriptions (see IRC § 125(b)(2) and 416(i)(1)):

an officer of the Employer whose annual compensation exceeds \$130,000 (as adjusted for inflation);

for a corporate Employer - a person:

who owns, directly or indirectly, more than 50% of the value of the corporation's outstanding stock or stock possessing more than 5% of the total combined voting power of all stock of the corporation; or

whose annual compensation exceeds \$150,000 and who owns, directly or indirectly, more than 1% of the value of the corporation's outstanding stock or stock possessing more than 1% of the total combined voting power of all stock of the corporation;

for a non-corporate Employer - a person:

who owns, directly or indirectly, more than 5% of the capital or profits interest in the Employer; or

whose annual compensation exceeds \$150,000 and who owns, directly or indirectly, more than 1% of the capital or profits interest in the Employer.

NOTE: Final determination of a Key Employee will be based on the applicable sections of the Code and as it may be amended from time to time.

Plan - The entity which provides the benefits described by the Plan Document, its amendments and addendums. The name of the Plan is shown in the **General Plan Information** section.

Plan Administrator - see "Plan Sponsor"

Plan Document - A formal document which describes the plan of benefits and the provisions under which such benefits will be paid to Covered Persons, including any amendments.

Plan Sponsor - The entity sponsoring this Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **General Plan Information** section for further information.

Plan Year - see **General Plan Information** section

Reserve Account or **Account** - An individual account established by the Plan Sponsor and in the name of the Employee, for the purpose of accounting for Flexible Dollars allocated to and benefits paid under the Plan. Reserve Accounts are for record keeping purposes only and are not funded. A Reserve Account is not an interest-bearing account.

Separate accounting will be performed for each benefit elected by an Employee. Amounts attributed to one benefit cannot be transferred, in any manner, to another benefit.

Salary Reduction Agreement - An agreement between an Employee and the Employer under which the Employer reduces the Employee's salary with before-tax dollars (Flexible Dollars) and allocates them to one or more Reserve Accounts on behalf of the Employee.

The Salary Reduction Agreement will apply only to amounts of the Employee's pay that have not been actually or constructively received by the Employee. Any amounts so elected will not become currently available to the Employee.

DEFINITIONS, continued

Each Employee may make a Salary Reduction Agreement which will reduce his salary by an amount equal to that necessary to provide for the types of benefits elected under the Plan. The amount of the salary reduction elected by the Employee will be deemed to be an Employer contribution for purposes of the Code.

The Salary Reduction Agreement will be irrevocable during the Plan Year except as provided in "Mid-Year Changes in Elections" in the **Eligibility and Effective Date** section.

GENERAL PLAN INFORMATION

Name of Plan:	Diocese of Monterey Flexible Spending Plan
Plan Sponsor / Plan Administrator:	Diocese of Monterey
Address:	631 Abrego Street Monterey, CA 93942
Business Phone Number:	(831) 373-4345
Participating Employer(s):	Diocese of Monterey
Plan Year:	January 1 through December 31
Contract Administrator:	Delta Health Systems
Address:	1234 W. Oak Street Stockton, CA 95201
Phone:	(209) 474-5587 or (800) 291-0726

FUNDING

Reserve Accounts are set up for each Plan participant and for each elected benefit. Reserve Accounts are for record keeping purposes only and are not funded. All benefits (reimbursements) are paid from the general assets of the Plan Sponsor.

All Reserve Account amounts must be used within the Plan Year during which the pre-tax deductions were made or they will be forfeited by the Employee to the Plan.

The costs and expenses incurred by the Employer in administering the Plan shall be paid by the Employer.

ADMINISTRATIVE PROVISIONS

Administration

The benefits of the Plan are administered by a Contract Administrator under the terms and conditions of an administration agreement between the Plan Sponsor and Contract Administrator.

Amendment or Termination of the Plan

The Plan Sponsor expects the Plan to be permanent, but since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, unless prohibited by applicable law. Any termination, suspension, withdrawal, amendment or modification will be done in writing, and by resolution of the Plan Sponsor's Human Resources Department.

With the exception of forfeited amounts, Plan funds will not at any time be used for or diverted to purposes other than for the exclusive benefit of Employees or their beneficiaries, and no amendment (aside from an amendment to terminate the Plan) will divest any person of his interest therein, except as may be required by the Internal Revenue Service or other governmental authority, or give any person any assignable or exchangeable interest or any right or thing of exchangeable value in advance of the time distribution is to be made to such person, except as otherwise permitted by law.

Annual Statements

To the extent required by law, the Plan Sponsor will furnish to each Employee within a reasonable period of time following the close of a Plan Year, a written statement showing the amounts paid or expenses incurred by the Plan Sponsor for Plan benefits during the prior Plan Year.

Anticipation, Alienation, Sale or Transfer

No benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Beneficiary Designation & Facility of Payment

An Employee receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto.

Each Employee shall designate upon such forms as may be provided for the purpose, a beneficiary or beneficiaries who are to receive, in the event of his death, payment of a reimbursement to which he is entitled under the Plan. The designation of a beneficiary will not be effective for any purpose unless and until it has been filed with the Plan Sponsor. In the event that an Employee fails to designate a beneficiary in the specified manner, or if for any reason such designation is legally ineffective or if such beneficiary predeceases the Employee or dies simultaneously with him, then, for the purposes of the Plan, distribution will be made by the Plan to the Employee's spouse (if any). If there is no spouse, at the discretion of the Plan the benefits will be paid to either: (1) any one or more of the persons comprising the group consisting of the Employee's descendants, the Employee's parents, or the Employee's heirs-at-law, and the Plan may pay the entire benefit to any member of such group or apportion such benefit among any two or more of them in such shares as the Fiduciaries, in their sole discretion, shall determine, or (2) the estate of the deceased Employee. The Fiduciaries may elect to have a court of applicable jurisdiction determine to whom a payment or payments will be paid.

In the event that an Employee is survived by a spouse, payment will be made to another beneficiary only in the event the surviving spouse consents in writing to the payment to the other beneficiary and such election is witnessed by either a notary public or a Plan Fiduciary.

Discrepancies

In the event that there is a discrepancy between any separate booklet which may be provided to Employees (a "Summary Plan Description") and the Plan Document, the Plan Document will prevail.

Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account(s) of any Employee, or the amount of distributions made or to be made to an Employee or other person, the Plan Sponsor will, to the extent it is lawful and deemed possible, cause to be allocated or cause to be withheld or accelerated or otherwise make adjustment of, such amounts as will in its judgment accord to such Employee or other person the credits to the account or distributions to which he is properly entitled under the Plan.

The Employer will not be liable in any manner for any determination of fact made in good faith.

Entire Contract

The Plan Document, any amendments and addendums, the individual applications, if any, and Employee Salary Reduction Agreements will constitute the entire contract between the parties.

Exclusion from Income

The Plan Sponsor intends that nontaxable benefits will be eligible for exclusion from the gross income of the Employee, as provided in IRC § 125, and all provisions of the Plan will be construed in a manner consistent with that intent.

HOWEVER, neither the Plan Sponsor, the Employer, nor the Fiduciaries in any way guarantee or ensure that any of the benefits provided under the Plan will not be subject to income or other taxes. Furthermore, neither the Plan Sponsor, the Employer, nor the Fiduciaries will be liable for any income or other taxes imposed upon an Employee, spouse, dependent, or any other person by reason of any benefits received under the Plan.

Fiduciary Responsibility, Authority and Discretion

Fiduciaries shall discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries shall administer the Plan and shall have the authority to exercise the powers and discretion conferred on them by the Plan and shall have such other powers and authorities necessary or proper for the administration of the Plan as will be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries may adopt such rules and procedures for the administration of the Plan as they shall consider advisable and shall have discretionary authority to interpret the terms of the Plan and Plan Document and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

The Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) as in their opinion may be desirable for the administration of the Plan, and may pay any such person reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan.

Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Gender and Number

Except when otherwise indicated by the context, any masculine terminology will also include the feminine and any term in the singular will also include the plural.

Illegality of Particular Provision

The illegality of any particular provision of the Plan Document will not affect the other provisions and the Plan Document will be construed in all respects as if such invalid provision were omitted.

Indemnification

To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries, will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions

No Employee or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Plan Document. No action may be brought for benefits provided by the Plan or an amendment or modification thereof, or to enforce any right thereunder, until after the claim has been submitted to and determined by the Plan and then action may only be brought within one (1) year after the date of such decision.

Non-Discrimination

It is intended that the Plan will comply with all Federal tax law requirements necessary to obtain the tax benefits of a cafeteria (Section 125) plan, including the requirements that the Plan not discriminate in favor of certain Key Employees or Highly Compensated Participants. Therefore, the salary reduction amounts available to such participants may be limited or reduced to assure compliance and non-discrimination. See also "Exclusion from Income" above.

Privacy Rules & Intent to Comply

The Plan Sponsor certifies that the Plan is amended (by separate addendum) to comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rules") of the Health Insurance Portability and Accountability Act (HIPAA). Such standards control the dissemination of "protected health information" (herein also "PHI") of Plan participants. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entities ("business associates") that may assist in the operation of the Plan and that handle PHI.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

Right of Recovery

Whenever any benefit payments have been made by the Plan in excess of the maximum amount required under the terms of the Plan Document, the Plan will have the right to recover all such excess amounts from any persons, insurance companies or other payees, and the Employee shall make a good faith attempt to assist the Plan in such recovery.

Rights Against the Plan Sponsor

Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Titles or Headings

Where titles or headings precede explanatory text throughout the Plan Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Plan Document and will not affect the validity, construction or effect of the Plan Document provisions.

Unclaimed Accounts

If the Plan is unable, within two (2) years after any amount becomes due and payable from a Reserve Account to an Employee or beneficiary, to make payment because the identity or whereabouts of such person cannot be ascertained, the Plan Sponsor may mail a notice by registered mail to the last known address of such person outlining the action to be taken unless such person makes written reply to the Plan Sponsor within sixty (60) days from the mailing of such notice. The Plan Sponsor may direct that such amount and all further benefits with respect to such person will be discontinued and all liability for the payment will terminate; however, in the event of the subsequent reappearance of the Employee or beneficiary prior to termination of the Plan, the benefits which were due and payable and which such person missed will be paid in a single sum.

OTC PRODUCTS ADDENDUM

The following lists of “Medical-Only Items” and “Dual-Purposes Items” can be purchased over-the-counter (i.e., without a physician’s prescription) and may be eligible for reimbursement under the Health Care Expense Reimbursement Benefit. A claim for reimbursement of any such item must include:

- Name of the medicine, drug or item
- Date of purchase
- Name of vendor
- Price (per item)
- Participant’s statement that the item is for medical use only and was purchased for use by a family member only

Medical-Only Items – The following is a sample list of items which may be eligible for reimbursement when they are primarily for medical care:

- Allergy prevention and treatment drugs
- Antacids
- Anticandial drugs
- Anti-diarrhea medicines or laxatives
- Anti-fungal medications
- Antihistamines
- Anti-itch creams or lotions (athlete’s foot, jock itch, poison ivy)
- Carpal tunnel wrist supports
- Cold remedies
- Cold sore / fever blister creams
- Cough drops and syrups
- Dehydration products for children (e.g., Pedialyte)
- Diabetic supplies (e.g., blood sugar test kits)
- Eye products (e.g., Visine, reading glasses, contact lens solutions)
- First aid products (e.g., band aids, bandages, gauze pads, rubbing alcohol, liquid adhesive for cuts, first aid kits, hot/cold packs, Bactine, diaper rash ointments, calamine lotions, bug bite medications)
- Head lice drugs (e.g. Pediculicide)
- Hemorrhoid creams and suppositories
- Incontinence supplies
- Joint pain products (e.g., BenGay, Tiger Balm)
- Menstrual cycle products for pain and cramp relief
- Motion sickness pills
- Nasal strips
- Nicotine drops or patches
- Ointments or creams for sunburn
- Pregnancy tests
- Sleeping aids (when used for occasional insomnia only)
- Toothache and teeth pain relievers
- Wart remover treatments

Dual-Purpose Items – The following is a sample list of dual-purpose items (i.e., items that can serve both a medical and a personal/cosmetic/general purpose). In addition to the information required for any non-Rx product, a claim for reimbursement of a dual-purpose item will require a medical practitioner’s diagnosis and recommendation in order to be considered. If the item is used on a recurring or potentially indefinite basis, the medical practitioner’s recommendation must clearly state the duration on which it is based:

- Aloe lotion
- Acne treatments / creams
- Dental fluoride products
- Fiber supplements
- Glucosamine / Chondroitin for arthritis
- Black Cohosh / OTC hormone therapy
- Herbal medicines / dietary supplements to treat specific medical conditions
- Lactose-intolerance drugs
- Orthopedic shoes and inserts (excess costs for)
- Nasal sprays
- Prenatal vitamins

OTC PRODUCTS, continued

Shampoos, medicated (e.g., Denorex Dry Scalp)
St. John's Wort
Sunscreen
Vaginal douche
Vitamin E lotion
Weight-loss drugs to treat a specific disease

Excluded Items – The following items are primarily for general health and well-being are not reimbursable:

Cosmetics (articles for cleansing, beautifying, altering appearance, etc.)
Dietary supplements
Excess purchases (purchases in excess of a reasonable quantity – ex: in excess of a 90-day supply)
Lip balm
Face creams, moisturizers, suntan lotions
Shampoos or soaps (unless a medicated shampoo or soap is prescribed for special treatment for a limited time)
Toiletries (shaving creams or lotions, deodorants, mouthwashes, etc.)
Toothpaste or toothbrushes (even if recommended by a dentist)
Vitamins (i.e., one-a-day or multivitamins)

BENEFITS AND ELECTION MAXIMUMS

The following are the Benefits and Election Maximums for the flexible spending account benefits of the **Diocese of Monterey Flexible Spending Plan**. This schedule applies for the Plan Year beginning January 1, 2006. This schedule will apply to subsequent Plan Years unless a revised **Benefits and Election Maximums** schedule is adopted by the Plan Sponsor.

BENEFITS	ELECTION MAXIMUMS
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Health Care Expense Reimbursement , per Plan Year up to	\$ 1,500
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Dependent Care Assistance , per Plan Year up to	\$ 5,000
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NOTE: For a married individual filing a separate tax return, the Election Maximum is \$2,500.

IMPORTANT: Notwithstanding any other Plan provision, the Employer in its discretion may suspend, modify or terminate salary reduction elections under the following circumstances:

to prevent discrimination, if the Employer finds that the Plan is or is likely to be discriminatory under applicable law;

if the amount of any payroll reduction agreed to is greater than an Employee's taxable pay from the Employer.

ADOPTION OF THE DOCUMENT

Adoption and Purpose of the Plan

The Plan Sponsor hereby adopts and creates by this document a plan (the "Plan") to provide certain benefits for eligible Employees of the Employer. The benefits provided by the Plan include the following:

- Health Care Expense Reimbursement
- Dependent Care Assistance

Governing Laws

It is intended that the Plan Document will serve to describe the nature, funding and benefits of the Plan. It is also intended that the Plan will conform to the requirements found in: (1) Section 125 of the U.S. Internal Revenue Code, and (2) the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time, as that act may apply to benefits included in Section 125 cafeteria plans. If any portion of the Plan does now, or in the future, conflict with any IRS, ERISA or federal regulations which apply to this Plan, such regulations will govern.

To the extent not superceded by federal law, this Plan (and each component plan, unless otherwise required by law) will be governed, construed and administered in accordance with the laws of the State of California.

Participating Employers

Employers participating in this Plan are as stated in the list of Participating Employers (see section entitled **General Plan Information**).

The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

Acceptance of the Plan Document

IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of January 1, 2006.

Document Accepted By:

Diocese of Monterey (Plan Administrator)

Signature of Authorized Representative

Title of Authorized Representative