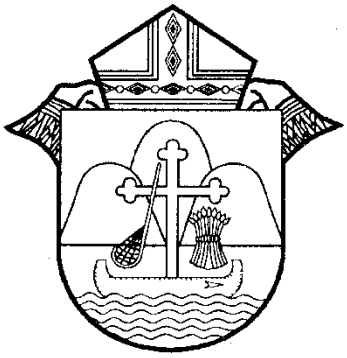
Employee Name: _____

Effective Date: _____

Plan Deductible Elected: _____

Plan deductible is as of effective date above but may be changed each year at renewal. See HR Administrator for plan deductible currently in effect.



DIOCESE of LA CROSSE

LAY GROUP
EMPLOYEE MEDICAL BENEFIT PLAN

GROUP NUMBER: 8201

Effective Dates: July 1, 2018

Original Effective Date: January 1, 2013

Administrative Service Manager:
Benefit Plan Administrators of Eau Claire, Inc.
402 Graham Avenue – 4th Floor
Eau Claire, WI 54701
Phone: (800) 236-7789 or (715) 832-5535

RECORD OF SUMMARY PLAN DESCRIPTION (SPD) RECEIPT

To the Employee:

Please sign and date below, remove this page and return to the Human Resources Department.

****

I hereby acknowledge that I have received a copy of the Summary Plan Description for the Diocese of La Crosse Lay Group Employee Medical Benefit Plan.

_____ _____

Employee Signature Date

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NON-GRANDFATHERED HEALTH PLAN NOTICE

This Diocese of La Crosse Lay Group Employee Medical Benefit Plan believes that this Plan is a "non-grandfathered health plan" under the Affordable Care Act (ACA).

IMPORTANT MESSAGE

It is important that ANY CHANGE OF ELIGIBILITY for You and/or any of Your eligible Dependents be reported to Your Employer, as soon as possible.

Changes of eligibility include:

- Marriage or divorce
- Death of any Dependent
- Birth of a child
- Legal guardianship of a child
- Adoption or placement for adoption of a child
- Dependent child reaching the limiting age
- IRS ineligible Dependent child
- Total Disability
- Retirement
- Change of address
- Medicare eligibility

For specific details regarding eligibility/enrollment, termination and continuation of coverage, refer to SECTION 3 - ELIGIBILITY of this Summary Plan Description.

NOTICE OF RELIGIOUS EMPLOYER EXEMPTION

The Diocese of La Crosse Lay Group Employee Medical Benefit Plan has certified that it qualifies for a religious Employer Exemption with respect to the Federal requirement to cover contraceptive services. Coverage under your group health plan will not include coverage of contraceptive services.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

Under the Federal Women's Health and Cancer Rights Act of 1998, you are entitled to the following services:

a. Reconstruction of the breast on which the mastectomy has been performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema).

Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other Sickness.

TABLE OF CONTENTS **Page**

SECTION 1

MEDICAL BENEFITS

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Note: Throughout this Summary Plan Description, BPA means Benefit Plan Administrators of Eau Claire, Inc., the Plan's Administrative Service Manager.

PREFERRED PROVIDER ORGANIZATION PROVISIONS

WHAT IS A PREFERRED PROVIDER ORGANIZATION?

Preferred Provider Organizations (PPO) are Networks of Hospitals, Qualified Treatment Facilities, Qualified Practitioners and other providers ("PPO Providers") that are contracted to furnish, at negotiated fees, medical services for Employees (and their covered Dependents) of participating Employers. In return, the PPO Providers receive a higher volume of patients due to the Plan's incentives to use PPO Providers. Using PPO Providers will, in most cases, reduce Your costs.

REASONS TO USE A PPO PROVIDER

1. The PPO negotiates fees for medical services resulting in lower costs for You when You use Hospitals, Qualified Treatment Facilities, Qualified Practitioners and other providers in the PPO network.

2. In addition, You may receive a better benefit and Your out-of-pocket expenses will be minimized.

3. You will have a wide variety of selected Hospitals, Qualified Treatment Facilities, Qualified Practitioners and other providers in the PPO network to help You with Your medical care needs.

The highest level of benefits under this Plan is available for services through PPO Providers; however You may choose any provider You wish for Your care.

Any provider who is not a member of the PPO Network at the time You received care or treatment is a Non-PPO Network Provider ("Non-PPO Provider").

FREE CHOICE OF PROVIDER

Any Participant may select any provider of service for care, treatment, services or supplies he wishes. This Plan does not dictate the choice of provider nor will it interfere in the provider/patient relationship or the course of treatment. The benefits available under this Plan will be provided, however, only to those providers and services defined and listed for coverage in the Summary Plan Description.

HOW TO SELECT A PROVIDER

Your Plan Administrator may contract one or more PPO's to provide services to this Plan in the areas where it has Participants. The PPO network that is applicable to You is shown on Your medical ID card. A directory of the participating Hospitals, Qualified Treatment Facilities, Qualified Practitioners and other providers in Your PPO network will be given to You at no cost when Your coverage becomes effective. The provider directory is a separate document from this Plan and is subject to change. To confirm that Your Hospital, Qualified Treatment Facility, Qualified Practitioner and other provider is a current participant in Your PPO Network, You must call the number listed on the back of Your medical ID card.

If You are traveling or need Emergency care and are unable to access care from Your PPO Provider, benefits will be paid at the non-Preferred Provider level.

TRAVEL/COMPLIMENTARY/WRAP PPO NETWORK

This network is available for you when you travel outside your primary network area. This does not include charges incurred if You traveled to such location for the purpose of obtaining medical services, drugs or supplies. The Complimentary/travel network identifier is on the back of your ID card. If you access a provider within this network, your benefits will be paid at the PPO level of benefits. For providers within the Multiplan Complimentary network, contact Multiplan, Inc. at (800) 546-3887 or via their website at www.Multiplan.com.

If you are traveling or need Emergency care and are unable to access care from your PPO Provider or the travel/complimentary/wrap network, benefits will be paid at the non-Preferred Provider level unless otherwise specified in the Schedule of Benefits.

DIOCESE OF LA CROSSE LAY GROUP
EMPLOYEE MEDICAL BENEFIT PLAN

HIGH DEDUCTIBLE HEALTH PLAN/HEALTH SAVINGS ACCOUNT
SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	PREFERRED PROVIDER	NON-PREFERRED PROVIDER (Subject to Usual and Customary and Reasonable Charges)
ANNUAL MAXIMUM BENEFIT	Unlimited	
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Individual-Employee only plan	$2,000.00	$2,000.00
Individual-Family plan	$2,600.00	$2,600.00
Family (Embedded)	$4,000.00	$4,000.00
* Embedded deductible requires the individual deductible of $2,600 to be satisfied prior to the benefit plan coverage taking effect. This applies to participants enrolled under a family contract only.		
MAXIMUM OUT-OF-POCKET LIMIT PER CALENDAR YEAR		
Individual	$3,000.00	$5,000.00
Family (Embedded)	$6,000.00	$10,000.00
After the deductible has been satisfied, allowable charges will be paid at 80% or 70% until the maximum out-of-pocket limit expense amount is met. Allowable charges from Preferred Providers will be paid at 80%. Allowable charges from all other qualified providers will be paid at 70%. Once the maximum out-of-pocket expense amount is met, the Plan will then pay 100% of all allowable charges.		
The following charges are excluded from the major medical deductible or maximum out-of-pocket expense and are never paid at 100%: • Pre-Certification penalties • Ineligible Charges • Charges in excess of the Plan maximums/limitations • Charges over the Usual and Customary and Reasonable Fee • Rx Ancillary Charges **Note:** **1. Maximum out-of-pocket includes the major medical deductible.** **2. Deductible and/or maximum out-of-pocket amounts are combined for Preferred Provider and non-Preferred Provider expenses and accumulates towards each other.**		

Pre-admission certification is required on Inpatient confinements and certain Outpatient services. See section ***"Utilization Review Program"*** for details. If the Inpatient pre-admission and Outpatient pre-certification requirements are not followed, penalties will apply.

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
Ambulance Services	80% after PPO Deductible	
Autism Spectrum Disorder Treatment Calendar benefit is limited to the annual Intensive level and Non-Intensive level specified by state law statute 632.895. These amounts change each year based on the Consumer Price Index.	80% after Deductible	70% after Deductible
Chiropractic/Spinal Manipulation Includes office visit, x-rays, manipulations and supportive care. Routine/Maintenance Care is **not** covered by the Plan.	80% after Deductible	70% after Deductible
Custom-Molded Orthotics	80% after Deductible	70% after Deductible
Durable Medical Equipment	80% after Deductible	70% after Deductible
Emergency Room Services Includes facility charge, Physician fee and miscellaneous Hospital expenses.	80% after PPO Deductible	
Express/Retail/Walk-In Clinic Care	80% after PPO Deductible	
Hearing Aids Children under 18 years of age – Limited to one aid per ear every 36 months. Also includes cochlear implants.	80% after Deductible	70% after Deductible
Home Health Care	80% after Deductible	70% after Deductible
Calendar Year maximum benefit	40 visits	
Hospice	80% after Deductible	70% after Deductible
Hospital Services Inpatient/Outpatient	80% after Deductible	70% after Deductible
Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine	80% after Deductible	70% after Deductible

Pre-admission certification is required on Inpatient confinements and certain Outpatient services. See section ***"Utilization Review Program"*** for details. If the Inpatient pre-admission and Outpatient pre-certification requirements are not followed, penalties will apply.

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
Mental/Nervous Conditions and/or Substance Abuse Inpatient/Outpatient Treatment	80% after Deductible	70% after Deductible
Natural Family Planning	80% after Deductible	70% after Deductible
Lifetime maximum benefit	$400.00 per married couple	
Oral Surgery, Temporomandibular Joint Disorder Services and other Dental Services Refer to Covered Expenses section for list of eligible services.	80% after Deductible	70% after Deductible
Physician/Qualified Practitioner/Clinic Office Visit other than for Preventive Care Office visit charge only.	80% after Deductible	70% after Deductible
Physician/Qualified Practitioner Fees for Surgical and Medical Services	80% after Deductible	70% after Deductible
Pre-admission Testing In lieu of testing on admission and performed within 7 days of covered inpatient Confinement.	80% after Deductible	70% after Deductible
Pregnancy/Maternity Services Maternity charges not included under the Preventive Services benefit.	80% after Deductible	70% after Deductible
Prescription Drugs Retail (30-day supply) Mail Order (90-day supply) Specialty Drugs (90-day supply)	 80% after Deductible 80% after Deductible 80% after Deductible	 70% after Deductible Not Covered Not Covered
Healthcare Reform (ACA) – Preventive drugs are covered at 100%, not subject to deductible or coinsurance (Generic and single source Brand only).		
If you are without your ID card or use a non-participating pharmacy, you must pay for the prescription and submit a claim to the Prescription Drug Card service. A completed claim form and the paid receipt must be submitted as proof of claim. If the prescription drug is covered under the plan, reimbursement will be based on the contracted rate less the applicable deductible/coinsurance.		

Pre-admission certification is required on Inpatient confinements and certain Outpatient services. See section ***"Utilization Review Program"*** for details. If the Inpatient pre-admission and Outpatient pre-certification requirements are not followed, penalties will apply.

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
Preventive Care Services Breast Pump	100% Deductible waived	70% after Deductible
Maximum benefit	One pump in conjunction with each birth	
Breast pumps purchased from a retail store must be paid for up front and the receipt submitted to the Claims Administrator for reimbursement. Reimbursement will be based on the Preferred Provider level of benefits and Usual and Customary and Reasonable does not apply.		
Preventive Care Services Preventive services included under Healthcare Reform. *To comply with statutes and regulations, preventive services are outlined in the Covered Expenses section in their entirety.*	100% Deductible waived	70% after Deductible
Preventive Care Services All other preventive services not included under Healthcare Reform. *See the Covered Expenses section for those services.*	100% Deductible waived	70% after Deductible
Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Participants who have current symptoms or have been diagnosed with a medical condition are not considered to be receiving Preventive Care for that condition.		
Scalp Hair Prosthesis/Wig For chemotherapy related diagnosis only	80% after Deductible	70% after Deductible
Lifetime maximum benefit	$400.00	
Skilled Nursing Home	80% after Deductible	70% after Deductible
Per confinement maximum benefit	30 days	
Therapy Services Physical Therapy Speech Therapy Occupational Therapy	80% after Deductible	70% after Deductible

Pre-admission certification is required on Inpatient confinements and certain Outpatient services. See section ***"Utilization Review Program"*** for details. If the Inpatient pre-admission and Outpatient pre-certification requirements are not followed, penalties will apply.

BENEFIT DESCRIPTION	PREFERRED PROVIDER	NON-PREFERRED PROVIDER (Subject to Usual and Customary and Reasonable Charges)
Transplants	80% after Deductible	70% after Deductible
Urgent Care	80% after PPO Deductible	
Virtual Care	80% after Deductible	70% after Deductible
X-ray, Laboratory and Pathology Services other than for Preventive Care	80% after Deductible	70% after Deductible
All Other Covered Expenses	80% after Deductible	70% after Deductible

DIOCESE OF LA CROSSE LAY GROUP
EMPLOYEE MEDICAL BENEFIT PLAN

TRADITIONAL DEDUCTIBLE PLAN SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	PREFERRED PROVIDER	NON-PREFERRED PROVIDER (Subject to Usual and Customary and Reasonable Charges)
ANNUAL MAXIMUM BENEFIT	Unlimited	
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Individual	$1,000.00	$1,000.00
Family (Embedded)	$2,000.00	$2,000.00
MAXIMUM OUT-OF-POCKET LIMIT PER CALENDAR YEAR		
Individual	$2,000.00	$4,000.00
Family (Embedded)	$4,000.00	$8,000.00

After the deductible has been satisfied, allowable charges will be paid at 80% or 70% until the maximum out-of-pocket limit expense amount is met. Allowable charges from Preferred Providers will be paid at 80%. Allowable charges from all other qualified providers will be paid at 70%.

Once the maximum out-of-pocket expense amount is met, the Plan will then pay 100% of all allowable charges.

The following charges are excluded from the major medical deductible or maximum out-of-pocket expense and are never paid at 100%:

- Pre-Certification penalties
- Ineligible Charges
- Rx Copays
- Charges in excess of the Plan maximums/limitations
- Charges over the Usual and Customary and Reasonable Fee
- Rx Ancillary Charges

Note:

1. **Maximum out-of-pocket includes the major medical deductible.**
2. **Deductible and/or maximum out-of-pocket amounts are combined for Preferred Provider and non-Preferred Provider expenses and accumulate towards each other.**
3. **Copays apply towards the maximum out-of-pocket expense with the exception of prescription drug Copays.**

Pre-admission certification is required on Inpatient confinements and certain Outpatient services. See section ***"Utilization Review Program"*** for details. If the Inpatient pre-admission and Outpatient pre-certification requirements are not followed, penalties will apply.

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
Ambulance Services	80% after PPO Deductible	
Autism Spectrum Disorder Treatment Calendar benefit is limited to the annual Intensive level and Non-Intensive level specified by state law statute 632.895. These amounts change each year based on the Consumer Price Index.	80% after Deductible	70% after Deductible
Chiropractic/Spinal Manipulation Includes office visit, x-rays, manipulations and supportive care Routine/Maintenance Care is **not** covered by the Plan. Per visit maximum Calendar Year maximum benefit	50% Deductible waived $25.00 $2,000.00	
Custom-Molded Orthotics	80% after Deductible	70% after Deductible
Durable Medical Equipment	80% after Deductible	70% after Deductible
Emergency Room Services Includes facility charge, Physician fee and miscellaneous Hospital expenses. (Copay waived if admitted within 24 hours for the same condition)	$200.00 Copay then, 80% after PPO Deductible	
Express/Retail/Walk-In Clinic Care	80% after PPO Deductible	
Hearing Aids Children under 18 years of age – Limited to one aid per ear every 36 months. Also includes cochlear implants.	80% after Deductible	70% after Deductible
Home Health Care	80% after Deductible	70% after Deductible
Calendar Year maximum benefit	40 visits	
Hospice	80% after Deductible	70% after Deductible
Hospital Services Inpatient/Outpatient	80% after Deductible	70% after Deductible

Pre-admission certification is required on Inpatient confinements and certain Outpatient services. See section ***"Utilization Review Program"*** for details. If the Inpatient pre-admission and Outpatient pre-certification requirements are not followed, penalties will apply.

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine	80% after Deductible	70% after Deductible
Mental/Nervous Conditions and/or Substance Abuse Inpatient/Outpatient Treatment	80% after Deductible	70% after Deductible
Natural Family Planning	80% after Deductible	70% after Deductible
Lifetime maximum benefit	$400.00 per married couple	
Oral Surgery, Temporomandibular Joint Disorder Services and other Dental Services Refer to Covered Expenses section for list of eligible services.	80% after Deductible	70% after Deductible
Physician/Qualified Practitioner/Clinic Office Visit other than for Preventive Care Office visit charge only.	80% after Deductible	70% after Deductible
Physician/Qualified Practitioner Fees for Surgical and Medical Services	80% after Deductible	70% after Deductible
Pre-admission Testing In lieu of testing on admission and performed within 7 days of covered inpatient Confinement.	100% Deductible waived	
Pregnancy/Maternity Services Maternity charges not included under the Preventive Services benefit.	80% after Deductible	70% after Deductible
Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Participants who have current symptoms or have been diagnosed with a medical condition are not considered to be receiving Preventive Care for that condition.		

Pre-admission certification is required on Inpatient confinements and certain Outpatient services. See section ***"Utilization Review Program"*** for details. If the Inpatient pre-admission and Outpatient pre-certification requirements are not followed, penalties will apply.

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
Preventive Care Services Preventive services included under Healthcare Reform. *To comply with statutes and regulations, preventive services are outlined in the Covered Expenses section in their entirety.*	100% Deductible waived	70% after Deductible
All other preventive services not included under Healthcare Reform. *See the Covered Expenses section for those services.*	100% Deductible waived	70% after Deductible
Calendar Year maximum benefit Under age 6 Ages 6 and over	 n/a n/a	 n/a $700.00
Preventive Care Services Breast Pump	100% Deductible waived	70% after Deductible
Maximum benefit	One pump in conjunction with each birth	
Breast pumps purchased from a retail store must be paid for up front and the receipt submitted to the Claims Administrator for reimbursement. Reimbursement will be based on the Preferred Provider level of benefits and Usual and Customary and Reasonable does not apply.		
Scalp Hair Prosthesis/Wig For chemotherapy related diagnosis only.	80% after Deductible	70% after Deductible
Lifetime maximum benefit	$400.00	
Skilled Nursing Home	80% after Deductible	70% after Deductible
Per confinement maximum benefit	30 days	
Therapy Services Physical Therapy Speech Therapy Occupational Therapy	80% after Deductible	70% after Deductible
Transplants	80% after Deductible	70% after Deductible
Urgent Care	80% after PPO Deductible	

Pre-admission certification is required on Inpatient confinements and certain Outpatient services. See section ***"Utilization Review Program"*** for details. If the Inpatient pre-admission and Outpatient pre-certification requirements are not followed, penalties will apply.

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
Virtual Care	80% after Deductible	70% after Deductible
X-ray, Laboratory and Pathology Services other than for Preventive Care	80% after Deductible	70% after Deductible
All Other Covered Expenses	80% after Deductible	70% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
MAXIMUM OUT-OF-POCKET PER CALENDAR YEAR Individual Family (Embedded)	 $1,000.00 $3,000.00	
Prescription Drug – Retail (30-day supply) Generic Brand Name	 30% Copay – minimum $10.00 Copay 30% Copay	 30% Copay – minimum $10.00 Copay 30% Copay
Prescription Drug – Mail Order (90-day supply) Generic Brand Name	 $25.00 Copay $75.00 Copay	 Not Covered Not Covered
Prescription Drug – Specialty (90-day supply)	Applicable Copay tier will apply	Not Covered
Healthcare Reform (ACA) – Preventive drugs are covered at 100%, not subject to deductible, coinsurance or Copay requirements (Generic and single source Brand only).		
If you are without your ID card or use a non-participating pharmacy, you must pay for the prescription and submit a claim to the Prescription Drug Card service. A completed claim form and the paid receipt must be submitted as proof of claim. If the prescription drug is covered under the plan, reimbursement will be based on the contracted rate minus Copay.		

HOW TO FILE A MEDICAL CLAIM

You will receive a Plan identification (ID) card showing Your name, Your group number and Your effective date of coverage.

Show Your ID card to the Hospital, clinic or Qualified Practitioner's office at the time medical services are rendered. Claims should be directed to the address shown on Your ID card by or You or Your provider. BPA does not require special claim forms. In the event that the service provider does not file the claim, You may submit the claim directly to BPA at the address shown below. Claims filed with BPA must be in writing and delivered by mail (postage prepaid), by fax or by e-mail.

Claims should be submitted to BPA at the address indicated below or to the address listed on the Participant's ID card, if different, in order for the claim to be deemed submitted.

Attention: Claim Department
Benefit Plan Administrators
402 Graham Avenue – 4th Floor
Eau Claire, WI 54701

Phone: (715) 832-5535or (800) 236-7789
Fax: (715) 838-8507

Claims submissions must be in a format acceptable to BPA and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable Federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by the Plan.

Post-Service Claims must be complete. They must contain, at a minimum:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges, which reflect any applicable PPO repricing;
6. The name of the Plan;
7. The name of the Covered Employee; and
8. The name of the patient.

Presentation of a prescription to a pharmacy does not constitute a claim. If a Participant pays the cost of a covered prescription Drug, however, a claim may be submitted to BPA for that purchase. A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure is covered by the Plan, prior to providing treatment, is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits. Payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable, if any, under the Plan.

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

PAYMENT OF CLAIMS

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

CLAIM FILING LIMIT

You must provide the plan with written proof of Your claim. Proof should be provided within 90 days after the claim was Incurred. Your claim will not be denied if it was not reasonably possible to give such proof within 90 days, however, except in the case of legal incapacity, written notice must be given no later than 12 months after the date the claim was Incurred.

If the Plan is terminated, written proof of loss for any claims Incurred prior to the termination must be filed with the Plan Administrator within 90 days of the termination. Any claim received by the Plan Administrator more than 90 days after this Plan is terminated will not be a Covered Expense.

PRESCRIPTION DRUG CHARGES

Retail Pharmacy

If you are without Your ID card or use a non-participating pharmacy, You must pay for the prescription and submit a claim to the Prescription Drug Card service. A completed claim form and the paid receipt must be submitted as proof of claim. If the prescription drug is covered under the plan, reimbursement will be based on the contracted rate less the applicable deductible/coinsurance/Copay.

For more information regarding Your benefits or to check for a participating pharmacy, please contact NPS at (800) 546-5677.

Mail Order

The mail service program provides Participants with an easy and convenient way to obtain Your maintenance medical. An order form, which explains the mail service program is greater detail, is available. Please contact Your Human Resource Department or NPS at (800) 546-5677if You have any questions regarding this program.

RIGHT TO CONSIDER SUBSTITUTION FOR COVERED CHARGES

The Claims Administrator shall have the right to consider alternate charges incurred for treatment, services or supplies not specifically listed as covered charges for payment of benefits under this Plan. The charges will be considered at the Plan Administrator's sole option and:

1. Must have the knowledge and consent of the Covered Individual;

2. Must be prescribed and approved by the Physician and be generally accepted and approved by the medical profession;

3. Must offer a medical therapeutic value equal to the treatment or service that would otherwise be performed or given; and

4. Must be Medically Necessary.

The Plan Administrator may cease to pay benefits for these substitute treatments, services or supplies at any time with written notification to the Covered Individual.

BALANCE BILLING

In the event that a claim submitted by a Preferred or non-Preferred Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many jurisdictions, and the Plan has no control over non-Preferred Providers that engage in balance billing practices.

In addition, with respect to services rendered by a Preferred Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Preferred Provider and the amount determined to be payable by the Plan Administrator and should not be balance billed for such difference. Again, the Plan has no control over any Preferred Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Preferred Provider.

The Participant is responsible for any applicable payment of coinsurances, deductibles and out-of-pocket maximums and may be billed for any or all of these.

MEDICAL BENEFITS

DEDUCTIBLE AND COINSURANCE INFORMATION

Covered Expenses are payable, after satisfaction of the Deductible, at the coinsurance percentages, up to the Maximum benefits, shown on the Schedule of Benefits and contained in the "Medical Covered Expenses" section.

Individual Deductible

This is the amount of Covered Expense You must pay before the Plan will reimburse Covered Expenses in excess of the Deductible amount. There is a Deductible which is applicable to PPO Provider Covered Expenses and may be a different Deductible applicable to Non-PPO Provider Covered Expenses; however, the total You pay for both PPO Provider Deductibles and Non-PPO Provider Deductibles will not exceed the maximum for Non-PPO Provider Deductible expense. The Deductibles apply to each Participant, each Calendar Year. The amount of each Deductible is shown on the Schedule of Benefits.

Family Deductible

This is the total amount of Deductible expense You must pay for Yourself and all of Your covered Dependents during a Calendar Year. There is a different maximum for PPO Provider Deductible expenses and Non-PPO Provider Deductible expenses; however, the total You pay for both PPO Provider Deductibles and Non-PPO Provider Deductibles will not exceed the maximum for Non-PPO Provider Deductible expense. The maximum family Deductible amounts are shown in the Schedule of Benefits. Once You have paid the applicable maximum family Deductible, no further Deductibles will be applied during that Calendar Year.

Coinsurance

Covered Expenses in excess of any required Deductibles will be reimbursed at the coinsurance percentages shown in the Schedule of Benefits. There is a coinsurance percentage that will be applied to PPO Provider Covered Expenses, and a different coinsurance percentage that will be applied to Non-PPO Provider Covered Expenses.

Copay (TraditionalDeductible plan only)

The Copay is the amount payable by the covered Participant for certain services, supplies or treatment rendered by a provider. The service and applicable Copay are shown on the Schedule of Benefits. The covered Participant selects a provider and pays the provider the Copay. The Copay must be paid each time a treatment or service is rendered. The Copay (with the exception of the prescription drug Copay) applies toward satisfaction of the Out-of-Pocket Maximums. The Copay will not be applied toward satisfaction of the Plan Year deductible.

Out-of-Pocket Limit

Except as noted below, when the combined Covered Expenses You must pay for Yourself and all of Your covered Dependents to satisfy the Plan's Deductible and coinsurance provisions equals the amount shown in the Schedule of Benefits, the Plan will reimburse additional Covered Expenses Incurred during the remainder of the Calendar Year at 100%. There is an individual out-of-pocket limit and a family maximum out-of-pocket limit that applies to Covered Expenses for PPO Providers, and limits for Non-PPO Providers. The out-of-pocket limits are shown in the Schedule of Benefits.

The following charges are excluded from the deductible requirement and coinsurance out- of- pocket requirement and are never paid at 100%:

1. Failure to comply with the Utilization Review Plan including pre-certification penalties
2. Ineligible charges
3. Charges in excess of the Plan maximum/limitations
4. Charges over the Usual and Customary and Reasonable Fee
5. Prescription drug Copays (Traditional Deductible Plan only)
6. Prescription drug Ancillary Charges

UTILIZATION REVIEW PROGRAM

Utilization review is the process of evaluating if services, supplies or treatment are Medically Necessary and appropriate to help ensure cost-effective care. Utilization review can eliminate unnecessary services, hospitalizations and shorten confinements while improving quality of care and reducing costs to the Participant and the Plan.

Contact the utilization review organization by **CALLING THE 800-NUMBER LISTED ON YOUR HEALTH BENEFITS IDENTIFICATION CARD FOR CERTIFICATION.**

The following services REQUIRE pre-certification:

All Inpatient Admissions

- Hospital
- Maternity if length of stay that is greater than 48 for a vaginal delivery or 96 hours for a cesarean delivery.
- Skilled Nursing Facilities
- Mental/Nervous Disorders and/or Substance Abuse services (inpatient)

Outpatient

- Chemotherapy/Radiation Therapy at a facility or Physician's office
- Dialysis

IMPORTANT: PRE-CERTIFICATION DOES NOT VERIFY OR GUARANTEE COVERAGE. BENEFITS ARE SUBJECT TO ALL PLAN PROVISIONS, LIMITATIONS AND EXCLUSIONS.

HOW THE PROGRAM WORKS

A. **"ELECTIVE ADMISSIONS"** or non-Emergency Hospital treatment is medical care that is scheduled several days in advance, usually at a time convenient for both you and your Physician.

When your Physician is scheduling an elective Hospital admission, **CALL THE 800-NUMBER LISTED ON YOUR HEALTH BENEFITS IDENTIFICATION CARD FOR ADMISSION CERTIFICATION** at least one week before the Hospital admission.

You, your Physician, the Physician's staff or even a family member may call for admission certification.

REMEMBER: Notification of admission must be obtained within the required time frame to assure maximum benefits coverage.

B. **"EMERGENCY or URGENT CARE ADMISSIONS"** or hospitalizations for potentially life-threatening causes are exempt from the pre-admission certification requirement. However, following an Emergency or Urgent care admission, certification must be obtained within 48 hours following the admission or on the first business day following weekend or holiday admission.

C. **"MATERNITY ADMISSIONS"** Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

If your maternity stay admission exceeds the periods stated above, Your utilization review organization must be contacted within 24 hours or the next business day, whichever is sooner, or benefits otherwise payable will be subject to the penalty described under "Pre-Certification Penalty".

D. **"OUTPATIENT SERVICES"** Certain Outpatient services must be pre-certified in advance of the proposed procedure in order for full Plan benefits to be payable. The Participant or their representative should call the utilization review organization at least three (3) business days prior to the performance of the procedure

After admission to the Hospital, the utilization review organization will continue to evaluate the Participant's progress through concurrent review to monitor the length of confinement and Medical Necessity of treatment. If the utilization review organization disagrees with the length of confinement recommended by the Physician, the Participant and the Physician will be advised. If the utilization review organization determines that continued confinement is no longer necessary, additional days will not be certified. Benefits payable for days not certified as Medically Necessary by the utilization review organization shall be denied.

Pre-Certification Penalty

The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to pre-certify the required services as identified above, **will be reduced by $200.** This penalty does not apply to the deductible or maximum out-of-pocket expenses. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

MEDICAL COVERED EXPENSES

Please remember that, although a Qualified Practitioner may prescribe, recommend or approve certain treatment, services or supplies, a Qualified Practitioner's recommendation does not necessarily mean that such treatment, services or supplies satisfy the Plan's criteria for coverage or make the expense a Covered Expense under the Plan.

HOSPITAL BENEFITS

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for the following services by a Qualified Treatment Facility or Hospital.

Room and Board

Average daily semi-private, ward, intensive care, isolation or coronary care room charges and general nursing services for each day of Confinement. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the Hospital where You are confined. If the Hospital in which You are confined has private rooms only, the private room rate will be covered.

Hospital Miscellaneous Charges

Charges made by the Hospital on its own behalf for services and supplies furnished for Your treatment during Confinement, including the following charges made by a Qualified Practitioner, whether billed directly or separately by the Hospital:

1. Professional services of a radiologist or pathologist for diagnostic x-ray and laboratory tests;

2. Professional services of an anesthesiologist.

PRE-ADMISSION TESTING

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for Pre-admission testing. Benefits are payable when pre-admission testing is performed in a Qualified Practitioner's office or the outpatient department of a Hospital, within seven days of a covered inpatient Confinement and accepted by the inpatient facility in lieu of like tests performed after Your admission.

QUALIFIED PRACTITIONER BENEFITS

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for the following services by a Qualified Practitioner:

1. Home and office calls;

2. Administration of anesthesia:

3. A surgical procedure, including post-operative care;

4. Multiple or bilateral surgical procedures including post-operative care.

   The Plan will follow CMS Physician Fee Schedule and NCCI guidelines in determining procedures subject to multiple surgical procedure reductions. This includes:
   a. If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Usual and Customary charge that is allowed for the primary procedures; Each additional procedure performed through the same incision will be allowed based on the CMS Physician Fee Schedule and NCCI guidelines. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
   b. If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Customary charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Usual and Customary percentage allowed for that procedure; and
   c. If an assistant surgeon is required, the assistant surgeon's covered charge will be allowed based on the CMS Physician Fee Schedule and NCCI guidelines.

5. Second surgical opinions.

ORAL SURGERY

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for the following services by a Qualified Practitioner for oral surgery:

1. Surgical removal of unerupted teeth;

2. Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth;

3. Apicoectomy (excision of the apex of the tooth root);

4. Frenectomy (incision of the membrane connecting the tongue to the floor of the mouth);

5. Osseous surgery (removal or correction of disease bone);

6. Surgical and non-surgical treatment of any jaw joint problem, including but not limited to appliances and therapy. Jaw Joint problems include: temporomandibular joint (TMJ); craniomaxillary or craniomandibular disorders (CMD), or other conditions of the joint linking the jaw bone and skull; treatment of the facial muscles used in expression or mastication functions; or symptoms thereof including headaches. These Covered Expenses do not include orthodontic treatment or services.

7. Gingivectomy (excision of gun tissue to eliminate infection);

8. Repair of or initial replacement of natural teeth damage due to Injury. Damage resulting from biting or chewing will not be considered an Injury; and

9. X-rays and anesthesia in connection with the covered procedure.

10. Hospital or Ambulatory Surgical Center charges Incurred and Anesthetics provided, in conjunction with dental care that is provided to a Participant in a Hospital or ambulatory surgery center provided:
    a. the Participant is a Child under the age of five;
    b. the Participant has a chronic Disability or medical condition that requires Hospitalization or general Anesthesia for dental care

PREVENTIVE CARE BENEFIT

Preventive Care services as outlined by Section 2713 of the Public Health Service Act (PHS Act) and its implementing regulations relating to coverage of preventive services require non-grandfathered group health plans to provide benefits for, and prohibit the imposition of cost-sharing requirements with respect to, the following:

1. Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography and prevention issued in or around November 2009. For the most current listing, please visit the USPSTF website at http://www.uspreventiveservicestaskforce.org.

2. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. http://www.cdc.gov/vaccines/acip/index.html

3. With respect to infants, children and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). The HRSA supports the comprehensive guidelines in the *Periodicity Schedule of the Bright Futures Recommendations* for Pediatric Preventive Health Care and the *Recommended Uniform Screening Panel* of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. https://www.aap.org/en-us/professional-resources/practice-support/Pages/PeriodicitySchedule.aspx

4. With respect to women, evidence-informed Preventive Care and screening provided for in comprehensive guidelines supported by HRSA to the extent not already included in the current recommendations of the USPSTF. http://www.hrsa.gov/womensguidelines

Changes to the guidelines and recommendations will be adopted in compliance of the rules of the regulation. **NOTE:** Preventive Care services will be covered at 100% for non-Preferred Providers if there is no Preferred Provider who can provide a required preventive service.

Covered Expenses will be payable, as shown in the Schedule of Benefits, for the following services. Checkups or routine examinations include the office visit and related charges for:

Preventive Services for Adults

1. Abdominal aortic aneurysm one-time screening for men ages 65 to 75 who have ever smoked.

2. Alcohol misuse screening and counseling.

3. Blood pressure screening.

4. Bowel preps for use in colorectal cancer screening for adults ages 50 to 75.

5. Cholesterol screening for adults ages 40 to 75

6. Colorectal cancer screening for adults ages 50 to 75. Screenings include but are not limited to Cologuard, colonoscopy, CT colonography, flexible sigmoidoscopy, flexible sigmoidoscopy with FIT, gFOBT, FIT, FIT-DNA, serology tests and other tests and procedures that are medically recognized and are non-Experimental/Investigational in nature. This includes all related surgical and pathology services furnished in the same clinical encounter of the colorectal cancer screening should the screening (diagnostic) procedure be converted to a therapeutic procedure.

7. Depression screening.

8. Diabetes screening for adults ages 40 to 70 who are overweight or obese.

9. Diet and physical activity counseling to prevent cardiovascular disease for adults with cardiovascular risk factors (i.e., those who are overweight or obese and have additional cardiovascular disease risk factors).

10. Hepatitis B screening for adults at high risk for infection.

11. Hepatitis C virus infection screening for adults at high risk for infection and one-time screening for adults born between 1945 and 1965.

12. HIV screening for adults ages 18 to 65 and for older adults who are at increased risk.

13. Immunization vaccines for adults –Doses, recommended ages and recommended populations vary:
    a. Hepatitis A
    b. Hepatitis B
    c. Herpes Zoster (shingles)
    d. Human Papillomavirus (HPV)
    e. Influenza (flu)
    f. Measles, Mumps, Rubella
    g. Meningococcal (e.g., meningitis)
    h. Pneumococcal (e.g., pneumonia)
    i. Tetanus, Diphtheria, Pertussis (whooping cough)
    j. Varicella (chicken pox)

14. Low-dose aspirin use to prevent cardiovascular disease and colorectal cancer for adults ages 50 to 59 who are at increased risk of cardiovascular disease.

15. Lung cancer annual screening with low-dose computed tomography in adults ages 55 to 80 who have a 30-pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

16. Obesity screening for all adults followed by intensive, multicomponent behavioral interventions for adults with a body mass index of 30 kg/m^2 or higher.

Medical Covered Expenses (continued)

17. Prevention of falls – Physical therapy for community-dwelling adults ages 65 and older who are at risk for falls.

18. Sexually transmitted infections – Intensive behavioral counseling for adults who are at increased risk for sexually transmitted infections.

19. Statin preventive medication: adults ages 40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater

20. Skin cancer behavioral counseling for adults ages 18 to 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk.

21. Syphilis screening for adults at increased risk.

22. Tobacco use screening and behavioral interventions and FDA-approved pharmacotherapy for cessation for all adult tobacco users.

23. Tuberculosis screening for adults at increased risk

24. Vitamin D supplements, OTC only, to prevent falls in community-dwelling adults ages 65 and older.

Preventive Services for Women, including Pregnant Women or Women Who May Become Pregnant

1. Bacteriuria urinary tract or other infection screening for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.

2. BRCA risk assessment and counseling about genetic testing for women at higher risk. This includes referral for genetic counseling and genetic testing, if appropriate.

3. Breast cancer chemoprevention counseling and medications for women at higher risk..

4. Breast cancer mammography screenings every 1 to 2 years for women ages 40 and over.

5. Breast feeding support, supplies and counseling – Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period. Rental or purchase of one standard electric breast pump is allowed in conjunction with each birth. A standard electric breast pump is defined as double electric pump and does not include Hospital grade pumps. Breast pumps purchased from a retail store will be paid at the Preferred Provider level of benefits and Usual and Customary and Reasonable does not apply. Purchases from a retail store must be paid for up front and the receipt submitted to the Claims Administrator for reimbursement.

6. Cervical cancer and dysplasia screening for women ages 21 to 65 with cytology (Pap smear) every 3 years or, for women ages 30 to 65 who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.

7. Chlamydia and gonorrhea screening in sexually active women age 24 or younger and in older women who are at increased risk for infection.

8. Domestic/intimate partner violence – Annual screening and counseling for interpersonal and domestic violence for women of childbearing age.

9. Folic acid daily supplements containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid for women who may become pregnant.

10. Gestational diabetes screening in pregnant women after 24 weeks of gestation and at the first prenatal visit for pregnant women who are high risk.

11. Hepatitis B screening for pregnant women at their first prenatal visit.

12. Human papillomavirus (HPV) DNA testing in women with normal cytology results. Screening should begin at 30 years of age and should occur no more frequently than every 3 years.

Medical Covered Expenses (continued)

13. Osteoporosis screening for women ages 65 and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.

14. Preeclampsia screening and prevention in pregnant women with blood pressure measurements throughout pregnancy and low-dose aspirin after 12 weeks of gestation for those who are at high risk.

15. Rh incompatibility screening for all pregnant women during their first visit for pregnancy-related care. Also repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation unless the biological father is known to be Rh (D)-negative.

16. Sexually transmitted infections counseling for sexually active women

16. Syphilis and HIV screening for all pregnant women.

17. Tobacco use screening and behavioral interventions for cessation for all pregnant women who use tobacco.

18. Well-woman visits – Visit for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. Frequency: Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.

Preventive Services for Children

1. Alcohol and drug use assessments.

2. Autism screening for children at 18 and 24 months.

3. Behavioral assessments.

4. Bilirubin screening for all newborns

5. Blood pressure screening.

6. Congenital hypothyroidism screening for all newborns.

7. Critical congenital heart disease screening for all newborns.

8. Dental caries prevention up to age 5 – Limited to fluoride varnish to primary teeth and oral fluoride. Oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.

9. Depression screening for children ages 12 years and older.

10. Developmental screening for children under age 3 and surveillance throughout childhood.

11. Dyslipidemia screening once between ages 9 and 11 years and once between ages 17 and 21 years.

12. Gonorrhea prevention medication for the eyes of all newborns.

13. Hearing screening up to age 21 as indicated by the American Academy of Pediatrics.

14. Height, weight and Body Mass Index measurements.

15. Hematocrit or hemoglobin screening.

16. Hemoglobinopathies or sickle cell screening for newborns.

17. Hepatitis B screening for children at high risk for infection.

18. HIV screening for children ages 15 to 18 years and for younger children who are at increased risk.

19. Immunization vaccines for children from birth to age 18 – Doses, recommended ages and recommended populations vary:

a. Diphtheria, Tetanus, Pertussis (whooping cough)
b. Haemophilus influenza type b (Hib disease)
c. Hepatitis A
d. Hepatitis B
e. Human Papillomavirus (HPV)
f. Inactivated Poliovirus
g. Influenza (flu)
h. Measles, Mumps, Rubella
i. Meningococcal (e.g., meningitis)
j. Pneumococcal (e.g., pneumonia)
k. Rotavirus
l. Varicella (chicken pox)

20. Lead screening.

21. Medical history.

22. Obesity screening for children ages 6 years and older followed by comprehensive, intensive behavioral interventions to promote improvement in weight status.

23. Oral health risk assessment.

24. Phenylketonuria (PKU) screening for this genetic disorder in newborns.

25. Sexually transmitted infections – Intensive behavioral counseling and screening for adolescents.

26. Skin cancer behavioral counseling for children who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk.

27. Syphilis screening for children at increased risk.

28. Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents

29. Tuberculosis testing.

30. Vision acuity screening for all children.

Limitations and Exclusions

No benefits are payable under this provision for:

1. Medical examinations for Injury or Sickness;

2. Hearing Exams except as indicated above.

3. Third party requested physicals; or

4. Any dental examinations.

Additional Preventive Care Services

The Plan shall cover the following additional **Preventive Care services as outlined in the schedule of benefits:**

1. Breast cancer mammography screening coverage is increased to include screenings without age or frequency limitations. This includes screening mammograms that are converted to a medical diagnosis at the clinical encounter the screening is performed and any additional mammograms required for clarity.

2. Cervical cancer and dysplasia screening is increased to include screenings without age or frequency limitations.

3. Cholesterol screening coverage is increased to include screenings without age or risk limitations.

Medical Covered Expenses (continued)

4. Immunizations for the purpose of travel.

5. Prostate cancer screening.

6. Routine vision exams (including refractions)

7. Diabetes screening coverage is increased to include screenings without age or risk limitations.

PRESCRIPTION DRUG BENEFIT

Definitions apply to this benefit only:

Ancillary Charge: an additional charge will be required when the Participant chooses a brand medication for which a generic alternative is available. The Ancillary Charge is calculated as the difference between the brand medication and generic medication reimbursement rate for the Network Pharmacy.

Non-Participating Pharmacy: any retail or mail order pharmacy that is not contracted by the Pharmacy Benefits Administrator to be included in a network of pharmacies at a contracted amount.

Prescription Legend Drug: any medicine if the Federal Food, Drug and Cosmetic Act requires its label to say, "Caution: Federal Law prohibits dispensing without prescription."

Prescription Order: the request a licensed Physician, dentist, or registered podiatrist, makes for medicine for a patient.

Provider: a pharmacy, Physician or other entity with a legal license or registration to dispense drugs participating in the prescription drug program.

Pharmacy Benefits Administrator: an organization that manages payment for Prescriptions and services under the Plan.

Drugs Covered

1. legend drugs. Exceptions: See Exclusion list below;

2. amphetamines;

3. anabolic steroids;

4. insulin;

5. disposable insulin needles/syringes;

6. insulin injection devices, disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Test-Tape);

7. lancets;

8. blood glucose monitors; ABBOTT products only;

9. antivirals, specifically indicated for the treatment of HIV/AIDS;

10. growth hormones (requiring prior authorization);

11. Tretinoin Topical (e.g., Retin-A) for individuals through the age of 25 years;

12. prenatal and pediatric vitamins requiring a prescription;

13. meclizine tablets, over-the-counter (OTC) and legend;

14. *bowel preps for use in colorectal cancer screening. Over-the-counter (OTC) requires a prescription;

15. *aspirin to prevent cardiovascular disease. Over-the-counter (OTC) requires a prescription;

16. *aspirin to prevent preeclampsia. Over-the-counter (OTC) requires a prescription;

17. *breast cancer chemoprevention medications;

Medical Covered Expenses (continued)

18. *oral fluoride supplements. Over-the-counter (OTC) requires a prescription;
19. *folic acid supplements. Over-the-counter (OTC) requires a prescription;
20. *vitamin D supplements. Over-the-counter (OTC) requires a prescription;
21. *smoking deterrent medications. Over-the-counter (OTC) requires a prescription;
22. *immunizations;
23. *statin preventive medicine;
24. compounded medication of which at least one ingredient is a legend drug;
25. any other drug which under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.

* Type and dosage of medication, as well as age and gender criteria, are determined based on Affordable Care Act (ACA) requirements and recommendations by the U.S. Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) and Health Resources and Services Administration (HRASA). Contact your Pharmacy Benefit Manager for the most current listing of covered medications. Changes to the guidelines and recommendations will be adopted in compliance of the rules of the regulation.

Dispensing Limitations

The amount normally prescribed by a Physician but not to exceed a 30-day supply for retail or 90-day supply for mail order. Specialty drugs will not exceed a 90-day supply regardless of whether they are retail or mail order.

Additional Charges

Your drug benefit program is designed to help restore your health by helping you receive the most effective, affordable medications to treat your medical condition or disease state. This Plan encourages you to obtain high-quality generic drugs. Generic drugs provide the same effectiveness and safety as your brand name counterparts, but save a substantial amount of money. If you request a brand name medication when there is a generic available, you will be required to pay the difference in cost between the generic and the brand medication (Ancillary Charge) in addition to the deductible and coinsurance if applicable or in addition to the applicable Copay.

Specialty Medications

Your pharmacy benefit program may include coverage for certain products that are referred to as Specialty Medications. Medications covered under this provision include, but are not limited to, immunosuppressants, antiretrovirals, cancer therapies, recombinant biological pharmaceuticals, interferons, growth hormones, drugs to treat other rare disorders, and most injectable medications (except those specifically covered under the Prescription Drug Expense Benefit provision of this Plan).

If you are unsure if your medication is considered a specialty drug, please call the NPS helpdesk at (800) 546-5677 for further clarification concerning your medication.

Most Specialty Medications are injectables; however, some may be oral or transdermal. Specialty Medications may be medications that you administer to yourself or have a healthcare provider administer to you. When a Physician administers a covered Specialty Medication, you may be responsible to procure the product and take to your appointment with you. If Specialty Medications are covered under your pharmacy benefit and you choose to have the medication administered at your Physician's office, you may be billed for an office visit in addition to your prescription.

Prior Authorization

To promote appropriate utilization, selected high-risk or high-cost medications may require prior authorization to be eligible for coverage under the Participant's prescription drug benefit. To obtain a prior authorization, you or your pharmacy will need to contact the NPS helpdesk at (800) 546-5677 to request that a prior authorization be started for a specific medication. The helpdesk will need your Physician's name and fax number. The helpdesk will then fax a Coverage Determination Form to the doctor's office for the Physician to complete and fax back to NPS. Once the NPS clinical department has received the fax, they will have up to 48 hours to review the request.

Exclusions

1. anorectics (any drug used for the purpose of weight loss);
2. anti-wrinkle agents (e.g., Renova) regardless of intended use;
3. dermatologicals, hair growth stimulants;
4. dietary supplements, except specifically listed above in covered drugs;
5. contraceptives;
6. immunization agents, blood or blood plasma, except specifically listed above in covered drugs;
7. infertility medications (e.g., Clomid, Metrodin, Perfonal, Profasi);
8. erectile dysfunction drugs, all dosage forms;
9. female sexual dysfunction drugs, all dosage forms;
10. fluoride (topical fluoride dental products) other than those listed above;
11. non-legend drugs other than those listed above;
12. Tretinoin Topical (e.g., Retin-A) for individuals 26 years of age or older;
13. vitamins, singly or in combination except specifically listed above in covered drugs;
14. smoking deterrent medications containing nicotine or any other smoking cessation aids, other than those listed above;
15. therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, other than those listed above;
16. any medication, legend or not, which is taken or administered at the place where it is dispensed;
17. charges for the administration of or injection of any drug, other than those covered under the preventive benefit;
18. drugs labeled "Caution – Limited by federal law to Investigational use" or Experimental drugs, even though a charge is made to the individual;
19. medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
20. any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order.

OUTPATIENT HOSPITAL BENEFIT

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for the following outpatient services by a Qualified Treatment Facility:

1. Hospital miscellaneous charges for services and supplies of a Hospital provided on an outpatient basis.
2. Regularly scheduled treatments, such as physical therapy, kidney dialysis, chemotherapy, inhalation therapy and radiation therapy, when ordered by Your attending Qualified Practitioner and rendered on an outpatient basis.

EXPRESS/RETAIL WALK-IN CLINIC CARE

Covered Expenses will be reimbursed, as shown in the Schedule of Benefits, for charges made by an Express/Retail Walk-In Clinic Care Qualified Treatment Facility and Practitioner, on its own behalf, for services and supplies in connection with the Express/Walk In Care visit.

URGENT CARE

Covered Expenses will be reimbursed, as shown in the Schedule of Benefits, for charges made by an Urgent Care Qualified Treatment Facility and Practitioner, on its own behalf, for services and supplies in connection with the Urgent Care visit.

EMERGENCY ROOM MEDICAL CARE

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for the following services by a Qualified Treatment Facility emergency room:

1. Emergency Accident treatment provided within 48 hours of the Accident;
2. A surgical procedure; or
3. Treatment of a Sickness which is a medical Emergency.

AMBULATORY SURGICAL CENTER

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for charges made by an Ambulatory Surgical Center, on its own behalf, for services and supplies in connection with covered surgical procedures.

X-RAY AND LABORATORY TESTS

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for diagnostic x-ray and laboratory tests when performed by a Qualified Practitioner and not covered under the Hospital benefits provision of this Plan. These Covered Expenses do not include dental x-rays, unless related to a covered Injury.

AMBULANCE SERVICE BENEFIT

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for local professional ground ambulance service. If Your Injury or Sickness requires special treatment not available in a local Hospital, appropriate transportation to the nearest Hospital equipped to provide the necessary treatment is covered.

NATURAL FAMILY PLANNING

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for Natural Family Planning services provided by a Qualified Practitioner who is also a certified NFP instructor. Charges by the Qualified Practitioner for the following services are included:

1. Counseling;
2. Training in Natural Family Planning methods;
3. Follow-up sessions;
4. Textbooks;
5. Thermometer; and
6. Charting supplies.

To be eligible for benefits, the couple must be married and must be active participants of the Plan. Treatment of any covered medical conditions discovered as a result of these services will be paid like any other Sickness or Injury.

PREGNANCY/MATERNITY BENEFIT

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for services by Qualified Treatment Facilities and Qualified Practitioners on behalf of any female Participant on the same basis as a Sickness.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NEWBORN BENEFITS

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for newborn benefits. Note: The benefits described in this section are available only if You apply for coverage for Your newborn Dependent within 31 days of the birth. Refer to the "Eligibility" section of this booklet for more information.

Well-Newborn

Covered Expenses will be reimbursed, as shown in the Schedule of Benefits, for Hospital charges for nursery room and board, Hospital miscellaneous charges, the Qualified Practitioner's charges for circumcision of a male newborn Child, and the Qualified Practitioner's charges for routine examination of the newborn Child before release from the Hospital. (refer to Preventive Care benefit section for those services that are included within Healthcare Reform.)

Sick-Newborn

Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits, for expenses Incurred for necessary care and treatment of Injury or Sickness. Covered Expenses do not include Expense incurred for plastic or Cosmetic Surgery, except surgery for:

1. Reconstruction due to Injury, infection or other disease of the involved part; or

2. Congenital disease or anomaly which resulted in a functional defect.

BIRTHING CENTER BENEFIT

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for services and supplies provided for prenatal care and delivery of children.

SKILLED NURSING HOME BENEFIT

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for the following services by a Skilled Nursing Home which:

1. Begins within 14 days after discharge from an inpatient Hospital Confinement of at least three consecutive days, prior Skilled Nursing Home Confinement of at least three consecutive days or Outpatient observation (in lieu of Inpatient admission). If the Participant is Medicare eligible, the Confinement must meet Medicare guidelines;

2. Is necessary for care or treatment of the same Injury or Sickness which caused the prior Confinement or Outpatient observation; and

3. Occurs while You are under the regular care of the Qualified Practitioner who certified the required Skilled Nursing Home Confinement.

Covered Expenses will include semi-private daily room and board, including general nursing services and necessary miscellaneous services and supplies. Benefits are limited to 30 days per confinement.

HOME HEALTH CARE BENEFIT

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for Home Health Care, as described below:

The Maximum weekly benefit for such coverage will not exceed the Usual and Customary fee for weekly care in a Skilled Nursing Home facility.

Each visit by a person providing services under a home health care plan, or evaluating the need for, or developing a plan of home health care will be considered as one home health care visit.

Up to four consecutive hours of home health aide service in a 24-hour period is considered one home health care visit. A home health aide visit of four hours or more is considered one visit for every four hours or part thereof. Benefits are limited to 40 visits per Calendar Year.

Home Health Care will not be reimbursed unless the Qualified Practitioner certifies that:

1. Hospitalization or Confinement in a Skilled Nursing Home would be required if home care was not provided;

2. Necessary care and treatment are not available from members of Your immediate family or other persons residing with You, without causing undue hardship;

   Immediate family, for purposes of this section, means Your spouse, children, parents, grandparents, brothers and sisters and their spouses.

3. The home health care services will be provided or coordinated by a state-licensed or Medicare-certified Home Health Care Agency or certified rehabilitation agency.

If You were hospitalized immediately prior to the commencement of home health care, the home health care plan must also be initially recommended by the Qualified Practitioner who was the primary provider of services during Your hospitalization.

The home health care plan may consist of:

1. Part-time or intermittent home nursing care by or under the supervision of a registered nurse (RN);

2. Part-time or intermittent home health aide services which are necessary as part of the home health care plan, provided under the supervision of a registered nurse (RN) or medical social worker, and which consist solely of caring for the patient;

3. Physical, respiratory, occupational or speech therapy;

4. Medical supplies, Drugs and medications prescribed by a Qualified Practitioner and laboratory services by or on behalf of a Hospital, when necessary under the home care plan and to the extent such items would be covered under the Plan if You had been hospitalized.

5. Nutritional counseling provided under the supervision of a registered dietician, when such services are necessary as part of the home care plan; and

6. The evaluation of the need for and the development of a plan of home health care by a registered nurse (RN), physician assistant or medical social worker, when home health care is recommended or requested by Your attending Qualified Practitioner.

Specifically excluded from coverage under this benefit are the following:

1. Services and supplies not included in the home health care plan; and

2. Transportation services.

HOSPICE CARE BENEFIT

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for Hospice care when it is furnished in a Hospice Facility or by a Hospice Care Agency in Your home. A Qualified Practitioner must certify that You are terminally ill with a life expectancy of six months or less.

For hospice care only, Your immediate family is considered to be Your parent, spouse and dependent children.

When Hospice Care is in lieu of a covered Confinement in a Hospital or Skilled Nursing Home, Covered Expenses may include:

1. Room and board and other services and supplies;
2. Part-time nursing care by or supervised by a registered nurse (RN);
3. Counseling services by a licensed clinical social worker or pastoral counselor for the hospice patient and immediate family;
4. Medical social services provided to You or Your immediate family under the direction of a Qualified Practitioner. Services include:
   a. assessment of social, emotional and medical needs, and the home and family situation,
   b. identification of the community resources available and assisting in obtaining those resources;
5. Dietary counseling;
6. Consultation and case management services by a Qualified Practitioner;
7. Physical or occupational therapy;
8. Part-time home health aide service; and
9. Medical supplies, Drugs and medicines prescribed by a Qualified Practitioner.

Special Limitations on Hospice Care Benefits

Covered Expenses for Hospice Care do not include private or special nursing services, a Confinement not required for pain control or other acute chronic symptom management, funeral arrangements, or financial or legal counseling, including estate planning or drafting of a will.

Covered Expenses for Hospice Care do not include homemaker or caretaker services including a sitter or companion services, house cleaning or household maintenance, services of a social worker, other than a licensed clinical social worker, services by volunteers or persons who do not regularly charge for their services, or services by a licensed pastoral counselor to a member of his congregation.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for the following expenses Incurred for treatment of a Mental and Nervous Condition or for Substance Abuse:

1. Charges made by a Qualified Practitioner;
2. Charges made by a Qualified Treatment Facility;
3. Charges for Drugs which may be obtained only on the written prescription of a Qualified Practitioner.

Inpatient Benefits

Covered Expenses while confined as a registered bed patient in a Qualified Treatment Facility are payable as shown in the Schedule of Benefits. Treatment includes residential treatment services.

Outpatient Benefits

Covered Expenses for outpatient treatment received while not confined in a Hospital or Qualified Treatment Facility are payable as shown in the Schedule of Benefits. Treatment includes partial confinement and psychological testing.

Special Limitations on Nervous Conditions, Substance Abuse and Alcoholism

Covered Expenses for Nervous Conditions, Substance Abuse and alcoholism do not include treatment for court ordered examinations or counseling should this be the sole reason for treatment. This limitation does not apply if the treatment would otherwise be covered.

OTHER COVERED EXPENSES

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for the following:

1. Services of a registered nurse (RN) or licensed practical nurse (LPN) for nursing care ordered by Your attending Qualified Practitioner while You are not Confined.

2. Blood and/or blood plasma that is not replaced by donation and administration of blood and blood products including blood extracts or derivatives.

3. Prosthetic appliances for the replacement of the loss of natural limbs and eyes. Replacement appliances will only be covered when necessary due to a pathological change. Repair and maintenance expenses are not a Covered Expense under this Plan.

4. Special supplies when prescribed by Your attending Qualified Practitioner, including:
   a. Casts, splints, surgical dressings, trusses, braces and crutches,
   b. Oxygen and other gases, and rental of equipment for their administration,
   c. Catheters,
   d. Colostomy bags, belts and rings,
   e. Ureterostomy bags,
   f. Flotation pads,
   g. Needles and syringes,
   h. Custom-molded orthotics (with an exclusion on treating diagnosed flat feet), or
   i. Initial contact lenses or eyeglasses following cataract surgery.

5. Treatment of diabetes. Installation and use of an insulin infusion pump, other equipment and supplies (except where covered under the Prescription Drug Benefit) used in the treatment of diabetes, and diabetic self-management education programs. Coverage for an insulin infusion pump is limited to the purchase of one pump per year. The pump must be in use for 30 days before purchase. Insulin and syringes are covered under the Prescription Drug Benefit

6. Rental up to the total purchase price or, when approved by the Plan, purchase of a wheelchair, Hospital bed, respirator or other Durable Medical Equipment. Repair and maintenance expenses are not a Covered Expense under this Plan.

7. Mechanical medical devices implanted in a body cavity to aid the function of an internal body organ.

8. Chiropractic Care for the treatment of an Injury or Sickness. Routine or maintenance Chiropractic Care is not a Covered Expense. Benefits are paid as shown on the Schedule of Benefits.

9. Treatment by a licensed physical, speech or occupational therapist to restore loss or to correct impairment due to an Injury or Sickness. Charges for pool therapy, aquatic therapy and hydrotherapy are also recognized as Physical Therapy when performed by a Physical Therapist or other recognized licensed provider for Physical Therapy modalities, administered in a pool, which requires direct one-on-one patient contact. The therapist must be providing the therapy under the direction of a Physician for a condition that is Medically Necessary, Reasonable and appropriate for Physical Therapy treatment. Therapy will end when:
   a. treatment goals have been reached; or
   b. no substantive change is seen by the patient's condition after a reasonable period; or
   c. maximum medical improvement has been reached.

Medical Covered Expenses (continued)

10. Radiation therapy and chemotherapy.

11. Acupuncture and acupressure.

12. Services and supplies in connection with Medically Necessary non-Experimental transplant procedures, subject to the following conditions:
    a. a concurring opinion must be obtained prior to undergoing any transplant procedure. This mandatory opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this concurring opinion must be qualified to render such a service either through experience, specialist training, education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery;
    b. if the donor is covered under this Plan, eligible medical expenses Incurred by the donor will be considered eligible. If the donor is not covered under this Plan, reference provision (5);
    c. if the recipient is covered under this Plan, eligible medical expenses Incurred by the recipient will be considered eligible;
    d. if both the donor and the recipient and covered under this Plan, eligible medical expenses Incurred by each person will be treated separately for each person;
    e. the Usual and Customary fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology and pathology fees for the removal of the organ, and a Hospital's charge for storage or transportation of the organ will be considered eligible.

    Transplant coverage is limited to those transplants that are medically recognized and are non-Experimental/Investigational in nature.

13. Treatment of kidney disease, including dialysis.

14. Diagnostic testing for infertility. The plan will not cover any expenses or charges incurred by or for the treatment of infertility.

15. The initial pair of eyeglasses, vision aids or hearing aids needed as a result of an Injury sustained while covered under the Plan. This is not meant to cover the replacement of such items.

16. Services in connection with a mastectomy for which benefits are payable under the Plan and reconstructive surgery has been elected in a manner determined in consultation with the attending Physician and the patient:
    d. Reconstruction of the breast on which the mastectomy has been performed;
    e. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
    f. Prosthesis to replace the breast on which the mastectomy has been performed; and
    g. Physical complications resulting from all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes)

17. Covered Expenses incurred outside the United States, provided an itemized statement is submitted which includes a description of the services rendered, the diagnosis and the cost of each service. The cost of the services must be provided in U.S. currency, and any payments will be sent directly to the Employee.

18. Hair pieces and wigs for those who are undergoing chemotherapy and limited to a $400.00 Lifetime maximum benefit.

19. Charges for a qualified Participant for routine costs of an Approved Clinical Trial when the routine costs would be a Covered Expense if provided outside of the Approved Clinical Trial. This excludes:
    a. The Investigational item, device or service itself.
    b. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
    c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

    A qualified individual is a Participant who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or another life-threatening disease or condition. The referring health care provider must conclude that the Participant's involvement in the clinical trial is appropriate or the Participant must provide information establishing why participation in the clinic trial is appropriate.

Medical Covered Expenses (continued)

20. Charges for Virtual Care.

21. Sales tax, if any, on Medically Necessary services

22. Charges for diagnostic testing, intensive and non-intensive level services for autism disorder, Asperger's syndrome and any pervasive development disorder not otherwise specified. This coverage will be provided in accordance with all the terms and conditions of Wis. Stat. 632.895(12m), including the definition of a licensed provider, covered items, limitations, exclusions, applicable dollar limits, etc.

23. Hearing aids, cochlear implants and related treatment for Participants under age 18 only. Must be prescribed by a Physician for an eligible Participant who is certified as deaf or hearing impaired by a Physician or licensed Audiologist. Includes the cost of treatment related to hearing aids and cochlear implants including procedures for the implantation of cochlear devices. Hearing aids are limited to one hearing aid per ear once every 36 months. Coverage is excluded for Participants ages 18 and older.

LIMITATIONS AND EXCLUSIONS

This Plan does not provide benefits for:

1. Services or supplies:
   a. Furnished while You are not under the regular care of a Qualified Practitioner,
   b. Not authorized or prescribed by a Qualified Practitioner,
   c. That are provided to You for which the Provider of a service customarily makes no direct charge, or for which the Participant is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the Participant or this benefit plan, may be liable for necessitating the fees, care, supplies, or services.
   d. From providers who waive Copay, Deductible and coinsurance payments by the Participant, except in cases of undue financial hardship,
   e. Furnished by or payable under any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid), or
   f. Furnished in the treatment of any Uniformed Service-related Injury or Sickness (past or present) while You are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies.

2. Vision therapy (orthoptics), radial keratotomy or keratoplasty to correct refractive disorders, eyeglasses, (including for the treatment of keratoconus), or eyeglasses. The initial purchase of eyeglasses or contact lenses following cataract surgery is a Covered Expense.

3. Hearing aids or the fitting or repair of any hearing aid and cochlear implants except as specifically provided in the Plan or required due to an accidental Injury. The exclusion shall not apply to the initial purchase of a hearing aid if the loss of hearing is a result of a surgical procedure performed.

4. Prophylactic procedures to prevent a Sickness that has not yet occurred.

5. Exams directed or requested by a third party or a court of law; including but not limited to routine physical exams for licensure, occupation, sports participants, employment or the purchase of insurance. This does not include court-ordered exams for mental-health services.

6. Any charges for, relating to or resulting from sex change operations.

7. Any condition, Sickness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit: If you are covered as a Dependent under this Plan and you are self-employed or employed by an employer that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases workers compensation insurance will cover your costs, but if you do not have such coverage you may end up with no coverage at all.

8. Plastic or Cosmetic Surgery, including any services or supplies related to, resulting from complications of, or for reversal of Cosmetic Surgery, unless for reconstructive surgery due to Injury, infection or other disease of the involved part; or due to congenital disease or anomaly which resulted in a functional defect of a Dependent Child.

9. Dental care or treatment except as specifically described.

10. Any loss to a Participant who is not a member of the armed forces which was caused or contributed to by:
    a. War or any act of war, whether declared or not, or
    b. Any act of international armed conflict, or any conflict involving armed forces or any international authority.

11. Any Services that are Experimental or Investigational.

12. Services provided by a person who ordinarily resides in Your home or who is a Family Member.

13. Custodial Care.

14. Charges in excess of the Usual and Customary fee for the service or supply.

15. Any medical Expense Incurred prior to Your effective date or after the date Your coverage under the Plan terminates, except as specifically described.

Limitations and Exclusions (continued)

16. An Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occurs, criminal charges be filed, or if filed, that a conviction results. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

17. Services not Medically Necessary for diagnosis and treatment of an Injury or Sickness.

18. Private duty nursing while confined in a Hospital or other Qualified Treatment Facility.

19. Birth control Drugs, biologicals, implants and devices, whether or not dispensed by prescription, which are purchased or prescribed for the sole purpose of preventing conception.

20. Any charges that would have been paid by Your primary plan, as determined by the Coordination of Benefit rules of this Plan, if You had complied with all of the requirements of that plan, including any penalties for failure to pre-certify the services.

21. Abortions.

22. Dental implantology techniques, including prosthetic devices related to such techniques.

23. Charges incurred outside the United States, if You traveled to such location for the purpose of obtaining medical services, drugs or supplies.

24. Expenses in connection with the treatment of developmental delays, including but not limited to Speech Therapy, Occupational Therapy, Physical Therapy and any related diagnostic testing will not be considered eligible. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of ADD or ADHD or autism disorder, Asperger's syndrome, and any pervasive development disorder not otherwise specified. Coverage does not include services that are considered Experimental, Investigational and/or not Medically Necessary in the assessment and/or treatment of Autism Spectrum Disorders (ASD's).

25. Recreational and educational therapy; learning disabilities; behavior modification therapy; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships will not be considered eligible. This exclusion will not apply to diabetic self-management education programs or expenses related to the diagnosis, testing and treatment of ADD or ADHD or autism disorder, Asperger's syndrome, and any pervasive development disorder not otherwise specified. Coverage does not include services that are considered Experimental, Investigational and/or not Medically Necessary in the assessment and/or treatment of Autism Spectrum Disorders (ASD's).

26. Any charges for weight control or reduction including, but not limited to, nutritional supplements, dietary or nutritional counseling, individual or behavior modification therapy, body composition or underwater weighing procedures, exercise therapy, weight control or reduction programs, or any obesity surgery including but not limited to stomach stapling, gastric bubble, intestinal or stomach bypass or suction lipectomy.

27. Chelation (metallic ion therapy), except in the treatment of heavy metal poisoning.

28. Phone consultations, completion of claim forms or forms necessary for Your return to work or school, or for an appointment You did not attend.

29. Any charge for holistic medicine or other programs with an objective to provide complete personal fulfillment.

30. Homeopathic medicines and/or supplies.

31. Charges for a standby surgical team, unless surgery is actually performed.

32. Any charge for rolfing, colon therapy, homeopathy, reiki or visualization sessions.

33. Treatment of a sexual dysfunction including, but not limited to, implants and hormonal therapy.

Limitations and Exclusions (continued)

34. Genetic testing or counseling unless medically necessary to treat the sickness or injury of a Participant or used in the treatment of a high risk pregnancy or as otherwise specified in the Plan.

35. Elective sterilizations, vasectomies and tubal ligations.

36. Medical supplies and equipment for personal comfort, personal hygiene or convenience, including, but not limited to, air conditioners; air cleaners; humidifiers; physical fitness equipment; physician's equipment; disposable supplies, other than colostomy supplies; or self-help devices not medical in nature.

37. Any expense or charge incurred by or in behalf of a Participant for:
    a. Treatment of infertility;
    b. The promotion of fertility;
    c. Treatment to achieve a condition of pregnancy; or
    d. Treatment of a Sickness causing an infertility condition when such treatment is done in an attempt to bring about a pregnancy.

    For purposes of this exclusion, treatment includes, but is not limited to, all related charges for the following:
    a. Fertility tests and drugs;
    b. Tests and exams done to prepare for or follow through with induced conception;
    c. Sperm enhancement procedures; and
    d. Any artificial means to achieve pregnancy including, but not limited to:
        (1) Hormone therapy or drugs;
        (2) Artificial insemination;
        (3) In-vitro fertilization;
        (4) Embryo transfer; or
        (5) GIFT.

    As used in this exclusion, infertility means the condition of a person who is unable to conceive or produce conception.

    A resulting condition of pregnancy will be paid the same as any other Sickness subject to all of the terms and conditions of this Plan.

38. Charges for services and supplies that are to treat Injuries for which a Participant is reimbursed or may be entitled to be reimbursed by another party or insurer; however, the Plan may make payment on these claims if the terms of the Plan's Subrogation Provision have been satisfied.

39. Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

40. Any treatment, service or supplies due to complications of a non-covered expense.

41. Charges for routine, palliative or cosmetic foot care, including, but not limited to, treatment of weak unstable, flat, strained or unbalanced feet, unless an open-cutting operation is performed; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails unless the treatment is medically necessary. Medically Necessary pedicures provided by a qualified Health Care Professional are considered a Covered Expense.

42. Charges for wigs, artificial hair pieces, artificial hair transplants, or any drug, prescription or otherwise, used to eliminate baldness, unless specifically provided in the Plan

43. Services that are not "Reasonable," or are required to treat Sickness or Injuries arising from and due to a Provider's error, wherein such Sickness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and that are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

44. Expenses actually Incurred by other persons.

45. Services that are not accepted as standard practice by the AMA, ADA or the Food and Drug Administration.

Limitations and Exclusions (continued)

46. Services not actually rendered.

47. Services to the extent that payment under this Plan is prohibited by law.

48. Required as a result of unreasonable provider error.

49. Incremental nursing charges which are in addition to the Hospital's standard charge for Room and Board. This exclusion will not apply in the event that Room and Board charges are appropriately modified when billed with documented extraordinary or non-routine nursing care services, also known as incremental nursing charges.

50. Initial Friday, Saturday and Sunday Room and Board charges Incurred for Hospital confinement which begins on Friday, Saturday or Sunday. This exclusion does not apply to Emergency admissions or scheduled surgery within the 24-hour period immediately following Hospital admission.

51. Services of a Social Worker including a psychological or psychiatric Social Worker, other than for which there is a benefit available under Home Health Care Services, Hospice Care Services or the Outpatient treatment of a Mental and Nervous condition or alcohol/drug dependency.

52. Hospice care services by volunteers or individuals who do not regularly charge for their services. Hospice care services by a licensed pastoral counselor to a member of his or her congregation. These are the services in the course of duties to which he or she is called as a pastor or minister.

53. Vitamins, appetite suppressants, nutritional supplements, tobacco dependency products, contraceptives and over-the-counter drugs and prescription drugs with exact over-the-counter equivalents, except as specifically provided in the Plan.

54. Any loss directly or indirectly caused by or contributed to or arising from:
    a. ionizing radiation, pollution or contamination by radioactivity from nuclear waste from the combustion of nuclear fuel; and
    b. the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof, as covered under the U.S. Atomic Energy Pool.

55. Services that are not specifically covered under this Plan.

56. Pool therapy, aquatic therapy and hydrotherapy, except as specifically provided in the Plan. Charges for aquatic exercise programs or separate charges for the use of a pool will not be considered eligible.

57. Charges for any care, supplies, treatment and/or service that are required to treat Injuries that are sustained or an Sickness that is contracted, including infections and complications, while the Participant was under, and due to, the care of a provider wherein such Sickness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition (including both physical and mental health conditions). ***To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.***

Remember that the foregoing list of Limitations and Exclusions is not exhaustive. Please contact the Plan's Administrative Service Manager if You have any questions regarding the Plan's coverage of a particular expense.

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SECTION 2

DEFINITIONS

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DEFINITIONS

Certain words and phrases used in this Summary Plan Description are defined below as an explanation of how the terms are used. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this Summary Plan Description for that information.

Accident:

Accident means a happening, definite as to time and place, by chance and without intention or design, which is unforeseen and unexpected.

Actively at Work:

Actively at Work or Active Employment means performing on a regular full-time basis all customary occupational duties at the Employer's locations of religious service as:

1. A full-time teacher or other teacher working at least 30 hours per week during the school year (1,140 annual hours);

2. A non-teacher , school-year Employee working at least 30 hours per week during the school year (1,140 annual hours); or

3. All other Employees working at least 30 hours per week for 50 weeks per year (1,500 annual hours).

An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor. An Employee shall be deemed Actively at Work on any Employer-approved holiday or vacation provided that the Employee was Actively at Work on his last regularly scheduled working day before such vacation or holiday. In no event will an Employee be considered Actively at Work if he has effectively terminated employment.

Full-time, theology-level seminarians of the Diocese and Aspirants will be considered Actively at Work for purposes of eligibility under this Plan and will not be subject to the minimum hours requirement.

Administrative Period:

Administrative Period means a period of time selected by the Employer beginning immediately following the end of the Measurement Period and ending immediately before the start of the associated Stability Period. This period of time is used by the Employer to determine if Variable Hour Employees and/or Ongoing Employees are eligible for coverage and, if so, to make an offer of coverage.

Administrative Service Manager:

Administrative Service Manager is the person or firm employed by the Plan Administrator to provide certain services in connection with the operation of the Plan including the processing of claims. In the event that no Administrative Service Manager is employed by the Plan Administrator at any particular point in time, Administrative Service Manager will mean the Employer.

ADA:

ADA means the American Dental Association.

Adverse Benefit Determination:

Adverse Benefit Determination means any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A termination of benefits;
4. A rescission of coverage, even if the rescission does not impact a current claim for benefits;
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review; or
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

AHA:
AHA means the American Hospital Association.

Allowable Expenses:
Allowable Expenses means the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

AMA:
AMA means the American Medical Association.

Amendment:
Amendment means a formal document, duly authorized by the person or persons designated by the Plan Administrator, that changes the plan provisions of the Plan.

Ambulatory Surgical Center:
Ambulatory Surgical Center means any public or private state licensed and approved (whenever required by law) establishment with an organized medical staff of Qualified Practitioners, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous Qualified Practitioner services and registered professional nursing service whenever a patient is in the facility, and which does not provide service or other accommodations for patients to stay overnight.

Anesthesia:
Local Anesthesia means the condition produced by the administration of specific agents to achieve the loss of conscious pain response in a specific location or area of the body. General Anesthesia means the condition produced by the administration of specific agents to render the patient completely unconscious and completely without conscious pain response.

Anesthetic:
Anesthetic means a drug that produces loss of feeling or sensation either generally or locally.

Approved Clinical Trial:
Approved Clinical Trial means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, Centers for Medicare and Medicaid Services ("CMS"), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the FDA (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to

provide benefits for routine patient care services provided outside of the Plan's Network area unless out-of-network benefits are otherwise provided under the Plan.

Aspirants:

Aspirants are women committed to a full-time formation program including prayer, volunteer service and study at Mater Redemptories House of Formation connected with the Diocese of La Crosse.

Assignment of Benefits:

Assignment of Benefits means an arrangement whereby the Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an Assignment of Benefits previously issued to a provider at its discretion and continue to treat the Participant as the sole beneficiary.

Authorized Representative:

Authorized Representative means a Claimant may authorize a representative to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Claimant must authorize the representative in writing, and this written authorization must be provided to the Plan. The Plan will recognize this Authorized Representative when the Plan receives the written authorization. In the case of a claim involving urgent care, a Health Care Professional with knowledge of the Claimant's medical condition is also permitted to act as the Claimant's Authorized Representative.

Birthing Center:

A Birthing Center is a licensed facility which:

1. Provides:
   a. Prenatal care,
   b. Delivery and immediate postpartum care, and
   c. Care of a child born at the birthing center;
2. Is directed by a Qualified Practitioner specializing in obstetrics and gynecology;
3. Has a Qualified Practitioner or certified nurse midwife present at all births and during the immediate postpartum period;
4. Extends staff privileges to Qualified Practitioners who practice obstetrics and gynecology in the area;
5. Has at least two beds or birthing rooms for use by patients during labor and delivery;
6. Provides full-time skilled nursing services (directed by a RN or certified nurse midwife) in the delivery and recovery rooms;
7. Provides diagnostic x-ray and laboratory services for the mother and newborn;
8. Has the capacity to administer a local anesthetic and perform minor surgery (including episiotomy and repair of perineal tear);
9. Is equipped and staffed to handle medical emergencies and provide immediate life support measures;
10. Accepts only patients with low risk pregnancies;
11. Has a written agreement with an area Hospital for Emergency transfer of patients and ensures its staff is aware of the procedure;
12. Provides an ongoing quality assurance program; and
13. Keeps a medical record for each patient.

Calendar Year:

Calendar Year is the 12-month period of time beginning on January 1 and ending on December 31.

Child:
Child means, in addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, any stepchild, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the federal Omnibus Budget Reconciliation Act of 1993, or any other Child for whom the Employee has obtained legal guardianship.

CHIP:
CHIP refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to as such act, provision or section may be amended from time to time.

CHIPRA:
CHIPRA refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

Chiropractic Care:
Chiropractic Care means office visits, x-rays, manipulations, supplies, heat treatment and cold treatment.

Claim for Benefits:
Claim for Benefits means a request for a plan benefit or benefits made by a Participant in accordance with a Plan's Reasonable procedure for filing benefit claims. A Claim for Benefits includes and Pre-Service and Post-Service Claims. A request for benefits includes a request for coverage determination, for preauthorization or approval of a plan benefit, or for a utilization review determination in accordance with the terms of the Plan.

Clean Claim:
Clean claim is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Participant has failed to submit required forms or additional information to the Plan as well.

Complications of Pregnancy:
Complications of Pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy, but adversely affected by pregnancy or caused by pregnancy. Such conditions include acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;

2. A non-elective cesarean section surgical procedure;

3. A terminated ectopic pregnancy; or

4. A spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not mean:

1. False labor;

2. Occasional spotting;

3. Prescribed rest during the period of pregnancy; or

4. Similar conditions associated with the management of a difficult pregnancy, but not constituting a distinct complication of pregnancy.

Concurrent Care:
Concurrent Care means ongoing care or course of treatment.

Confinement:
Confinement means being admitted to a Hospital, Skilled Nursing Home or other Qualified Treatment Facility for treatment where charges are made for Room and Board to the Participant as a result of such treatment. Confinement does not include observational care.

Contract Year:
Contract Year is the 12-month period of time beginning on July 1 and ending on June 30.

Copay:
Copay means the charge a Participant pays for certain services under the Plan. The Participant pays the Copay directly to the provider of the health care.

Cosmetic Surgery or Cosmetic:
Cosmetic Surgery or Cosmetic means any Surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

Covered Expense:
Covered Expense means a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Participant's health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Schedule of Benefits and as determined elsewhere in this document.

Custodial Care:
Custodial Care means care or Confinement provided primarily for the maintenance of the Participant, essentially designed to assist the Participant, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Deductible:
Deductible means the amount of Covered Expenses which must be paid by a Participant before the Plan will begin reimbursement of additional Covered Expenses.

Dependent:
Dependent means one or more of the following person(s):

1. An Employee's lawfully married Spouse (of the opposite sex) under a legal marriage (who is neither divorced nor legally separated);

2. An Employee's common law spouse, based upon a common law marriage which is legally recognized in the jurisdiction in which the Employee has his principal residence;

3. An Employee's Child who is less than 26 years of age

4. An Employee's unmarried Child who was continuously covered prior to attaining the limiting age under (3) above, who is mentally or physically incapable of sustaining his own living and is still primarily dependent upon the Employee for support. Such Child must have been mentally or physically incapable of earning his own living prior to attaining the limiting age under (3) above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age of (3) above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two-year period, the Plan may require such proof, but not more often than once each year; or

5. A covered Employee's grandchild, as long as the Employee's covered Dependent child, who is the parent of the grandchild, is not yet 18 years old and unmarried.

6. An Employee's Child who was under the age of 27 when called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while a Full-Time Student at an institution of higher education

For the purposes of this Plan, the definition of Dependent does not include any person who is a member of the armed forces of any country or who is a resident of a country outside the United States.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.

Diagnostic Service:

Diagnostic Service means a test or procedure performed for specified symptoms to detect or to monitor a Sickness or condition. It must be ordered by a Qualified Practitioner.

Drug:

Drug means insulin and prescription legend drugs. A prescription legend drug is a Federal legend drug (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription") or a state restricted drug (any medicinal substance which may be dispensed only by prescription, according to state law) and which, in either case, is legally obtained from a licensed drug dispenser only upon a prescription of a currently licensed Physician.

Durable Medical Equipment:

Durable Medical Equipment means equipment which:

1. Can withstand repeated use;

2. Is primarily and customarily used to serve a medical purpose;

3. Generally is not useful to a person in the absence of an Sickness or Injury; and

4. Is appropriate for use in the home.

The equipment must be prescribed by a Physician as needed in the treatment of the Sickness or Injury and will be provided on a rental basis for the period of treatment unless the cost for rental for such a period is in excess of the purchase price. Purchase of the equipment will then be considered by the Plan Administrator.

Durable Medical Equipment does not include:

1. items and self-help devices not chiefly medical in nature;
2. items for comfort and convenience;
3. Physician's equipment;
4. disposable supplies unless provided in connection with direct Physician care or covered home care; or
5. exercise and hygienic equipment.

Embedded:
Embedded means an Embedded deductible wherein the individual deductible is included within the family deductible. Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits. For example, if there is a family deductible of $3,000 with an individual Embedded deductible of $1,500, then when any one individual family member reaches $1,500 in expenses, their benefit plan coverage takes effect.

Emergency:
Emergency means a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan Administrator may, in its discretion, request satisfactory proof that an Emergency or acute condition did exist.

Emergency Medical Condition:
Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

Emergency Services:
Emergency services mean, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Employee:
Employee means a person who is a regular full-time Employee of the Employer, regularly scheduled to work for the Employer in an employer-Employee relationship as follows:

1. a full-time teacher or other teacher working at least 30 hours per week during the school year (1,140 annual hours);

2. a non-teacher, school-year Employee working at least 30 hours per week during the school year (1,140 annual hours); or

3. all other Employees working at least 30 hours per week for 50 weeks per year (1,500 annual hours).

A full-time, theology-level seminary student of the Diocese and Aspirants are also considered an Actively at Work Employee for purposes of eligibility under this Plan.

The following Employees shall not be eligible Employees: i) leased Employees, as defined in Code Section 414(n), ii) individuals classified by the Employer as temporary Employees due to their limited work assignment which will not exceed 90 days, iii) individuals classified by the Employer as independent contractors or leased Employees (including those who are at any time reclassified as Employees by the Internal Revenue Service or a court of competent jurisdiction).

Employer:
Employer means Diocese of La Crosse, the sponsor of this Plan.

Enrollment Date:
Enrollment Date means the first day of coverage (or, if there is a Waiting Period, the first day of the Waiting Period).

Essential Health Benefits:

"Essential Health Benefits" shall mean, under section 1302(b) of the Affordable Care Act (ACA), those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care

Experimental or Investigational:

Experimental or Investigational means services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or

2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
   a. maximum tolerated dose;
   b. toxicity;
   c. safety;
   d. efficacy; and
   e. efficacy as compared with the standard means of treatment or diagnosis; or

3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
   a. maximum tolerated dose;
   b. toxicity;
   c. safety;
   d. efficacy; and
   e. efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;

2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or

3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

Express/Retail Walk-In Clinic:

Means a walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other place of service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.

Family and Medical Leave Act of 1993:
All previous provisions including coverage under this Plan, effective date of coverage and termination of coverage are intended to be in compliance with the Family and Medical Leave Act of 1993 (FMLA), as amended. To the extent the FMLA applies to the Employer, group health benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements, the obligations of the Employer and Employee concerning conditions of leave, notification and reporting requirements are specified in the FMLA. Any plan provisions which conflict with the FMLA are superseded by the FMLA to the extent such provisions conflict with the FMLA.

Family Member:
Family Member means Your lawful spouse, Child, parent, grandparent, brother or sister, or any person related in the same way to Your covered Dependent(For purposes of this section, "marriage or married" means a legal union between one man and one woman as husband and wife.).

FMLA:
FMLA means the Family and Medical Leave Act of 1993, as amended.

FMLA Leave:
FMLA Leave means a leave of absence, which the Company is required to extend to an Employee under the provisions of the FMLA.

Final Internal Adverse Benefit Determination:
Final Internal Adverse Benefit Determination shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

Genetic Information:
Genetic Information means and includes information about an individual's genetic tests and the genetic tests of an individual's family members, as well as information about any disease, disorder, or condition of an individual's family members (i.e., an individual's family medical history).

GINA:
GINA means the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of Genetic Information.

Health Care Professional:
Health Care Professional means a Physician or other Health Care Professional licensed, accredited, or certified to perform specified health services consistent with State law.

HIPAA:
HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended

Home Health Care Agency:
Home Health Care Agency means an agency or organization which provides a program of home health care and which fully meets one of the following three tests:

1. it is approved under Medicare;

2. it is established and operated in accordance with the applicable licensing and other laws;

3. it meets all of the following tests:
   a. it has the primary purpose of providing a home health care delivery system bringing supportive services to the home;
   b. it has a full-time administrator;
   c. it maintains written records of services provided to the patient;
   d. its staff includes at least one Registered Nurse (R.N.) or it has nursing care by a Registered Nurse (R.N.) available;

e. its Employees are bonded and it provides malpractice insurance.

Hospice:

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

Hospice Care Agency:

Hospice Care Agency means an agency which has the primary purpose of providing hospice services to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meet all of the following requirements: has obtained any required certificate of need; provides 24 hour a day, seven days a week service, supervised by a Qualified Practitioner; has a full-time coordinator; keeps written records of services provided to each patient; has a nurse coordinator who is a registered nurse (RN) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients; and has a licensed social service coordinator.

A Hospice Care Agency will establish policies for the provision of hospice care, assess the patient's medical and social needs and develop a program to meet those needs. It will provide an ongoing quality assurance program, permit area medical personnel to use its services for their patients and use volunteers trained in care of and services for non-medical needs.

Hospice Care Program:

Hospice Care Program means a written plan of hospice care which is established and reviewed by the Qualified Practitioner attending the person and the Hospice Care Agency, and provides palliative and supportive care to hospice patients. It offers supportive care to the families of the hospice patients, an assessment of the hospice patient's medical and social needs, and a description of the care necessary to meet those needs.

Hospice Facility:

A Hospice Facility means a licensed facility, or part of a facility, which principally provides hospice care, has 24-hour a day nursing services provided under the direction of a registered nurse (RN), has a full-time administrator, keeps medical records of each patient, has an on-going quality assurance program, and has a Qualified Practitioner on call at all times.

Hospital:

Hospital means an institution accredited by the Joint Commission on Accreditation of Hospitals (sponsored by the AMA and the AHA), under the supervision of a staff of Physicians that maintains diagnostic and therapeutic facilities on premises, for the provision of medical (including surgical facilities for all institutions other than those specializing in the care and treatment of mentally ill patients, provided such institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA), diagnosis, treatment, and care to Injured or sick persons on an Inpatient basis with 24-hour a day nursing service by Registered Nurses.

To be deemed a "Hospital," the facility must be duly licensed, if it is not a State tax supported institution, and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution; or an institution which is supported in whole or in part by a Federal government fund.

Institutions and/or facilities not deemed to be a "Hospital" in accordance with Medicare shall not be deemed to be Hospitals for this Plan's purposes.

Hour of Service:

Hour of Service means each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer, and each hour for which an Employee is paid, or entitled to payment by the Employer for a period of time during which no duties are performed due to vacation, holiday, Sickness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Injury:
Injury means physical damage to the body caused by an external force and due directly and independently of all other causes to an Accident which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit. Muscle tiredness or soreness resulting from overexertion in an athletic or physical activity is considered a Sickness under the Plan.

Incurred:
Incurred means that a Covered Expense is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps of phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Inpatient:
Inpatient means the classification of a Participant when that person is admitted to a Hospital, Hospice, Specialized Treatment Facility or Skilled Nursing Facility for treatment and charges are made for Room and Board to the Participant as a result of such treatment.

Late Enrollee:
Late Enrollee means an individual who is enrolled for coverage after the expiration of the initial eligibility date described in Section 3. Note, however, a Special Enrollee shall not be considered a Late Enrollee.

Legally Employed:
Legally Employed means the Employee has presented valid documentation to the Employer showing evidence of his or her authorization to work in the United States.

Licensed Practical Nurse (L.P.N.):
Licensed Practical Nurse (L.P.N.) means an individual who has received specialized nursing training, performs practical nursing services and is licensed by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

Lifetime:
When used in reference to benefit Maximums and limitations, Lifetime means the time a Participant is covered under this Plan. In no circumstances does Lifetime mean a Participant's life span.

Maximum Amount and/or Maximum Allowable Charge:
Maximum Amount and/or Maximum Allowable Charge will be a negotiated rate, if one exists. In the absence of a negotiated rate, the Maximum Amount(s) will be calculated by the Plan Administrator taking into account any or all of the following:

1. The Usual and Customary amount;

2. The allowable charge specified under the terms of the Plan;

3. The Reasonable charge specified under the terms of the Plan; or

4. The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

Mastectomy:
Mastectomy means the surgical removal of all or part of a breast.

Measurement Period:
Measurement Period means a period of time selected by the Employer during which Variable Hour Employee's and/or Ongoing Employee's hours of service are tracked to determine your employment status for benefit purposes.

1. Initial Measurement Period – for a newly hired Variable Hour Employee, a Measurement Period that will start from the date of hire and end after 12 consecutive months of service.

2. Standard Measurement Period – for Ongoing Employees, this Measurement Period will start on August 1 each year and will last for 12 consecutive months.

Medical Care Necessity/Medically Necessary/Medical Necessity:

Medical Care Necessity/Medically Necessary/Medical Necessity means health care services ordered by a Physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, diagnosis or treatment of that Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be not more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Participant's Sickness or Injury without adversely affecting the Participant's medical condition.

1. It must not be maintenance therapy or maintenance treatment.

2. Its purpose must be to restore health.

3. It must not be primarily custodial in nature.

4. It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).

5. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participantis receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medical Record Review:

Medical Record Review is the process by which the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the **Maximum Allowable Charge** according to the medical record review and audit results.

Medicare:

Medicare means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Mental or Nervous Condition:

Mental or Nervous Condition means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and Human Services; or is listed in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association.

Network or PPO Network:
Network or PPO Network means the medical provider network ("PPO") allowing discounted fees for services to Participants. The PPO will be identified on the Participant's identification card.

New Employee:
New Employee means an Employee who has not been employed for at least one complete Standard Measurement Period, or who is treated as a New Employee following a period during which the Employee was credited with zero Hours of Service.

Non-Variable Hour Employee:
Non-Variable Hour Employee means an Employee reasonably expected at the time of hire to work 30 or more hours per week.

Nurse-Midwife:
Nurse-Midwife means a person who is licensed or certified to practice as a Nurse-Midwife and fulfills both of these requirements:

1. a person licensed by a board of nursing as a Registered Nurse;

2. a person who has completed a program approved by the state for the preparation of Nurse-Midwives.

Nurse Practitioner:
Nurse Practitioner means an individual who is licensed as a Registered Nurse under Chapter 441, Wisconsin Statutes or the laws of another state and who satisfies any of the following:

1. is certified as a primary care Nurse Practitioner or clinical nurse specialist by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates;

2. holds a master's degree in nursing from an accredited school of nursing;

3. prior to March 31, 1990, has successfully completed a formal one-year academic program that prepares Registered Nurses to perform an expanded role in the delivery of primary care, included at least four months of classroom instruction and a component of supervised clinical practice and awards a degree, diploma or certificate to individuals who successfully complete the program; or

4. has successfully completed a formal education program that is intended to prepare Registered Nurses to perform an expanded role in the delivery of primary care but that does not meet the requirements of (3) above, and has performed an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately before July 1, 1978.

Occupational Therapy:
Occupational Therapy means a program of care which focuses on the physical, cognitive and perceptual disabilities that influence the patient's ability to use his fingers and hands, (fine motor skills), perceptual skills, cognitive functioning and eye-hand coordination. Therapy sessions may also involve physical movement exercises. Functional tasks also may be used. The therapist may also perform splinting of the patient's arms or hands and may provide the patient with special equipment. Therapy which is intended to address primarily vocational rehabilitation issues (i.e., return to work skills) will not be considered covered services under this Plan.

Ongoing Employee:
Ongoing Employee means an Employee who has been employed by the Employer for at least one complete Measurement Period.

Open Enrollment:
Open Enrollment means the period that occurs annually during which Employees can enroll themselves and their eligible Dependents (as Late Enrollees), make other enrollment changes or switch to a different medical plan sponsored by the Employer (if applicable). Coverage for those enrolling during the Open Enrollment Period will become effective on the Plan's anniversary date.

Employees may only enroll during their initial 31-day eligibility period or an Open Enrollment Period unless You qualify as a Special Enrollee (see Section 3).

Other Plan:
Other Plan shall include, but is not limited to

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering the Participant;
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Worker's compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, and medical Disability or other benefit payments, and school insurance coverage.

Other Services and Supplies:
Other Services and Supplies means services and supplies furnished to the individual and required for treatment, other than the professional services of any Physician and any private duty or special nursing services (including intensive nursing care by whatever name called).

Outpatient:
Outpatient means the classification of a Participant when that Participant receives medical care, treatment, services or supplies at a clinic, a Physician's office, a Hospital if not a registered bed patient at that Hospital or Outpatient Specialized Treatment Facility.

Participant:
Participant means any Employee or Dependent who has been enrolled and approved for coverage under the Plan.

Physical Therapy:
Physical Therapy means a plan of care provided to return a patient to the highest level of motor functioning possible. The physical therapist extensively evaluates the patient's muscle tone, movement, balance, endurance, ability to ambulate, ability to plan motor movements, strength and coordination. If the patient requires special equipment (such as a wheelchair, walker or splint) the therapist evaluates the patient's ability to use the equipment and determines the correct size and type of equipment for the specific patient. The therapist constructs a program of exercises and movements to maximize the patient's motor skills.

Physician:
Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), psychiatrist or midwife.

Plan:
Plan means this Plan of benefits, established by the Plan Sponsor and administered by the Plan Administrator, including any schedules, attachments and Amendments to the Plan. The Plan is a legal entity. This Summary Plan Description provides a description of the Plan.

Plan Administrator:
Plan Administrator means St. Ambrose Financial Services, Inc., who is responsible for the day-to-day functions and engagement of the Plan. The Plan Administrator may employ other persons or firms to process claims and perform other Plan connected services.

Plan Sponsor/Named Fiduciary:
Plan Sponsor/Named Fiduciary means Diocese of La Crosse, which has the authority to control and manage the operation of the Plan.

Plan Year:
Plan Year means a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

Post-Service Claim:
Post-Service claim means all claims that are not Pre-Service claims.

Pre-Admission Tests:
Pre-Admission Tests means tests performed on You or Your dependent in a Hospital before confinement as a resident Inpatient provided they meet all of the following requirements:

1. the tests are related to the performance of scheduled surgery;
2. the tests have been ordered by a Physician after a condition requiring surgery has been diagnosed and Hospital admission for surgery has been requested by the Physician and confirmed by the Hospital;
3. You or Your dependent are subsequently admitted to the Hospital or the confinement is canceled or postponed because a Hospital bed is unavailable or because there is a change in Your or Your dependent's condition which precludes the surgery.

Pre-Service Claim:
Pre-Service claim means any request for approval of a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Preferred Provider:
Preferred Provider means a Physician, Hospital or other provider that is currently a participating member of a network of providers who have agreed with the Plan to provide services to eligible Participants at a negotiated rate. For prescription drugs available through the prescription drug and/or specialty drug program (as applicable), Preferred Provider means the prescription drug card program or specialty drug program and does not include any other network of providers with which the Plan contracts.

Pregnancy:
Pregnancy means carrying a child, resulting childbirth, miscarriage and non-elective abortion. The Plan considers Pregnancy as a Sickness for the purpose of determining benefits.

Preventive Care:
Preventive Care means certain Preventive Care services and capitalized wording in document. This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer in-Network coverage for certain preventive services without cost-sharing. To comply with the ACA, and in accordance with the recommendations and guidelines, the Plan will provide in-Network coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org or at https://www.healthcare.gov/coverage/preventive-care-benefits. For more information, you may contact the Plan Administrator / Employer.

Prior to Effective Date or After Termination Date:
Prior to Effective Date or After Termination Date are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

PPO (Preferred Provider Organization):
PPO means the medical provider network ("PPO Network") allowing discounted fees for services to Participants. The PPO will be identified on the Participant's identification card.

Psychiatric Hospital:
Psychiatric Hospital means a Qualified Treatment Facility constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician;

2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;

3. It is licensed as a psychiatric hospital;

4. It requires that every patient be under the care of a Physician; and

5. It provides 24-hour-a-day nursing service.

The term Psychiatric Hospital does not include a Qualified Treatment Facility, or that part of a Qualified Treatment Facility, used mainly for nursing care, rest care, Skilled care, care of the aged, Custodial Care or educational care.

Psychiatric (Mental/Nervous) Treatment Facility:
Psychiatric (Mental/Nervous) Treatment Facility means an administratively distinct governmental, public, private or independent unit or part of such unit that provides psychiatric services and care; such facility is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse (R.N.); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs which is supervised by a Physician and meets appropriate licensing standards.

Psychologist:
Psychologist means such person:

1. who is so licensed; or
2. who is so certified; or
3. who is listed in the National Register of Health Service Providers; or
4. who is a diplomat in clinical psychology through the American Board of Professional Psychologists.

Qualified Practitioner:
Qualified Practitioner means a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

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

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

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

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

Registered Nurse (R.N.):
Registered Nurse (R.N.) means an individual who has received specialized nursing training and is authorized to use the designation "R.N." and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Rescission or Rescind:
Rescission or rescind is a cancellation of coverage or discontinuance of coverage under the Plan that has retroactive effect, unless attributable to: a) failure to timely pay the cost of coverage; or b) fraud or intentional misrepresentation of material fact, as those circumstances are described under Health Care Reform and regulatory guidance.

Room and Board:
Room and Board means room, board, general duty nursing, intensive nursing care by whatever name called and any other services regularly furnished by the Hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of Physicians nor special nursing services rendered outside of an Intensive Care Unit by whatever name called.

Qualified Treatment Facility:
Qualified Treatment Facility means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, Psychiatric Treatment Facility, Substance Abuse Treatment Center, alternative Birthing Center, Home Health Care Center, or any other such facility that the Plan approves.

Sickness:
Sickness means any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an employee under any worker's compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness.

Skilled Nursing Home:
A Skilled Nursing Home is an institution, or distinct part thereof, which is lawfully run in the jurisdiction where it is located and maintains and provides:

1. Permanent and full-time bed care facilities for resident patients;

2. A Qualified Practitioner's services available at all times;

3. A registered nurse (RN) or Qualified Practitioner in charge and on full-time duty and one or more registered nurses (RN's) or licensed vocational or practical nurses on full-time duty;

4. A daily record for each patient; and

5. Continuous skilled nursing care for persons during their convalescence from Sickness or Injury.

A Skilled Nursing Home is not, except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of drug addicts or alcoholics.

Skilled Nursing Home also includes any institution referring to itself as a skilled nursing facility or extended care facility.

Social Worker:
Social Worker means only a person who specializes in clinical social work and is licensed or certified as a Social Worker by the appropriate authority.

Special Enrollee:
A Special Enrollee is an eligible Employee or eligible Dependent who is entitled to and who requests Special Enrollment (as described in Section 3):

1. Within 31 days of losing other health coverage; or

2. For a newly acquired Dependent, within 31 days of the marriage, birth, adoption or placement for adoption.

Speech Therapy/Pathology:
Speech Therapy/Pathology means a program of care which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his social interaction skills such as the ability to maintain eye contact and initiate conversation. Therapy may also involve developing the patient's speech, listening and conversational skills and higher-level cognitive skills such as understanding abstract thought, making decisions, sequencing, etc. Therapy may be considered medically appropriate even for patients who do not have apparent speech problems, but who have deficits in higher level language functioning as a result of trauma or identifiable organic disease process.

Spouse:
Spouse means an Employee’s lawfully married husband or wife (of the opposite sex) under a legal marriage (who is neither divorced nor legally separated).

Stability Period:
Stability Period means a period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period and the Administrative Period associated with that Standard Measurement Period or Initial Measurement Period and is used by the Employer as part of the look-back measurement method. The Stability Period is a 12 month period in which the Variable Hour Employee’s and/or Ongoing Employee’s eligibility status is fixed.

Substance Abuse And/or Substance Use Disorder:
Substance Abuse And/or Substance Use Disorder means any use of alcohol, any drug (whether obtained legally or illegally), and narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of “Substance Use Disorder” is applied as outlined below.

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
    a. recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);
    b. recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
    c. craving or strong desire or urge to use a substance; or

d. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with Spouse about consequences of intoxication, physical fights);

Substance Abuse Treatment Center:

Substance Abuse Treatment Center means a Qualified Treatment Facility which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. The Qualified Treatment Facility must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;

2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or

3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a state agency having legal authority to do so.

Total Disability or Totally Disabled:

For an Employee or an employed spouse covered under this Plan, Total Disability means that, during the first 12 months of disability, the Employee or the covered spouse of an Employee is prevented by Injury or Sickness from performing each and every material duty of his or her job or occupation.

After the first 12 months disability, Total Disability or Totally Disabled means that the Employee or the covered spouse of an Employee is at all times prevented by Injury or Sickness from engaging in any job or occupation for wage or profit for which he or she is reasonably qualified by education, training, or experience.

Total Disability of a non-employed spouse or Child means being house- or inpatient-facility confined due to an Injury or Sickness.

Uniformed Services:

Uniformed Services means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

Urgent Care Claim:

Means any Pre-Service Claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function, or in the opinion of a Physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A Post-Service Claim is never an Urgent Care Claim.

USERRA:

USERRA means the Uniformed Services Employment and Reemployment Rights Act under which Employees will be eligible for coverage on the date they return to work, provided the Employee returns to work with the Employer within the specified time period in the Uniformed Services Employment and Reemployment Rights Act (USERRA). Coverage for a reservist will be on the same basis it is for active employees and dependents. Eligibility Waiting Periods will be imposed only to the extent they are applicable prior to the period of uniformed services.

Usual and Customary:

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

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

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

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Participant by a Provider of services or supplies, such as a physician, therapist, nurse, Hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

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

Variable Hour Employee:

Variable Hour Employee means an Employee, based on the facts and circumstances at the Employee's start date, whose reasonable expectation of average hours per week cannot be determined

Virtual Care:

Virtual Care means professional evaluation and medical management services provided to patients through live, interactive audio and visual transmissions. Virtual Care is used to address non-urgent medical symptoms for patients describing new or ongoing symptoms to which Physicians respond with substantive medical advice. Virtual Care does not include services that do not involve direct in person patient contact such as telephone calls or emails.

Waiting Period:

Waiting Period means the period of Active Employment before an eligible Employee or eligible Dependent may become covered under this Plan.

You and Your:

You and Your refers to an eligible covered Employee and any of his eligible covered Dependents, where appropriate in context and unless otherwise indicated.

SECTION 3

ELIGIBILITY

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ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

These provisions apply to Employees who become eligible on or after the effective date of this Plan and to Dependents who become eligible on or after the effective date of this Plan.

Employees who were eligible and covered under any plan that this Plan replaces will be eligible on the Effective Date of this Plan. Any Waiting Period or portion thereof satisfied under the prior plan will be applied toward satisfaction of the Waiting Period of this Plan. Eligibility will include Dependents of such an Employee.

EMPLOYEE COVERAGE

Employee Eligibility

You are eligible for coverage under the Plan if the following conditions are met:

1. You are a Non-Variable Employee who is a regular full-time Employee of the Employer, regularly scheduled to work for the Employer in an employer-Employee relationship as follows and You satisfy a Waiting Period of full-time employment with the Employer.
   a. a full-time teacher or other teacher working at least 30 hours per week during the school year (1,140 annual hours);
   b. a non-teacher, school-year Employee working at least 30 hours per week during the school year (1,140 annual hours); or
   c. all other Employees working at least 30 hours per week for 50 weeks per year (1,500 annual hours).
   d. full-time, theology-level seminarians of the Diocese of La Crosse.
   e. Aspirants of the Diocese of La Crosse

   and You satisfy a Waiting Period of full-time employment with the Employer.

   OR

   You are a Variable Hour Employee who in no event shall average the amount of time worked less than 30 hours per week or 130 hours per month during a completed Measurement Period. A Variable Hour Employee will remain eligible throughout the Stability Period regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an Employee in accordance with the Affordable Care Act (ACA) as amended.

2. You are Legally Employed.

The following Employees shall not be eligible Employees: i) leased Employees, as defined in Code Section 414(n), ii) individuals classified by the Employer as temporary Employees due to their limited work assignment which will not exceed 90 days, iii) individuals classified by the Employer as independent contractors or leased Employees (including those who are at any time reclassified as Employees by the Internal Revenue Service or a court of competent jurisdiction).

Your eligibility date is the date You satisfy the above conditions.

Employee Effective Date

Your effective date will be the first day of the month following Your eligibility date if You are a Non-Variable Hour Employee. Your coverage under this Plan will commence on Your effective date provided that You have enrolled on forms furnished and accepted by the Plan Administrator within 31 days of Your first day of work, and You are making any required contributions.

Each Variable Hour Employee who has averaged the requisite Hours of Service, as defined herein, will become eligible for coverage under this Plan with respect to himself or herself upon completion of a complete Measurement Period. Coverage shall begin on the first day of the Stability Period, as defined herein.

If Your completed enrollment forms are received by the Plan Administrator **more than 31 days after** Your first day of work, You will be a **Late Enrollee.** Application for coverage as a Late Enrollee is limited to Special Enrollment or to Open Enrollment in June of each year.

An eligible Employee must begin active work with the Employer before coverage will be effective under the Plan. Employee coverage will begin at 12:01 AM on the Employee's effective date of coverage under the Plan.

DEPENDENT COVERAGE

Dependent Eligibility

A Dependent will be considered eligible for coverage in accordance with the following:

1. Newborn or newly adopted children of a covered Employee will be eligible from the moment of birth or placement for adoption provided the child is properly enrolled on a form furnished and accepted by the Plan Administrator as a Dependent of the Employee within 31 days of the child's date of birth or placement for adoption.

2. A Spouse will be considered an eligible Dependent from the date of marriage, provided the Spouse is properly enrolled on a form furnished and accepted by the Plan Administrator as a Dependent of the Employee within 31 days of the date of marriage.

   If a Dependent is acquired other than at the time of birth, due to a court order, decree or marriage, that Dependent will be considered an eligible Dependent from the date of such court order, decree or marriage, provided that this new Dependent is properly enrolled on a form furnished and accepted by the Plan Administrator as a Dependent of the Employee within 31 days of the court order, decree or marriage.

3. A Dependent acquired through a Qualified Medical Child Support Order, a National Medical Support Notice or a Medical Child Support Order will be subject to the eligibility and effective date provisions contained in the section "Qualified Medical Child Support Order".

An Employee may cover Dependents only if the Employee is also covered.

If both parents are eligible for coverage under this Plan, only one may enroll eligible Dependents for coverage.

An individual's eligibility for any state Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.

Dependent Effective Date

An Employee who makes written request for Dependent Coverage shall have such coverage as follows:

1. If You make such written request within 31 days of Your effective date, Your eligible Dependents shall become covered as of Your Effective date.

2. For newly acquired Dependents, if You make such written request within 31 days of the Dependents' eligibility date, coverage will become effective for those Dependents on their eligibility date or the first day of the month following the date of the application is received. Newborns, adopted children or children placed for adoption can only be added on the date of birth, adoption or placement for adoption.

3. Except as otherwise provided under "Special Enrollment Period" or "Open Enrollment Period", if You make such written request more than 31 days after the date on which a Dependent became eligible for Dependent coverage, such Dependent will be a **Late Enrollee**, and will not be covered under this Plan except as provided in the section for Special and Open Enrollment.

4. A Dependent acquired through a Qualified Medical Child Support Order, a National Medical Support Notice or a Medical Child Support Order will be subject to the eligibility and effective date provisions contained in the section "Qualified Medical Child Support Order."

5. A Dependent acquired through legal guardianship can only be added on the date on which such Child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child

Dependent coverage will begin at 12:01 AM on the Dependent's Effective Date of coverage under the Plan.

SPECIAL AND OPEN ENROLLMENT

If You have a special enrollment event, the Plan will provide a new enrollment date for You to enter the Plan as shown below. At that time, You will be able to enroll in the Plan without being subject to the Late Enrollee provisions of the Plan. If the Plan has more than one benefit option, You will be able to select from all options for which You are eligible.

Special Enrollment for Individuals Losing Coverage

You and Your Dependents are entitled to enroll in the Plan during a Special Enrollment Period if You meet all of the following requirements:

1. You are eligible for coverage under the Plan but are not currently covered under the Plan;

2. You previously declined to enroll in the Plan and signed a written waiver of coverage, stating as the reason the existence of alternative group or other health coverage (including COBRA); and

3. You were covered under such alternative group or other health coverage at the time You signed the waiver, and such coverage is no longer available, for any of the reasons set forth below.

A loss of coverage occurs if the other coverage ends:

1. Due to Your exhaustion of the maximum COBRA period;

2. Due to Your loss of eligibility. "Loss of Eligibility" means loss of coverage resulting from:
   a. termination of employment, a reduction in the number of hours of employment, or any loss of eligibility after a period that is measured based on any of those events;
   b. legal separation or divorce;
   c. death;

   Loss of Eligibility shall not mean loss of coverage resulting from an individual's failure to pay premiums on a timely basis or any termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of fact in connection with such coverage.)

3. Due to termination of employer contributions towards the cost of the other coverage.

A special enrollment event occurs when one of the above takes place. You **must** provide proof that the other coverage was lost due to one of the above shown reasons. At that time, an Employee or Dependent may be enrolled in this Plan as follows:

1. When the Employee has a loss of coverage, the Employee and any Dependent may enroll. The Dependent does not have to have had a loss of coverage at that time to be enrolled;

2. When a Dependent has a loss of coverage, only that Dependent and the Employee may enroll. The Employee does not have to have had a loss of coverage at that time to enroll. Other Dependents that did not have a loss of coverage will be considered Late Enrollees.

Special Enrollment for Medicaid and Children's Health Insurance Program (CHIP)

You and Your Dependents are entitled to enroll in the Plan during a Special Enrollment Period if either of the following requirements is met:

1. You or Your Dependent is covered under a Medicaid program under Title XIX of the Social Security Act or under a state child health plan (CHIP) under Title XXI of the Act, and coverage under such plan or program is terminated because You or Your Dependent loses eligibility; or

2. You or Your Dependent is determined by the state to be eligible to receive contribution assistance from a Medicaid program or state child health plan to pay for coverage under this Plan.

Loss of eligibility shall not mean loss of coverage resulting from an individual's termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of fact in connection with such coverage.)

Special Enrollment for Marriage

If You, as the Employee, are now getting married, a special enrollment event will occur on the date of Your marriage. At that time, You may enroll in this Plan. Any Dependents acquired on the date of Your marriage may also be enrolled at this time.

Special Enrollment for Birth, Adoption, Placement for Adoption or Legal Guardianship

If You experience the birth of a Dependent Child, or the adoption or placement for adoption of a Dependent Child, or the placement of a Dependent Child for legal guardianship for a special enrollment event will occur on that date. At that time, You may enroll in this Plan. Your Dependent spouse and the newborn or adopted Child or Child by legal guardianship may also be enrolled at this time.

Special Enrollment Period (Time Frames for Enrollment)

1. "Special Enrollment Period" shall mean, with respect to "Special Enrollment for Individuals Losing Coverage," the period which ends 31 days after:
   a. The date on which the coverage is exhausted, if the coverage was COBRA continuation coverage; or
   b. The date on which the coverage terminated because of Loss of Eligibility or termination of employer contributions toward the cost of such coverage, for other individual or group health coverage.

2. With respect to "Special Enrollment for Medicare or Children's Health Insurance Program (CHIP)," the period which ends 60 days after the date on which the coverage terminated because of loss of eligibility or the date of eligibility to receive contribution assistance.

3. With respect to "Special Enrollment for Marriage" or "Special Enrollment for Birth, Adoption or Placement for Adoption," the period which ends 31 days after the date of one of the following, triggers the special enrollment rights:
   a. Marriage;
   b. Birth;
   c. Adoption;
   d. Placement for adoption: or
   e. Legal guardianship

Open Enrollment Period

Open Enrollment Period is the period that occurs annually, during which Employees can enroll themselves and their eligible Dependents (as Late Enrollees), make other enrollment changes or switch to a different dental plan sponsored by the Employer.

Employees may only enroll during their initial 31-day eligibility period or an Open Enrollment Period unless You qualify as a Special Enrollee as indicated above.

Effective Date of Coverage; Conditions

All conditions for effectiveness of coverage under the Plan which are set forth in "Employee Coverage" and "Dependent Coverage," will apply to persons enrolling during a Special (or Open) Enrollment Period. Coverage for Employees or Dependents enrolling during a Special Enrollment Period will become effective at 12:01 AM as follows:

1. For marriage or loss of coverage, provided these forms are received within 31 days of the marriage or loss of coverage:
   a. On the date of marriage or the date following the loss of coverage;
   b. On the first day of the month following the date of marriage or the date of loss of coverage; or
   c. The first day of the month following the receipt by the Plan of the required enrollment forms.

2. For Medicaid or Children's Health Insurance Program (CHIP), provided these forms are received within 60 days of the loss of eligibility or eligibility to receive contribution assistance:
   a. On the date following the loss of eligibility or eligibility to receive contribution assistance;
   b. On the first day of the month following the loss of eligibility or eligibility to receive contribution assistance; or
   c. The first day of the month following the receipt by the Plan of the required enrollment forms.

3. On the date of birth, adoption placement for adoption, or placement of legal guardianship provided these forms are received within 31 days of the birth, adoption, placement for adoption or placement of legal guardianship.

Enrollment must be in writing in a form established and accepted by the Plan Administrator and must be received by the Plan Administrator as outlined above. If You enroll for coverage more than 31 or 60 days (as applicable) after the date of qualifying event under the Special Enrollment Period, You (and/or any eligible Dependents) will be considered a Late Enrollee under the Plan. Coverage for those enrolling within the Open Enrollment Period will become effective on the Plan's anniversary date following that Open Enrollment Period.

CHANGE IN STATUS

If You have a change in status, as defined by the IRS, You have 31 days from the date of that change to make new elections under this Plan or request termination of coverage. Any changes in Your elections must be consistent with Your change in status or they will not be allowed. Change in status means a change as stated below.

This listing is not meant to be a complete listing of eligible change in status events according to the IRS regulations. If You have questions regarding whether an event qualifies as a change in status, please contact Your Plan Administrator.

1. **Legal Marital Status.** Your marriage, divorce, legal separation, annulment or the death of Your legal spouse;

2. **Number of Dependents.** An increase or decrease in the number of Dependents You have due to birth, adoption, placement for adoption or the death of a dependent.

3. **Employment Status.** Any of the following events that change the employment status of You or Your Dependent, including: termination or commencement of employment, strike or lockout, commencement or return from unpaid leave, change in worksite, and any change in employment status that results in a loss or gain of eligibility under the Section 125 plan or the underlying benefit plan. This includes a change from part-time to full-time employment or a change in eligibility plans.

4. **Dependent Status.** Your Dependent satisfies or ceases to satisfy eligibility requirements for coverage due to an age limit, or other requirement of the Plan.

5. **FMLA Leave Status.** At the time a leave under the FMLA begins, the Employee may change elections to the extent allowed under the federal Family and Medical Leave Act.

6. **COBRA Continuation.** You or Your dependent become eligible for continuation coverage under the employer's group health plan as provided by COBRA or a similar state law.

7. **Judgment, Decree or Court Order.** An order resulting from a divorce, legal separation, annulment, change in legal custody or Qualified Medical Child Support Order as defined by applicable law which requires You or another individual to provide health coverage for Your Dependent child.

8. **Entitlement to Medicare or Medicaid.** A gain or loss of eligibility under Medicare, Part A or Part B, or Medicaid for You or Your Dependent.

9. **HIPAA Special Enrollment Rights.** An event which qualifies as a special enrollment right under the Health Insurance Portability and Accountability Act.

10. **Changes in a Dependent's Coverage Under Another Employer's Plan.** Election changes are limited to changes that result from a change under the Plan of Your spouse's, ex-spouse's or other Dependent's employer. To qualify as a change in status under this Plan, the change must be permitted under the other employer plan and Section 125 of the Internal Revenue Code or be the result of a differing election period under the other employer plan.

If You have questions regarding whether an event qualifies as a Change in Status, the Plan Administrator will answer them.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If a child is the subject of a "Qualified Medical Child Support Order" ("QMCSO"), the child must be considered an "Alternate Recipient" under the Plan. Upon the Plan Administrator's determination that an order is a QMCSO, coverage must immediately be provided to the child.

"**Alternate Recipient**" shall mean any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as an eligible Dependent.

For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent. If an Employee does not enroll the child in the Plan, the Plan must recognize the child's right to be enrolled as an Alternate Recipient. The custodial parent or legal guardian of the child may also exercise this right. An Alternate Recipient will be treated as an Employee under the Plan for the purpose of receiving Plan information. The parent or legal guardian or the Department of Health and Social Services may have this right on behalf of the alternate recipient.

Eligibility and Effective Date of Coverage (continued)

"**Medical Child Support Order**" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant's child or directs the Participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or

2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"**National Medical Support Notice**" or "NMSN" shall mean a notice that contains the following information:

1. Name of an issuing state agency;

2. Name and mailing address (if any) of an employee who is a Participant under the Plan;

3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and

4. Identity of an underlying child support order.

"**Qualified Medical Child Support Order**" or "**QMCSO**" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;

2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

3. The period of coverage to which the order pertains; and

4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice;"
   a. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;
   b. Informs the Plan Administrator that, if a group health plan has multiple options and the Employee is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and

2. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants without regard to this Section, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and

2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and

2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

Payment for benefits under this Plan will be made to the Alternate Recipient or the provider of service. Payment may also be made to the custodial parent or legal guardian.

GINA

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of Genetic Information.

The term "Genetic Information" means, with respect to any individual, information about:

1. Such individual's genetic tests;

2. The genetic tests of family members of such individual; and

3. The manifestation of a disease or disorder in family members of such individual.

The term "Genetic Information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. Genetic Information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting condition limitations. Offering reduced premiums or other rewards for providing Genetic Information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect Genetic Information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon Genetic Information, request or require genetic testing or collect Genetic Information either prior to or in connection with enrollment or for underwriting purposes.

REINSTATEMENT OF COVERAGE

An Employee who is terminated and rehired will be treated as a New Employee upon rehire and be subject to all New Employee eligibility and waiting period requirements only if the Employee was not credited with an Hour of Service with the Employer for a period of at least one year immediately preceding the date of rehire.

A Variable Hour Employee who is terminated and rehired will be treated as an Ongoing Employee upon rehire only if the Employee break in service did not exceed one year.

Upon return, coverage will be effective the first of the month following the day You return to work, so long as all other eligibility criteria are satisfied.

Employees returning from an approved leave of absence or temporary layoff of less than one year and who did not continue coverage will be effective on the first of the month following the day of return, so long as all other eligibility criteria are satisfied (any applicable waiting period is waived). Employees returning from an approved leave of absence or temporary layoff exceeding one year and who did not continue coverage will be subject to all new Employee eligibility and waiting period requirements.

CHANGES IN EMPLOYEE/DEPENDENT STATUS

If both spouses are eligible Employees and each has enrolled for coverage as an Employee under this Plan, this Plan permits one spouse to change his or her status to that of a Dependent at any time.

In addition, if both spouses are Employees and eligible for coverage under this Plan, and one spouse previously waived coverage as an Employee in favor of coverage as a Dependent, this Plan permits the Dependent spouse to change his or her status to that of an Employee when:

1. Both Employees decide to transfer coverage under the Plan from one spouse to the other;

2. A spouse decides to take coverage as an Employee for any reason; or

3. One spouse terminates coverage under the Plan for any reason.

Other eligible Dependents may be transferred to the spouse with Employee coverage at the time of the change in status.

Each enrollment change must be made separately and in writing on a form furnished and accepted by the Plan Administrator within 31 days of the requested effective date. Failure to comply with this enrollment requirement by either spouse will cause that spouse to become a "Late Enrollee", and he or she will lose coverage under the Plan except as provided in "Special Enrollment Period" or "Open Enrollment Period."

If Your Dependent Child becomes an eligible Employee of the Employer and makes application as an eligible Employee such application must be made in accordance with the provisions contained in "Employee Coverage" in this section.

TERMINATION OF COVERAGE

Coverage under this Plan for any Participant will terminate at 12:01 AM on the earliest of the following:

For an Employee:

1. The date of termination of the Plan;

2. The day of the month in, or with respect to which, he requests that such coverage be terminated, provided such request is made on or before such date;

3. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his failure to make, when due, any contribution for coverage for himself to which he has agreed in writing;

4. The last day of the month in which the Non-Variable Employee ceases to be eligible for such coverage under the Plan;

5. The last day of the month following the end of the Stability Period for Variable Hour Employees, if the Employee failed to qualify during the previous Measurement Period;

6. The last day and time of the month in which the termination of employment occurs This would be the last actual day worked or the end of an approved Employer Continuation in accordance with this Plan; or

7. Immediately after an Employee or his Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Eligibility and Effective Date of Coverage (continued)

For Dependents:

1. The date of termination of the Plan;

2. Upon the discontinuance of coverage for Dependents under the Plan;

3. The date of termination of the Employee's coverage for himself under the Plan; In the event of the Employee's death, Dependent Coverage will continue to the last day of the month;

4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his failure to make, when due, any contribution for coverage for Dependents to which he has agreed in writing;

5. In the case of a Child for whom coverage is being continued due to mental or physical inability to earn his own living, the earliest to occur of:
   a. Cessation of such inability;
   b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
   c. Upon the Child's no longer being dependent on the Employee for his support;

6. The last day the Dependent enters full-time military, naval or air service of any country;

7. The last day of the month such person ceases to be a Dependent, as defined herein; or

8. Immediately after an Employee or his Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

RETIREE CONTINUATION

For purposes of determining eligibility to continue coverage with this Plan in a retiree status You must be retiring. However, the Plan will allow for a retiree to work not more than 20 hours a week without losing eligibility under this provision. Coverage may be continued under the provision for You and any covered Dependents. To be eligible as a retiree You must comply with one of the following conditions:

1. You have attained an age of 55 with a minimum of 20 years of full-time service as an Employee of the Diocese of La Crosse (do not have to be consecutive) and covered under the Plan at the date of retirement;
   a. You may continue coverage until age 65 by paying the full premium that is being charged to all active employees without regard to Employer contributions.
   b. Upon reaching age 65, you must elect Medicare and may continue with the Medicare Prime level of benefits at the rate being charged at that time; or

2. You are at least age 65, are covered by Medicare and are covered under the Plan at the date of retirement. There is no minimum length of service. You may continue coverage with the Medicare Prime level of benefits at the rate being charged at that time.

In the event that the Employee dies or the Employee and a covered spouse divorce, Continuation will be offered from the date of death or divorce.

IMPORTANT NOTICE FOR ACTIVE EMPLOYEES AND SPOUSES AGE 65 AND OVER

If You are an active Employee age 65 and over, or the spouse age 65 and over of an active Employee, and are eligible for Medicare, You have the option of either:

1. Continuing coverage under this Plan, in which case Medicare benefits would be secondary to this Plan; or

2. Electing Medicare coverage as primary, in which case **no benefits** would be payable under this Plan.

Contact Your Plan Administrator for further information.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act ("USERRA") is a federal law, effective October 13, 1994, which provides that You may elect to continue coverage under the Plan for Yourself and Your Dependents, where:

1. They were Participant s in the Plan immediately prior to the Employee's leave of absence for Uniformed Service; and

2. The reason for the Employee's leave of absence is service in the Uniformed Service of coverage during military leave.

The law requires that an Employer continue to provide coverage under this Plan during a military leave that is covered by the Act for You and Your Dependents which is identical to coverage provided under the Employer's Plan to similarly situated, Employees and Dependents. This means that if the coverage for similarly situated Employees and Dependents is modified, coverage for the individual on USERRA leave will be modified. The cost of such coverage will be:

1. For leaves of 30 days or less, the same as the Employee contribution required for similarly situated Employees;

2. For leaves of 31 days or more, up to 102% of the full Plan contribution.

Continuation applies to medical, dental, prescription drug, vision and other health coverages as provided under this Plan. Short and long term disability and life insurance coverage will not be included in this continuation.

For Employers subject to COBRA, continued coverage provided under this provision will reduce the allowed maximum period of continuation provided under COBRA.

Maximum Period of Coverage during USERRA Leave

Continued coverage under this provision will terminate on the earlier of the following events:

1. The date You fail to return to Employment with the Employer following completion of Your leave. Employees must return to employment within:
   a. The first full business day of completing Uniformed Service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such Uniformed Service,
   b. 14 days of completing Uniformed Service, for leaves of 31 to 180 days,
   c. 90 days of completing Uniformed Service, for leaves of more than 180 days; or

2. 24 months from the date Your leave began.

REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE

The law also requires, regardless of whether continuation as stated above was elected, that Your coverage and Your Dependents' coverage be reinstated immediately upon Your honorable discharge from Uniformed Service and return to employment, if You return within:

1. The first full business day of completing Your Uniformed Service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such Uniformed Service;

2. 14 days of completing Uniformed Service, for leaves of 31 to 180 days;

3. 90 days of completing Uniformed Service, for leaves of more than 180 days;

If, due to a Sickness or Injury caused or aggravated by Your Uniformed Service, You cannot return to work within the times stated above, You may take up to a period of two years, or as soon as reasonably possible if for reasons beyond Your control You cannot return within two years, to recover from such Sickness or Injury and return to employment within the times stated above.

Continued coverage through USERRA will not include coverage for any Sickness or Injury caused or aggravated by Your military service, as determined by the Secretary of Veteran Affairs.

NOTE: For complete information regarding Your rights under the Uniformed Services Employment and Reemployment Rights Act, contact Your Employer.

CONTINUATION OF COVERAGE

EMPLOYER CONTINUATION COVERAGE

If You and Your Employer continue to pay the required Plan contributions and the Plan is not terminated, Your coverage may, at the Employer's discretion, remain in force. Coverage will be continued for eligible Participants should the following occur:

1. In the event of a layoff, coverage will continue for 2 consecutive months following the date of layoff;

2. In the event of Total Disability, coverage will continue for 2 consecutive months following termination of Active Employment; or

3. In the event of an approved leave of absence, coverage will continue for 2 consecutive months. If this leave meets the requirements of FMLA, time under FMLA will run concurrently.

At the end of any period listed above, Employee and/or Insured Dependent Continuation will be offered.

If Your coverage under the Plan was terminated after a period of layoff or approved leave of absence and You are now returning to work within one year of such termination and are an eligible Employee, You may resume coverage under this Plan
effective the first day of the month following the day You return to work, and You will receive credit for prior coverage under this Plan toward satisfaction of the Waiting Period.

Continuation During FMLA Leave

The Plan shall at all times comply with FMLA. It is the intention of the Plan Administrator to provide these benefits only to the extent required by applicable law and not to grant greater rights than those so required. During a FMLA Leave, coverage will be maintained in accordance with the same Plan conditions as coverage would otherwise be provided if the covered Employee had been a continuously active employee during the entire leave period. If Plan coverage lapses during the FMLA Leave, coverage will be reinstated for the person(s) who had coverage under the Plan when the FMLA Leave began, upon the Employee's return to work at the conclusion of the FMLA Leave.

To the extent this Plan is required to comply with a State family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such State family and medical leave law, as well as under FMLA.

EMPLOYEE AND/OR INSURED DEPENDENT CONTINUATION

Benefits Affected by Employee and/or Insured Dependent Continuation

Any Employee and/or Insured Dependent Continuation option may include the benefits for which the person eligible for Employee and/or Insured Dependent Continuation was covered just prior to the "qualifying event" (the event which qualifies a person for continued coverage under Employee and/or Insured Dependent Continuation). Dental insurance, life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of the Employer's plan) are not eligible for continuance under Employee and/or Insured Dependent Continuation.

Employee Rights to Continuation

An Employee that is covered by this Plan has a right to elect continuation if coverage is lost or cost increases due to:

1. A reduction in the Employee's hour of work; or

2. The termination of the Employee's working hours. This will not apply if termination is due to gross misconduct on the Employee's part.

3. Loss of Eligibility as defined under this Plan.

Spouse Rights to Continuation

The spouse of an Employee that is covered by this Plan has a right to elect continuation if coverage is lost due to:

1. A reduction in the Employee's hours of work;

2. The termination of the Employee's working hours. This will not apply if termination is due to gross misconduct on the Employee's part;

3. The death of the Employee;

4. The end of the spouse's marriage to the Employee. The marriage must end due to dissolution, annulment, divorce or legal separation; or

5. The Employee becoming entitled to Medicare.

6. The Employee's loss of Eligibility as defined under this Plan.

Dependent Child Rights to Continuation

The Dependent child of an Employee that is covered by this Plan has a right to elect continuation if coverage is lost or cost increases due to:

1. A reduction in the Employee's hours of work;

2. The termination of the Employee's working hours. This will not apply if termination is due to gross misconduct on the Employee's part;

3. The death of the Employee;

4. The end of the Employee's marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;

5. The Employee becoming entitled to Medicare; or

6. The child ceasing to be considered a Dependent child as defined in this Plan.

7. The Employee's loss of Eligibility as defined under this Plan.

Maximum Time Periods

Continuation will be available for a qualified beneficiary up to the maximum time period shown in items 1, 2 or 3 below. Multiple qualifying events which may be combined under Employee and/or Insured Dependent Continuation will not continue a beneficiary's coverage for more than 36 months beyond the date of the original qualifying event. When the qualifying event is "entitlement to Medicare," the 36-month continuation period is measured from the date of Medicare entitlement. For all other qualifying events, the continuation period is measured from the loss of coverage date.

1. Up to 18 months for an Employee and his covered Dependents when coverage terminates due to reduction of hours worked, or termination of employment for reasons other than gross misconduct. Note: an individual who is disabled on the date of the qualifying event may have Employee and/or Insured Dependent Continuation coverage extended (and an extra fee may be charged) from 18 months to 29 months provided that:
   a. The individual is determined as being disabled for Social Security purposes before or during the first 60 days of Employee and/or Insured Dependent Continuation coverage; and
   b. The individual notifies the Plan Administrator within 60 days of the Social Security Administration's determination of disability and within the original 18-month Employee and/or Insured Dependent Continuation period which applies to the person.

2. Up to 36 months for:
   a. A Dependent child who is a Participant in the Plan and who ceases to be an eligible Dependent;
   b. A Dependent who is a Participant in the Plan and whose eligibility ceases due to the Employee's death;
   c. A spouse who is a Participant in the Plan and whose eligibility ceases due to divorce or legal separation; or
   d. A Dependent who is a Participant in the Plan, when the Employee's coverage ceases due to entitlement to Medicare. (NOTE: If Employee and/or Insured Dependent Continuation is already in force due to loss of coverage because of termination or reduction of hours, Medicare entitlement is not a second qualifying event and only 18 months is applicable.)

3. Under Employee and/or Insured Dependent Continuation's special bankruptcy rules for retirees and their Dependents who are Participants, continuation coverage following the qualifying event of the Employer's filing for reorganization under the Bankruptcy Code must extend until:
   a. The date of death of the retired Employee or the surviving spouse of the retiree, if the retiree died before the filing and the spouse still had coverage under the Plan; or

b. 36 months after the date of death of the retired Employee, in the case of the surviving spouse or Dependent child of the retired Employee.

For this item 3, coverage does not terminate when the person becomes entitled to Medicare.

Continued coverage may also cease before the end of the maximum period on the earliest to occur of the following dates:

1. The date that the Employer ceases to provide a group health plan to any Employee;

2. The date on which coverage ceases by reason of the qualified beneficiary's failure to make timely payment of any required premium. This is retroactive to the last day for which payment was received;

3. The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated in item 3 above); or

4. The first day of the month that begins more than 30 days after the date of the Social Security Administration's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Electing Employee and/or Insured Dependent Continuation

Each person covered by this Plan has an independent right to elect Employee and/or Insured Dependent Continuation for himself or herself. A covered Employee or spouse may elect Employee and/or Insured Dependent Continuation for all family members. A parent or legal guardian may elect coverage for a minor child.

If coverage has been terminated in anticipation of a qualifying event, the right to Employee and/or Insured Dependent Continuation will still apply at the time of the event. In this case, Employee and/or Insured Dependent Continuation will be effective on the date of the event even though it is after the date coverage is lost or cost increased.

If the Employee's Dependent Child is born during the Employee and/or Insured Dependent Continuation coverage period, that child may be added to the coverage. The Child will have all the rights that any other child would have under Employee and/or Insured Dependent Continuation. If a Child is adopted by or placed for adoption with the Employee during the Employee and/or Insured Dependent Continuation coverage period, that Child may be added to the coverage. The Child will have all the rights that any other child would have under Employee and/or Insured Dependent Continuation.

Notice and Election Requirements

When coverage terminates due to an Employee's death, termination or reduction of hours, entitlement to Medicare, bankruptcy or failure to return from FMLA Leave, the Employer has 30 days from the date of such event in which to notify the Plan Administrator or Administrative Services Manager of the qualifying event.

In the event of divorce, legal separation or change of Dependent status, the qualified beneficiary has 60 days from the qualifying event in which to notify the Plan Administrator that the qualifying event has occurred. With respect to qualified beneficiaries who are disabled, in the event the Social Security Administration issues a final determination that the qualified beneficiary is no longer disabled, the qualified beneficiary must notify the Plan Administrator or Administrative Services Manager of this determination within 30 days of the date it is made.

Complete instructions on how to elect continuation coverage will be provided by the Plan Administrator or Administrative Services Manager within 14 days of receiving notice of the qualifying event. Qualified beneficiaries then have 60 days in which to elect continuation. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing instructions. If You elect Employee and/or Insured Dependent Continuation within the 60-day period, Employee and/or Insured Dependent Continuation will be effective on the date that You would lose coverage. If You do not elect Employee and/or Insured Dependent Continuation within this 60-day period, Employee and/or Insured Dependent Continuation will not be available. Your coverage under the Plan will terminate.

Premium Requirements

Once coverage is elected, payment for the cost of the initial period of coverage must be made within 45 days. Thereafter, payments are due on the first day of each month to continue coverage for that month. If a payment is not received within

30 days of the due date, coverage will be canceled and will not be reinstated. If the initial or subsequent premium payments are not made, coverage will be retroactively terminated back the last day for which payment was received.

The Plan may add a 2% administration charge to the premium cost. The Plan may charge an additional 50% during the 11-month extension for total disability if the disabled individual is covered.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of Employee and/or Insured Dependent Continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of Employee and/or Insured Dependent Continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide notice to the Human Resource department of your employer of the disability within 60 days after the latest of: 1) The date of the SSA disability determination; 2) The date on which the qualifying event occurs; 3) The date on which the qualified beneficiary loses coverage; or 4) The date on which the qualified beneficiary is informed of the obligation to provide the disability notice.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of Employee and/or Insured Dependent Continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of Employee and/or Insured Dependent Continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Procedures for Providing Notice to the Plan

In order to maintain Your rights under Employee and/or Insured Dependent Continuation, You are required to provide the Plan with notice of certain events, as described above. The Plan will consider Your obligation to provide notice satisfied if you provide written notice to the Plan Administrator that includes:

1. The Employee's name and social security number or identification number;

2. The name of the individual(s) to whom the notice applies;

3. The reason for which notice is being provided; and

4. The address and phone number where You can be contacted.

Notice should be addressed to the Human Resources Department, Attn: Employee and/or Insured Dependent Continuation Administration. Notice should be mailed to the Plan Administrator's address shown in this Plan. Your notice will not satisfy Your obligation if it is not provided within the time frame stated above for that notice.

Other Information

The Plan Administrator will answer any questions You may have on Employee and/or Insured Dependent Continuation.

To protect Your rights under Employee and/or Insured Dependent Continuation, You should notify the Plan Administrator of any changes that affect Your coverage. Such changes include a change for You or a family member in marital status, address, or other insurance coverage. When providing any notice to the Plan, a copy should be maintained for Your own records.

SECTION 4

GENERAL PLAN INFORMATION

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ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Diocese of La Crosse, the "Plan Sponsor" as of July 1, 2018 hereby amends and restates the Diocese of La Crosse Lay Group Employee Medical Benefit Plan (the "Plan"), which was originally adopted by the Company, effective January 1, 2013.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, or on such other date as specified in an applicable collective bargaining agreement (if any) with respect to the Employees covered by such agreement (the "Effective Date").

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

PLAN DESCRIPTION INFORMATION

INTRODUCTION AND PURPOSE

The Plan Sponsor has established the Plan for the benefit of eligible Employees, on the terms and conditions described herein. Plan benefits are self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Participants and/or the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits.

The Plan Sponsor's purpose in establishing the Plan is to help to offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document and Summary Plan Description is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by the Plan Sponsor and may be inspected at any time during normal working hours by any Participant.

PLAN NAME	Diocese of La Crosse Lay Group Employee Medical Benefit Plan
TYPE OF PLAN	A self-funded welfare benefit plan providing certain medical and dental benefits to covered Employees and Dependents. This Plan is not financed or administered by an insurance company. The Plan's benefits are not guaranteed by a contract of insurance.
PLAN EFFECTIVE DATES	July 1, 2018
GROUP NUMBER	8201
PLAN YEAR FOR GOVERNMENT REPORTING	July 1 to June 30
PLAN ADMINISTRATOR	St. Ambrose Financial Services, Inc. 3710 East Avenue South P.O. Box 4004 La Crosse, WI 54602-4004 (608) 791-2669
PLAN SPONSOR	Diocese of La Crosse St. Ambrose Financial Services, Inc. 3710 East Avenue South P.O. Box 4004 La Crosse, WI 54602-4004 (608) 788-7700
PLAN NUMBER	501
PLAN SPONSOR IDENTIFICATION NUMBER	39-0807229
ADMINISTRATIVE SERVICE MANAGER	Benefit Plan Administrators of Eau Claire, Inc. 402 Graham Avenue – 4th Floor Eau Claire, WI 54701 (800) 236-7789 (Toll-free) or (715) 832-5535

Plan Description Information (continued)

AGENT FOR SERVICE OF LEGAL PROCESS	Mr. Dennis Herricks St. Ambrose Financial Services, Inc. 3710 East Avenue South P.O. Box 4004 La Crosse, WI 54602-4004 (608) 791-2669

This Plan is a legal entity. Service for legal process may be filed with the Agent for Service of Legal Process.

PLAN ADMINISTRATION

Plan Administrator

The Plan is administered by the Plan Administrator. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator has retained the services of the Administrative Service Manager to provide certain claims processing and other technical services.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Participant's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a Claims Administrator to pay claims;
9. To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
10. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
11. To perform each and every function necessary for or related to the Plan's administration.

COORDINATION OF BENEFITS

Benefits Subject to This Provision

This provision shall apply to all benefits provided under any section of this Plan with the following exception: Coordination does not apply to prescription drug benefits available under a prescription drug card.

Excess Insurance

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

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

1. any primary payer besides the Plan;

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

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

4. worker's compensation or other liability insurance company; or

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

Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

Allowable Expenses

"Allowable Expenses" shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

Claim Determination Period

"Claim Determination Period" shall mean each Calendar Year.

Effect on Benefits:

Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and

2. The rules to the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefits determination are:

1. A plan without a coordinating provision will always be the primary plan;

2. the benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;

3. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year falls earlier in the year will be primary, except:
   a. When the parents were never married, are separated, or are divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or
   b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan; which covers that child as a dependent of the parent without custody.

   Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a depend child; and

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expense claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

5. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

Right to Receive and Release Necessary Information

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

Facility of Payment

Whenever payment which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of Recovery

Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this section , the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any

insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents.

Provision for Coordination of Benefits with Medicare

Definitions

1. "Medicare" means that portion of Title 18 of the United States Social Security Act of 1965, as then constituted or as amended in the future.

2. "Fully Covered Person" means any person who is eligible for Medicare Coverage.

3. "Full Medicare Coverage" means coverage for all of the benefits provided under Medicare with the exception of Medicare Part D, including any benefits provided on an optional basis. F

Effects on Benefits

Coordination of benefits does not apply to Medicare Part D.

The benefits payable under this Plan for expenses incurred (as determined by the Covered Expenses section of this Plan) by a Fully Covered Person shall be reduced by the amount such Fully Covered Person is eligible for benefits under Full Medicare Coverage. Any benefits received from Full Medicare Coverage not covered by this Plan shall not reduce benefits payable under this Plan.

Except that:

For active Employees age 65 and older who continue to participate in this Plan, this Plan will provide its full regular benefits first and Medicare coverage may provide supplemental benefits for those expenses not paid by this Plan. If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 18 months of Medicare entitlement (with respect to charges Incurred on or after February 1, 1991 and before August 5, 1997) and for the first 30 months of Medicare entitlement (with respect to charges Incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law. This provision intends to comply with the TEFRA Act of 1982.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

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

2. Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

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

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

Subrogation

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

2. If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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

Third Party Recovery, Subrogation and Reimbursement (continued)

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

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, Disability or other expenses. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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

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

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

Participant is a Trustee over Plan Assets

1. Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or accident. By virtue of this status, the Participant understands that he or she is required to:
   a. notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release or receipt of applicable funds;
   b. instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
   c. in circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
   d. hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No Participant, beneficiary or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section, will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

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

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer or any other source on behalf of that party.

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

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

4. Workers' compensation or other liability insurance company.

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

Separation of Funds

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

Wrongful Death

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

Obligations

1. It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:
   a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions and/or cooperating in trial to preserve the Plan's rights.
   b. To provide the Plan with pertinent information regarding the Sickness, disease, Disability, or Injury, including accident reports, settlement information and any other requested additional information.
   c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
   d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
   e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
   f. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
   g. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or coverage.
   h. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.

i. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
j. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

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

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

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

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

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

Language Interpretation

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

Severability

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

GENERAL PROVISIONS

IN GENERAL

Any and all rights or benefits accruing to any person under this Plan shall be subject to all terms and conditions of this Plan. The adoption and maintenance of this Plan shall not constitute a contract between the Company and any Participant or be consideration for, or an inducement or condition of, employment of an Employee. Neither participation nor anything contained in this Plan shall give any Employee the right to be retained in the Employ of the Company, nor shall it interfere with the right of the Company to discharge any Employee at any time.

FILING OF INFORMATION

Each Covered Employee, Covered Dependent or other interested person shall file with the Plan Administrator such pertinent information concerning himself as the Plan Administrator may specify, including proof or continued proof of dependency or eligibility, and in such manner and form as the Plan Administrator may specify or provide, and such person shall not have rights or be entitled to any benefits or further benefits hereunder unless such information is filed by him or on his behalf.

PAYMENTS TO OTHERS THAN PARTICIPANTS

If the Plan Administrator shall find that any person to whom any benefits are payable under this Plan is unable to care for his affairs, is a minor or has died, then any payment due to him or his estate (unless a prior claim therefore has been made by a duly appointed legal representative) may be paid to the Spouse, a Child, a relative, an institution maintaining or having custody of such person or any other person deemed by the Plan Administrator to be a proper recipient on behalf of such person otherwise entitled to payment or the Plan Administrator may in its discretion hold such payment until a legal representative is appointed. Any such payment shall be a complete discharge of the liabilities of this Plan.

CANCELLATION OF BENEFITS

If the Plan Administrator is unable to ascertain the whereabouts of any person to whom benefits are payable under the Plan, and if, after one year from the date such payment is due, a notice of such payment due is mailed to the last known address of such person as shown on the records of the Plan Administrator, and within three months after such mailing such person has not filed with the Plan Administrator written claim therefore, the Plan Administrator may direct that such payment be cancelled and forfeited and, upon such cancellation the Plan shall have no further liability therefore.

CLERICAL ERROR/DELAY

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

CONFORMITY WITH APPLICABLE LAWS

This Plan is a church plan, (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a Federal law regulating Employee welfare and pension plans. The Participant's rights in the Plan are governed by the plan documents and applicable State law and regulations. This Plan shall be read in such a way so as to conform with any and all applicable law, regulation or court order (if such a court is of competent jurisdiction). Where necessary, the governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations are deemed to be automatically amended to so conform.

FRAUD

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration, that shall be deemed to be fraud. If a Participant is aware of any instance of fraud and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire family unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30-day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

HEADINGS

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

NO WAIVER OF ESTOPPEL

No term, condition or provision of the Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written instrument of the party charged with such waiver of estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than specifically waived.

INDEMNIFICATION

1. The Claims Administrator shall, to the extent possible, advise Employer of any legal actions against it or Employer which involve the Plan or the obligations of Employer or Claims Administrator under the Plan or this Agreement. Employer shall undertake the defense of such action (including the selection of counsel for Employer and Claims Administrator acceptable to Employer) and be responsible for the costs of defense; provided, however, that Employer shall not be responsible for defense costs for actions for which Claims Administrator is required to indemnify Employer (see Item 2 below). In addition, Claims Administrator shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of Claims Administrator. It is further agreed that Claims Administrator (provided no conflicts of interest exist) shall fully cooperate with Employer in Employer's defense of any action arising out of matters related to the Plan or this Agreement.

2. In performing its obligations under this Agreement, Claims Administrator shall use Reasonable diligence and that degree of skill and judgment possessed by one experienced in furnishing claim administration services to plans of similar size and characteristics as the Plan. Claims Administrator shall indemnify, defend and hold harmless Employer and the Plan, and their respective directors, shareholders, and agents (collectively, "Employer Group"), from and against any fine, penalty, loss, damage, Injury, claim, cost expense (including, without limitation, Reasonable attorneys' fees and other Reasonable costs and expenses incident to any suit, action, investigation, claim or proceeding) or other liability (collectively, "Liabilities") that may be asserted against or Incurred by Employer Group and that arise out of any act or omission of Claims Administrator, or its employees, agents or subcontractors ("Claims Administrator Personnel"), in connection with the performance of Claims Administrator's obligations hereunder, where such act or omission constitutes: (a) the failure of Claims Administrator to perform its obligations under the Agreement in

accordance with the standard set for the above; (b) breach of fiduciary duty by Claims Administrator; or (c) the failure to apply, or negligent application of, established oversight, monitoring, or credentialing standards to any members of the health care provider panel of any managed health care organization with whom Claims Administrator or Plan, directly or indirectly through one or more levels of contracting relationships; *provided, however,* that the foregoing indemnity shall not apply to (i) Liabilities resulting from the negligence or willful misconduct of Employer, or its employees, agents or subcontractors other than Claims Administrator, or (ii) the portion of any Liabilities represented by an amount or amounts payable to a Plan pursuant to the terms of a Plan (which amounts shall be discharged by Claims Administrator by making such payment or payments from assets of such Plan).

3. Claims Administrator does not insure or underwrite the liability of Employer under the Plan. Employer retains the ultimate responsibility for claims under the Plans and all expenses incident to the Plans, except as specifically undertaken in this Agreement by Claims Administrator. Employer agrees to defend, indemnify, and hold harmless Claims Administrator and its directors, officers and employees against any and all loss, liability, damages, penalties and expenses, including attorneys' fees, or other cost or obligation that may be asserted against or Incurred by Claims Administrator resulting from or arising out of claims, lawsuits, demands, settlements or judgments brought against Claims Administrator in connection with the design or of the Plans or its provision of services hereunder unless such liability is attributable to an action for which Claims Administrator is required to indemnify Employer (pursuant to Item 2 above).

PARTICIPANTS' PERSONALLY IDENTIFIABLE INFORMATION

"Participants' Information" means medical records, other medical information, social security numbers and all other personally identifiable information. Claims Administrator shall keep Participants' Information in confidence and shall not release or disclose such information to any person or organization unless (i) authorized to do so by the Member or the Employer or (ii) required by law. Claims Administrator shall be held liable for any breach of confidentiality by Claims Administrator of such Participants' Information, except that the Employer shall fully protect, indemnify, defend and hold harmless Claims Administrator from and against any and all loss, liability, damages, penalties and expenses, including attorneys' fees, or other cost or obligation that may be asserted against or Incurred by Claims Administrator resulting from or arising out of compliance by Claims Administrator with requests by the Employer to release or disclose Participants' Information.

FAILURE TO ENFORCE PLAN PROVISIONS

The Plan's failure to enforce any provision of the Plan will not affect the right, thereafter, to enforce such provision nor affect the right to enforce any other provision of the Plan.

PLAN CONTRIBUTIONS

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan. The amount of the Participant's contribution (if any) will be determined from time to time by the Plan Administrator.

PROTECTION AGAINST CREDITORS

Benefit payments under the Plan are not subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind. Any attempt to accomplish these will not be recognized. The Plan Administrator may, at its sole discretion, terminate Your interest in the benefits payable under this Plan, in which event the Plan will then apply the amount of the payment to the benefit of an adult child, guardian of a minor child, brother or sister, or other relative of the Participant. Such payment will fully discharge the Plan's liability to the extent of the payment.

STATEMENTS

In the absence of fraud, all statements made by a Participant will be deemed representations and not warranties. A statement will not be used to contest coverage under the Plan unless a signed copy of the statement is provided to the Participant or, if deceased, to his beneficiary.

DISCRETIONARY AUTHORITY

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

FILING OF INFORMATION

Each Covered Employee, Covered Dependent or other interested person shall file with the Plan Administrator such pertinent information concerning himself as the Plan Administrator may specify, including proof or continued proof of dependency or eligibility, and in such manner and form as the Plan Administrator may specify or provide, and such person shall not have rights or be entitled to any benefits or further benefits hereunder unless such information is filed by him or on his behalf.

MENTAL HEALTH PARITY

Pursuant to the Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008, (MHPAEA), collectively, the mental health parity provisions, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

NOT A CONTRACT

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

PRONOUNS

All personal pronouns used in the Plan shall include either gender unless the context clearly indicates otherwise.

LIMITATION OF ACTION

A Participant cannot bring any legal action against the Plan to recover reimbursement until 90 days after the Participant has properly submitted a request for reimbursement as described in this section and all required reviews of the Participant's claim have been completed. If the Participant wants to bring a legal action against the Plan, he or she must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or he or she loses any rights to bring such an action against the Plan.

A Participant cannot bring any legal action against the Plan for any other reason unless he or she first completes all the steps in the appeal process described in this section. After completing that process, if he or she wants to bring a legal action against the Plan he or she must do so within three years of the date he or she is notified of the final decision on the appeal or he or she will lose any rights to bring such an action against the Plan.

RIGHT OF RECOVERY

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the Maximum Amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative; any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount; and any future benefits payable to the Participant or his or her Dependents. See the Recovery of Payments provision for full details.

BINDING ARBITRATION

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this binding arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Participant and the Plan Administrator agree to be bound by this binding arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Participant and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Participant.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Participant and the Plan Administrator, or by order of the court, if the Participant and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

UNCLAIMED SELF-INSURED PLAN FUNDS

In the event a benefits check issued by the Claims Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Claims Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to any applicable State law(s).

CLAIMS PROCEDURES

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

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

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual Claim For Benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions.** Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-Service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Participant has the right to request a review of an adverse benefit determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a final adverse benefit determination. If the Participant receives notice of a final adverse benefit determination, or if the Plan does not follow the claims procedures properly, the Participant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the person involved in making these decisions.

Benefits will be payable to a Participant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

Pre-Service Claims

A "Pre-Service Claim" is a claim for benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "Pre-Service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan does not require the Participant to obtain approval of a specific medical service prior to getting treatment, then there is no Pre-Service Claim. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-Service Claim.

Concurrent Claim

A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

1. The Plan Administrator determines that the course of treatment should be reduced or terminated; or

2. The Participant requests extension of the course of treatment beyond that which the Plan Administrator has approved.

If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-Service Claim.

Post-Service Claims

A "Post-Service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Post-service health claims, which must be Clean Claims, must be filed with the Contract Administrator within 365 days of the date charges for the services were Incurred. Post-service Medicare Part D prescription claims must be filed with Benefit Plan Administrators within three years of the date the prescription was filled. Benefits are based upon the Plan's provisions at the time the charges were Incurred or the prescription filled. **Claims filed later than the indicated dates shall be denied.**

A Pre-Service Claim (including a concurrent claim that also is a Pre-Service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Contract Administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Contract Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Contract Administrator within 45 days from receipt by the Participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Administrator shall notify the Participant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-Service Claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-Service Urgent Care Claims:
    a. If the Participant has provided all of the necessary information, as soon as possible taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
    b. If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
    c. The Participant will be notified of a determination of benefits as soon as possible, but no later than 48 hours, taking into account the medical exigencies, after the earliest of:
        i. The Plan's receipt of the specified information; or
        ii. The end of the period afforded the Participant to provide the information.
    d. If there is an adverse benefit determination, a request for an expedited appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.

2. Pre-Service Non-Urgent Care Claims:
    a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
    b. If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but no later than 5 days after receipt of the claim. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant(if additional information was requested during the extension period).

Claim Procedures; Payment of Claims (continued)

3. Concurrent Claims:
   a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
   b. Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Participant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
   c. Request by Participant Involving Non-urgent Care. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a Post-Service Claim).
   d. Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:
      1) Notification to Participant- 30 days.
      2) Notification of adverse benefit determination on appeal - 30 days.

4. Post-Service Claims:
   a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-days extension period.
   b. If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by the date agreed to by the Plan Administrator and the Participant.

5. Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.

6. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

7. Extensions – Post-Service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

8. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Participant with notice, either in writing or electronically (or, in the case of Pre-Service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice). The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the Participant. The notice will contain the following information:

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

2. A reference to the specific portion(s) of the plan provisions upon which a denial is based;

3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;

4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

5. A description of the Plan's review procedures and the time limits applicable to the procedures.

6. A statement that the Participant 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 Participant's Claim for Benefits;

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

8. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant free of charge, upon request.

9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific of clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and

10. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes.

11. In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a Claim for Benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Participants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;

2. Participants the opportunity to submit written comments, documents, records, and other information relating to the Claim for Benefits.

3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse determination that is the subject of the appeal, nor the subordinate of such individual.

4. For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

6. For the identification of medical or vocational experts whose advise was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

7. That a Participant will be provide, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits in possession of the Plan Administrator or the Contract Administrator, information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances; and

8. In an urgent care claim, for an expedited review process pursuant to which:

9. A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Participant; and

10. All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Participant by telephone, facsimile or other available similarly expeditious method.

Requirements for Appeal

The Participant must file the appeal in writing (although oral appeals are permitted for Pre-Service Urgent Care claims) within 180 days following receipt of the notice of an adverse benefit determination. For Pre-Service Urgent Care Claims, if the Participant chooses to orally appeal, the Participant may telephone:

Benefit Plan Administrators of Eau Claire, Inc.
402 Graham Avenue – 4th Floor
Eau Claire, WI 54701
Phone: (715) 832-5535
Phone: (800) 236-7789
Fax: (715) 838-8507
Website: www.bpaco.com

American Health Holding, Inc.
7400 West Campus Road
New Albany, OH 43054
Phone: (800) 641-3224 ext. 9377063
Fax: (866) 881-9648
Email: AHH_appeals@ahhinc.com

To file an appeal in writing, the Participant's appeal must be addressed as follows and mailed or faxed as follows:

Benefit Plan Administrators of Eau Claire, Inc.
402 Graham Avenue – 4th Floor
Eau Claire, WI 54701
Phone: (715) 832-5535
Phone: (800) 236-7789
Fax: (715) 838-8507
Website: www.bpaco.com

American Health Holding, Inc.
7400 West Campus Road
New Albany, OH 43054
Phone: (800) 641-3224 ext. 9377063
Fax: (866) 881-9648
Email: AHH_appeals@ahhinc.com

It shall be the responsibility of the Participant to submit proof that the Claim for Benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the employee/Participant;

2. The employee/Participant's social security number;

3. The group name or identification number;

4. All facts and theories supporting the Claim for Benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal.**

5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

1. Pre-Service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.

2. Pre-Service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.

4. Post-Service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal. **NOTE:** This timeframe is reduced to no later than 30 days per internal appeal should the Plan allow for two levels of internal appeal.

5. Calculating Time Period. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination of Review

The Plan Administrator shall provide a Participant with notification, with respect to Pre-Service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

2. A reference to the specific portion(s) of the plan provisions upon which a denial is based;

3. Specific reason(s) for a denial, including the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;

4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

5. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

6. A description of the Plan's review procedures and the time limits applicable to the procedures.

7. A statement that the Participant 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 Participant's Claim for Benefits.

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

9. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request.

10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and

11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Document in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review

The decision by the Plan Administrator or other appropriate named fiduciary if the Plan on review will be final, binding the conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

Two Levels of Appeal

This Plan requires two levels of appeal by a Claimant before the Plan's internal appeals are exhausted. For each level of appeal, the Claimant and the Plan are subject to the same procedures, rights and responsibilities as stated within this Plan. Each level of appeal is subject to the same submission and response guidelines.

Once a Claimant receives an Adverse Benefit Determination in response to an initial claim for benefits, the Claimant may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If the Claimant receives an Adverse Benefit Determination in response to that initial appeal, the Claimant may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If the Claimant receives an Adverse Benefit Determination in response to the Claimant's second appeal, such Adverse Benefit Determination will constitute the Final Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

External Review Process

1. Scope

   The Federal external review process does <u>not</u> apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

a. The Federal external review process, in accordance with the current Affordable Care Act regulations, applies only to:
   1) Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and
   2) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

2. Standard external review

Standard external review is external review that is not considered expedited (as described in the "expedited external review" paragraph of this section).

a. Request for external review. The Plan will allow a Participant to file a request for an external review with the Plan if the request is filed within (4) months after the date of receipt of a notice of an adverse benefit determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by 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. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   1) The Participant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
   2) The adverse benefit determination or the Final Internal Adverse Benefit Determination does not relate to the Participant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
   3) The Participant has exhausted the Plan's internal appeal process unless the Participant is not required to exhaust the internal appeals process under the final regulations; and
   4) The Participant has provided all the information and forms required to process an external review.

   Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the Participant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Participant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

c. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

d. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or Final Internal Adverse Benefit Determination, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefit) for the claim.

3. Expedited external review

a. Request for expedited external review. The Plan will allow a Participant to make a request for an expedited external review with the Plan at the time the Participant receives:
   1) An adverse benefit determination if the adverse benefit determination involves a medical condition of the Participant for which the timeframe for completion of a standard internal appeal under the final regulations

would seriously jeopardize the life or health of the Participant or would jeopardize the Participant's ability to regain maximum function and the Participant has filed a request for an expedited internal appeal; or

2) A Final Internal Adverse Benefit Determination, if the Participant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Participant or would jeopardize the Participant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, available of care, continued stay, or health care item or service for which the Participant received Emergency Services, but has not been discharged from the facility.

b. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review to the Participant of its eligibility determination.

c. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or Final Internal Adverse Benefit 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, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

d. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the Participant'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 that notice, the assigned IRO will provide written confirmation of the decision to the Participant and the Plan.

Appointment of Authorized Representative

A Participant is permitted to appoint an Authorized Representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An Assignment of Benefits by a Participant to a Provider will not constitute appointment of that Provider as an Authorized Representative. To appoint such a representative, the Participant must complete a form which can be obtained from the Plan Administrator or the Benefit Plan Administrators. However, in connection with a claim involving Urgent Care, the Plan will permit a Health Care Professional with knowledge of the Participant's medical condition to act as the Participant's Authorized Representative without completion of this form. In the event a Participant designates an Authorized Representative, all future communications from the Plan will be with the representative, rather than the Participant unless the Participant directs the Plan Administrator, in writing, to the contrary.

Physical Examinations

The Plan reserves the right to have a Physician of its own choosing examine any Participant whose condition, Sickness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Participant must comply with this requirement as a necessary condition to coverage.

Autopsy

The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, Sickness or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits

All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

Assignments

Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. This prohibition applies to providers as well.

A provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, if bound by the rules and provisions set forth within the terms of this document.

Non-U.S. Providers

Medical expense for care, supplies, or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a "Non-U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non-U.S. Provider;

2. The Participant is responsible for making all payments to Non-U.S. Providers, and submitting receipts to the Plan for reimbursement;

3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;

4. The Non-U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and

5. Claims for benefits must be submitted to the Plan in English.

Recovery of Payments

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

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

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

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

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

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

1. In error;

2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;

3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;

4. With respect to an ineligible person;

5. In anticipation of obtaining a recovery if a Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or

6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deductible may be made against any Claim for Benefits under this Plan by a Participant or by any of his Covered Dependents if such payment is made with respect to the Participant or any person covered or asserting coverage as a Dependent of the Participant.

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

Medicaid Coverage

A Participant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Participant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Participant, as required by the State Medicaid program, and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a compete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the converse, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge in accord with the terms of this Plan Document.

Right to Amend and Terminate

The Company shall have the right at any time to amend or modify this Plan, retroactively or otherwise, or to terminate or partially terminate this Plan; provided that no such amendment or termination shall:

1. Cause or permit the benefit funds to be used for any purpose other than the payment of benefits to Participants or Reasonable administrative expenses;

2. In any manner impair the right of a Participant who has Incurred Covered Charges or is entitled to benefits under this Plan upon the adoption of such amendment to receive benefit payments provided for under this Plan prior to such amendment.

HIPAA PRIVACY

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Participant's personal health information. It also describes certain rights the Participant has regarding this information. Additional copies of our Notice of Privacy Practices are available by calling the Privacy Officer as outlined in the Health Insurance Portability and Accountability (HIPAA) section.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that 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; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

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

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

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

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is:

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

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

6. Not use or disclose genetic information for underwriting purposes.
7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
8. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
12. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
13. Train Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections;
14. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer:
    b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
    c. In the event any of the individuals identified above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

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

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or through Benefit Plan Administrators of Eau Claire, Inc., to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule;
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information; and
3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;
2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
   a. a public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect;
   b. report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
   c. locate and notify persons of recalls of products they may be using; and
   d. a person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law;
3. The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect, when required or authorized by law, or with the Participant's agreement, if the Plan reasonably believes he or she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Participant that such a disclosure has been or will be made unless the Plan believes that informing him or her would place him or her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI;
4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;
5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;
6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Participant's PHI in response to a law enforcement official's request if he or she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises;
7. Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years;
8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions;
9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public;
10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and

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

Required Disclosures of PHI

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

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

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

Instances When Required Authorization Is Needed From Participants Before Disclosing PHI

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures for marketing;
3. Sale of PHI; and
4. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Participant's Rights

The Participant has the following rights regarding PHI about him or her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him or her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions;
2. Right to Receive Confidential Communication: The Participant has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests;
3. The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer;
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six (6) years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Officer;
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him or her in certain records maintained by the Plan. If the Participant requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy his or her PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within thirty (30) days (in some cases, the Plan can request a thirty (30) day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial;
6. Amendment: The Participant has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the

Participant's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request; and

7. Fundraising contacts: The Participant has the right to opt out of fundraising contacts.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

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

Contact Information

Privacy Officer Contact Information:

St .Ambrose Financial Services, Inc.
3710 East Avenue South
P.O. Box 4004
La Crosse, WI 54602-4004
Phone: (608) 791-2669

Additional Contact Information for HIPAA Questions:

Benefit Plan Administrators of Eau Claire, Inc.
402 Graham Avenue – 4th Floor
Eau Claire, WI 54701
Phone: (715) 832-5535
Phone: (800) 236-7789
Fax: (715) 838-8507
Website: www.bpaco.com

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions

1. "*Electronic Protected Health Information*" (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.
2. "Security Incidents" is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

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

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware; and
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

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

1. Notify the Participant whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach. Breach Notification must be provided to individual by:
   a. Written notice by first-class mail to the Participant (or next of kin) at the last known address or, if specified by the Participant, e-mail;
   b. If the Plan has insufficient or out-of-date contact information for the Participant, the Participant must be notified by a "substitute form;
   c. If an urgent notice is required, the Plan may contact the Participant by telephone.
      i. The Breach Notification will have the following content:
         a) Brief description of what happened, including date of breach and date discovered;
         b) Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
         c) Steps the Participant should take to protect from potential harm;
         d) What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches;
2. Notify the media if the breach affected more than five hundred (500) residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than sixty (60) calendar days after the date the breach was discovered;

HIPAA (continued)

3. Notify the HHS Secretary if the breach involves five hundred (500) or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than five hundred (500) individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within sixty (60) days after the end of each Calendar Year; and
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach so that the affected Participants may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

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