DIOCESE of LA CROSSE

LAY GROUP EMPLOYEE DENTAL BENEFIT PLAN

GROUP NUMBER: 94015

Effective Date: September 1, 2015

Original Effective Date: January 1, 1992

Claims Administrator:
Delta Dental of Wisconsin, Inc.
PO Box 828
Stevens Point, WI 54481
Phone: 800-236-3712 or 715-344-6087

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 Employee Dental Benefit Plan.

_____ _____

Employee Signature Date

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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
- Adoption or placement for adoption of a child
- Dependent child reaching the limiting age
- IRS ineligible Dependent child
- Total Disability
- Retirement
- Change of address

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

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SECTION 1

DENTAL BENEFITS

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DENTAL HIGHLIGHTS

This page provides a quick guide to some of the Dental Insurance Plan features which people most often want to know about. It's not a complete description of your Dental Expense Insurance Plan. Read the following pages carefully for a complete explanation of what we pay, limit and exclude.

Calendar Year Cash Deductible

For Group I, II and III Services ..... None

Payment Rates:

For Group I Services (Preventive & Diagnostic) 100%
For Group II Services (Basic) 80%
For Group III Services (Major) 50%

Calendar Year Payment Limit

For Group I, II and III Services
- Individual $1,000
- Family $2,000

DENTAL BENEFITS

This insurance will pay many of your and your covered dependents' dental expenses. What we pay and the terms for payment are explained below.

COVERED CHARGES

Covered Charges are charges for the dental services named in the List of Covered Dental Services performed by or under the direct supervision of a Dentist.

We only pay for Covered Expenses incurred by a Covered Person while he or she is insured. Covered Charges are incurred:

1. For a crown, bridge or cast restoration, on the date the tooth is prepared.

2. For any other Prosthetic Device, on the date the master impression is made.

3. For root canal treatment, on the date the pulp chamber is opened.

All other services are incurred on the date the services are furnished.

PRE-TREATMENT REVIEW

After an examination, your dentist may recommend a treatment plan. If the services involve crowns, fixed bridgework, partial or complete dentures, or implants, ask your dentist to send the treatment plan with radiographs to Delta Dental. The available coverage will be calculated and printed on a Predetermination of Benefits form. Copies of the form will be sent to you and your dentist.

The Predetermination of Benefits form is valid for 1 year from the date issued.

Predeterminations are not required, but Delta Dental encourages you to use this service. Should you have any questions about a predetermination, just call us at 800-236-3712.

Before you schedule dental appointments, you should discuss with your dentist the amount to be paid by Delta Dental and your financial obligation for the proposed treatment.

OPTIONAL TREATMENT

Delta Dental will pay the applicable Maximum Plan Allowance for the least expensive dental procedure that is adequate to restore the tooth or dental arch to contour and function, but only if that dental procedure is a benefit under your dental Plan. You will be responsible for the remainder of the dentist's fee if a more expensive dental procedure is selected. The coinsurance and deductible will apply regardless of which dental procedure is selected.

BENEFITS FROM OTHER SOURCES

This Plan supplements your Major Medical.

This Plan, and your Major Medical may provide benefits for the same charges. If they do, we subtract what the Major Medical pays from what we'd otherwise pay.

Other plans may furnish similar benefits, too. For instance, you may be covered by this Plan and a similar plan through your spouse's employer. If you are, we coordinate our benefits with the benefits from these other plans. We do this so no one gets more in benefits than the charges he incurs. Read "Coordination of Benefits" to see how this works.

THE BENEFIT PROVISION - QUALIFYING FOR BENEFITS

Group I, II and III Services
There is no deductible for dental services. We pay for dental services at the applicable payment rate.

Maximum Annual Benefit
All charges must be incurred while the Covered Person is insured. We limit what we pay each Calendar Year to $1,000.00 per Covered Person and further limit Calendar Year benefits to $2,000 per family. What we pay is based on all of the terms of this Plan.

Payment Rates
Benefits for Covered Charges are paid at the following rates:

Benefits for Group I Services (Preventive & Diagnostic) are paid at a rate of.....100%

Benefits for Group II Services (Basic) are paid at a rate of.....80%

Benefits for Group III Services (Major) are paid at a rate of 50%

AFTER THIS INSURANCE ENDS

Benefits will be paid for the following work started while a Covered Person is insured under this Plan and is completed in the 60 days after this insurance ends:

1. A crown, bridge or cast restoration, if the tooth is prepared before coverage ends;

2. Any other Prosthetic Device, if the master impression is taken before the coverage ends; and

3. Root canal treatment, if the pulp chamber is opened before the coverage ends.

No benefits will be paid for any type of work not listed above which is completed after this insurance ends.

SPECIAL LIMITATIONS

Penalty for Late Enrollees
Benefits for Late Enrollees/Open Enrollees will be limited to preventive, diagnostic, ancillary and direct restorative services only during the first 12 months of coverage. After 12 months, all other Covered Expenses will be eligible for benefits.

A Late Enrollee includes Open Enrollees and is a person who:

1. Becomes insured more than 31 days after he is eligible; or

2. Becomes insured again, after his coverage terminated because he did not make required payments or due to his or her request to terminate.

Pre-Existing Condition (Teeth Lost Before Becoming Insured By This Plan)
We won't pay for a Prosthetic Device which replaces one or more teeth before a Covered Person became insured by this Plan if You declined to enroll when first given the opportunity (i.e. at initial enrollment).

If This Plan Replaces Another Plan
This Plan may be replacing another plan your Employer had with some other insurer.

We don't want anyone to lose benefits when this happens. So we pay for certain charges incurred before this Plan starts, if:

1. The Covered Person was insured by the old plan; and

2. The old plan would have paid for such charges.

This Plan must start right after the old plan ends, and the Covered Person must be insured by this Plan from the start.

We limit what we pay to the lesser of:

1. What the old plan would have paid; or

2. What we would otherwise pay.

We deduct any benefits actually paid by the old plan under any extension provision.

EXCLUSIONS

We won't pay for:

1. Oral hygiene, plaque control or diet instruction;

2. Precision or semi-precision attachments;

3. Treatment which does not meet accepted standards of dental practice or is experimental in nature;

4. Any Appliance or Prosthetic Device used to:
   a. change vertical dimension;
   b. restore or maintain occlusion;
   c. replace tooth structure lost as a result of abrasion or attrition;
   d. treat disturbances of the temporomandibular joint; and
   e. splint or stabilize teeth for periodontic reasons.

5. Services or supplies for appliances, including nightguards for the treatment of gum and bone disease or to limit tooth grinding or jaw clenching.

6. Replacing a lost, stolen or missing Appliance or Prosthetic Device*;*

7. Making a spare Appliance or device;

8. Replacing an Appliance or Prosthetic Device with a like Appliance or device, unless it is:
   a. at least ten years old and can't be made usable; or
   b. damaged while in the Covered Person's mouth in an Injury suffered while insured, and can't be fixed;

9. Any service furnished for cosmetic reasons. This includes, but is not limited to:
   a. characterizing and personalizing Prosthetic Devices*;* and
   b. making facings on Prosthetic Devices for any teeth in back of the second bicuspid;

10. Treatment needed due to:
    a. an on-the-job or job-related Injury; or
    b. a condition for which benefits are payable by Worker's Compensation or similar laws.

11. Treatment for which no charge is made. This usually means treatment furnished by:
    a. the Covered Person's Employer, labor union or similar group, in its dental or medical department or clinic;
    b. a facility owned or run by any governmental body; and
    c. any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made and we are legally required to pay it, we will.

12. Treatment for:
    a the Covered Person's commission of, or attempt to commit, a felony;
    b. the Covered Person's engaging in an illegal occupation;
    c. the Covered Person's participation in a riot; or
    d. any treatment, service or supply received in connection with orthodontia.

13. Services for infection control procedures (sepsis control – rubber gloves, gowns, etc.) when billed separately from actual dental treatment.

14. Charges for the completion of forms or for missed appointments.

15. Procedures or benefits not specifically provided under this dental plan or excluded by Delta Dental rules and regulations, including Delta Dental processing policies, which may change periodically and are printed on the Explanation of Benefits and Explanation of Payment forms.

If a charge is made and we are legally required to pay for it, we will.

LIST OF COVERED DENTAL SERVICES

The services covered by this Plan are named in this list. Each service on this list has been placed in one of three groups. A separate payment rate applies to each group. Group I is made up of preventive services. Group II is made up of basic services. Group III is made up of major services.

All covered dental services must be furnished by or under the direct supervision of a Dentist. They must be usual and necessary treatment for a dental condition.

GROUP I - PREVENTIVE DENTAL SERVICES

1. Examinations twice in a benefit year.

2. Full mouth x-rays, which include bitewing x-rays, at 5-year intervals. Full mouth x-rays may be either individual films or panoramic film.

3. Bitewing x-rays twice in a benefit year, limited to a set of 4 films.

4. Dental prophylaxis (teeth cleaning) twice in a benefit year.

5. Topical fluoride applications twice in a benefit year, for dependent children to age 19.

6. Space maintainers for retaining space when a primary tooth is prematurely lost.

7. Emergency treatment to relieve pain.

8. Topical application of sealants for dependents through age 13. Application is limited to the occlusal surface of permanent molars that are free of decay and restorations. Benefits are limited to 1 application per tooth per lifetime.

GROUP II - BASIC DENTAL SERVICES

1. Extractions and other oral surgery (cutting procedures), including preoperative and postoperative care.

2. Restorations:
   a. amalgam (silver) restorations;
   b. composite (tooth-colored) restorations in anterior (front) teeth;
   c. stainless steel prefabricated crowns — 1 per tooth in a 3-year period.

3. Local anesthetic as part of a dental procedure. General anesthetic or intravenous sedation is a benefit only when billed with covered oral surgery.

4. Endodontics (root canal treatment and root canal therapy).

5. Periodontics (procedures needed to treat diseases of the gums and the bone supporting the teeth) — nonsurgical treatment once each 2 years; surgical treatment once each 3 years. Periodontal maintenance — either periodontal maintenance or adult prophylaxis twice in a benefit year.

6. Repairs and adjustments to prosthetic appliances.

7. Denture reline once in any 12-month period and rebase once in any 3-year period.

GROUP III - MAJOR DENTAL SERVICES

1. Crowns, inlays or onlays are provided when teeth are broken down by dental decay or accidental injury and may no longer be restored adequately with a filling material. Coverage for the purpose of replacing a defective existing crown, inlay or onlay will be provided only after a 10 year period from the date on which the defective item was last supplied, whether or not Delta Dental paid for the original dental procedure as a benefit under this dental Plan. This frequency may be waived if replaced as the result of an accidental injury.

2. Prosthetics, including fixed bridgework, partial dentures, and complete dentures, or implants to replace missing permanent teeth. Coverage for the purpose of replacing a defective existing fixed bridge or partial/complete denture or

implant will be provided only after a 10 year period from the date on which the defective item was last supplied, whether or not Delta Dental paid for the original dental procedure under this dental Plan. This frequency may be waived if replaced as the result of an accidental injury.

Fixed bridges and partial/complete dentures or implants are provided where chewing function is impaired due to missing teeth. A fixed bridge, or implant and implant-related procedures may be a benefit if no more than two teeth are missing in the dental arch in which the bridge is proposed. Delta Dental will provide for replacement of missing teeth with the least elaborate procedure when three or more teeth are missing in the dental arch.

a. porcelain veneers on crowns or pontics on the six front teeth, bicuspids and upper first molars.

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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.

Active Appliance:
Active Appliance means an Appliance, like braces, used in Orthodontic Treatment to move teeth.

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 will be considered Actively at Work for purposes of eligibility under this Plan and will not be subject to the minimum hours requirement.

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.

AHA:
AHA means the American Hospital Association.

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.

Appliance
Appliance means any dental device other than a Prosthetic Device.

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

Child:

Definitions (continued)

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.

COBRA:

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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 Charges

Covered Charges means charges for the types of services and supplies described. The services and supplies must be:

1. Furnished or ordered by a recognized dental care provider;

2. Medically necessary;

3. Accepted by a professional dental society in the United States as beneficial; and

4. Furnished within the framework of generally accepted methods of dental management currently used in the United States.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all the terms of this Plan, we pay benefits for Covered Charges incurred by a Covered Person while he's insured by the Plan. Read the entire Plan to find out what we limit or exclude.

Covered Person:

A Covered Person is an eligible Employee or eligible Dependent who has met all of the conditions for coverage under the Plan.

Deductible:

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

Dentist:

Delta Dental PPO Dentists

Delta Dental PPO Dentists have signed a contract with Delta Dental, agreeing to accept reduced fees for the dental procedures they provide. This reduces your out-of-pocket costs, because you will be responsible only for applicable deductible amounts, copayments and coinsurance for benefits. And because these dentists agree to fees approved by Delta Dental, they receive payment directly from Delta Dental.

Dentists Outside the Delta Dental PPO Network

Delta Dental Premier Dentists

Delta Dental Premier Dentists have signed a contract with Delta Dental, agreeing to accept direct payment from Delta Dental. They have also agreed not to charge you any amount that exceeds the Maximum Plan Allowance (MPA). However, you are still responsible for deductibles, copayments, coinsurance, and fees for services that are not benefits under this dental Plan.

The Maximum Plan Allowance is the total dollar amount allowed for a specific benefit. The Maximum Plan Allowance will be reduced by any deductible and coinsurance you are required to pay.

Noncontracted Dentists

If your dentist has not signed a contract with Delta Dental, claim payments will still be calculated based on the MPA, but they will be sent directly to you rather than to the dentist. You will then reimburse your dentist through his or her usual billing

procedure. You will be responsible for any amount in excess of the Maximum Plan Allowance, as well as any deductible, copayment, coinsurance, and fees for services that are not benefits under this dental Plan.

Please note that if the fee charged by a noncontracted dentist is not allowed in full, Delta Dental is not implying that the dentist is overcharging. Dental fees vary and are based on each dentist's overhead, skill, and experience. Therefore, not every dentist will have fees that fall within the MPA.

For information on Delta Dental PPO or Delta Dental Premier Dentists, visit Delta Dental's website at www.deltadentalwi.com or call 800-236-3712.

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.

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.

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.

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.

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 is 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.

ERISA:
ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Expense Incurred:
Expense Incurred means the fee charged for services and supplies needed to treat the Injury or Sickness. The date a supply or service is provided is the Expense Incurred date.

Experimental:
Experimental means services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical or dental practice under the standards of the case and by the standards of a reasonable segment of the medical or dental 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.

All phases of clinical trials shall be considered experimental.

Drugs are considered Experimental if they are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

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.

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

Hospital:
Hospital means a Qualified Treatment Facility that meets all of the following requirements:

1. It provides medical and surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;

2. It is under the supervision of a staff of Physicians;

3. It provides 24-hour-a-day nursing service by registered nurses;

4. It is duly licensed as a hospital, except that this requirement will not apply in the case of a state tax-supported Qualified Treatment Facility;

5. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a Custodial or training-type Qualified Treatment Facility, or a Qualified Treatment Facility which is supported in whole or in part by a federal government fund; and

6. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Qualified Treatment Facility is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

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.

Injury also means all damage to a Covered Person's mouth due to an accident, and all complications rising from that damage. The term Injury does not include damage to teeth, Appliances or Prosthetic Devices which results from chewing or biting food or other substances.

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.

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

Maximum Amount or Maximum:
Maximum Amount or Maximum means the greatest benefit payable for a specific coverage item or benefit under the Plan.

Maximum Plan Allowance (MPA)
Maximum Plan Allowance (MPA) means the total dollar amount allowed under the contract for a specific benefit. The MPA will be reduced by any deductible and coinsurance subscriber or covered dependent is required to pay.

Delta Dental’s MPA varies by region due to contractual arrangements or, in some instances, state regulations. Delta Dental determines an MPA for each CDT code published in the most current version of Current Dental Terminology. The MPA established by Delta Dental is developed from various sources, such as contracts with dentists, input from our dental consultants, the simplicity or complexity of the procedure and the billed charges for the same procedures by dentist in the same geographic location.

Medically Necessary:
Medically Necessary means services or supplies which are determined by the Plan to be:

1. Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the medical or dental condition, Sickness, or Injury;

2. Provided for the diagnosis or direct care and treatment of the medical or dental condition, Sickness, or Injury;

3. Within standards of good medical practice within the organized medical or dental community;

4. Not primarily for the convenience of the Covered Person, the Covered Person's Qualified Practitioner or another provider of service; and

5. The most appropriate supply or level of service which can safely be provided.

The mere fact that the service is furnished, prescribed or approved by a Qualified Practitioner or Dentist 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.

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

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

Open Enrollment:
Open Enrollment means the period that occurs annually during which Employees can enroll themselves and their eligible Dependents (as Late Enrollees) or make other enrollment changes. 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).

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" has a special meaning in the provision entitled "Coordination of Benefits". See that provision for details.

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 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.

Prosthetic Device:
Prosthetic Device means a device which is used to replace missing or lost teeth or tooth structure. It includes all types of dentures, crowns, bridges, pontics and cast restorations.

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.

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.

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.

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).

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.

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.

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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 an Employee who is a regular full-time Employee of the Employer, regularly scheduled to work for the Employer in an employer-Employee relationship. An Employee will not be a leased, seasonal or temporary employee, or an independent contractor. You must be scheduled to work as:
   a. a full-time teacher or other teacher working at least 30 hours per week during the school year (1,140 annual hours);
   b. 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.

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

3. 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. 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.

If Your completed enrollment forms are received by the Plan Administrator **more than 31 days after** Your effective date, You will be a **Late Enrollee**. Application for coverage as a Late Enrollee is limited to Special Enrollment or to Open Enrollment in August 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. The Pre-existing Condition limitation will be waived for an adopted child, under age 18, of a covered Employee, and for a child, under age 18, placed in the home of a covered Employee in anticipation of adoption, provided the adoption (or placement for adoption) occurs while the Employee is covered under the Plan and provided coverage for such child becomes effective within 31 days of the adoption (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".

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. Benefits due to Your reaching the lifetime maximum for all benefits; or

4. 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 or Placement for Adoption

If You experience the birth of a Dependent Child, or the adoption or placement for adoption of a Dependent Child, 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 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; or
   d. Placement for adoption.

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 or placement for adoption, provided these forms are received within 31 days of the birth, adoption or placement for adoption.

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.

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 Covered Person 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.

"**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 Covered Person's child or directs the Covered Person 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 Covered Person under the Plan;

3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Covered Person 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 Covered Person 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 Covered Person 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 Covered Persons 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 Covered Person 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 Covered Person 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.

REINSTATEMENT OF COVERAGE FOLLOWING LAYOFF OR APPROVED LEAVE OF ABSENCE

If You are now an eligible Employee and 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, 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.

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 Covered Person 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 he ceases to be eligible for such coverage under the Plan;

5. The last day of the month in which termination of working hours occurs. This would be the last actual day worked or the end of an approved Employer Continuation in accordance with this Plan; or

6. 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.

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.

TERMINATION DUE TO FRAUD

The following actions by any Covered Person, or a Covered Person's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family Unit of which the Covered Person is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person of the Plan;

2. Attempting to file a claim for a Covered Person for services which were not rendered or Drugs or other items which were not provided;

3. Providing false or misleading information in connection with enrollment in the Plan; or

4. Providing any false or misleading information to the Plan.

UNIFORMED SERVICES EMPLOYMENT & 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 Covered Persons 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 Covered Persons 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.

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

Regardless of the established leave policies mentioned above, the Plan shall at all times comply with FMLA. During any leave taken under FMLA, the Employee will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

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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 September 1, 2015 hereby amends and restates the Diocese of La Crosse Lay Group Employee Dental Benefit Plan (the "Plan"), which was originally adopted by the Company, effective January 1, 1992.

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 may be self-funded through a benefit fund or a trust established by the Plan Sponsor or may be funded solely from the general assets of the Plan Sponsor. Covered Persons 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 hospital, medical, dental or vision charges or disability benefits. The Plan Document is maintained by the Plan Sponsor and may be inspected at any time during normal working hours by any Covered Person.

PLAN NAME	Diocese of La Crosse Lay Group Employee Dental Benefit Plan
TYPE OF PLAN	A self-funded welfare benefit plan providing certain 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 DATE	September 1, 2015
GROUP NUMBER	90415
PLAN YEAR FOR GOVERNMENT REPORTING	July 1 to June 30
PLAN ADMINISTRATOR AND PLAN SPONSOR	St. Ambrose Financial Services, Inc. 3710 East Avenue South P.O. Box 4004 La Crosse, WI 54602-4004 (608) 791-2669
PLAN NUMBER	502
PLAN SPONSOR IDENTIFICATION NUMBER	39-0807229
ADMINISTRATIVE SERVICE MANAGER	Delta Dental of Wisconsin, Inc. PO Box 828 Stevens Point, WI 54481 800-236-3712 or 715-344-6087
AGENT FOR SERVICE OF LEGAL PROCESS	Ms. Sondra Rieder 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 Covered Person'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 Covered Person 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 Covered Person'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 third party 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

Benefits described in this Plan are coordinated with benefits provided by other plans under which You are also covered. This is to prevent the problem of over insurance and a resulting increase in the cost of coverage.

Effect on Benefits

Benefits will be reduced under certain circumstances when You are covered both under this Plan and any other plan defined below which also provide coverage for Covered Expenses. Reimbursement under this Plan and any other plans included under this provision will not exceed 100% of the total Allowable Expenses Incurred under this Plan.

Benefits under this Plan will be coordinated with benefits paid or payable under another plan, as defined, whether or not a claim is filed with such other plan.

Definition of other plans

For the purposes of this provision, this Plan will coordinate benefits with other plans providing any coverage which includes reimbursement of medical or dental expenses, or provides benefits or services by:

1. Group or franchise insurance coverage, whether insured or self-insured;

2. Hospital or medical service organizations on a group basis and other group pre-payment plans;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage sponsored or provided by or through an educational institution;

5. Any governmental program or a program mandated by state statute;

6. Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of injuries arising out of a motor vehicle Accident, and any other medical and liability benefits received under any automobile policy;

7. Any coverage sponsored or provided by or through an Employer, trustee, union, Employee benefit, or other association.

This includes group-type contracts not available to the central public, obtained and maintained only because of the Covered Person's membership in or connection with a particular organization or group, whether or not designated as franchise, blanket, or in some other fashion.

How Coordination of Benefits Works

One of the plans involved will pay benefits first, without considering the benefits available under the other plans. This is called the primary plan. The other plans will then make up the difference, up to the total Allowable Expense.

When a plan provides benefits in the form of services rather than cash payments, the Customary, Usual and Reasonable cash value of each service will be deemed to be both a Covered Expense and a benefit paid. This Plan will not pay more than it would have paid without this provision.

"Allowable Expenses"

"Allowable Expenses" means any Medically Necessary, Customary, Usual and Reasonable item of expense, at least a portion of which is covered under this Plan. Benefits payable under any other plan include the benefits that would have been payable had claim been duly made therefor.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as Allowable Expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

Order of Benefit Determination

A plan will be considered the primary plan and pay benefits first if it meets one of the following conditions:

Coordination of Benefits (continued)

1. The plan has no coordination provision;

2. The plan covers the person as an Employee;

3. For a Child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the Calendar year pays before the plan covering the other parent. If both parents have the same birthday, the plan covering the parent for the longer period of time will pay first;

4. In the case of Dependent Children covered under the plans of divorced or separated parents (whether or not legally married):
   a. The plan of a parent who has custody will pay the benefits first,
   b. The plan of a stepparent who has custody will pay the benefits next,
   c. The plan of a parent who does not have custody will pay benefits next, and
   d. The plan of a stepparent who does not have custody will pay benefits next;
   e. If there is a court decree which gives one parent financial responsibility for the medical expenses of the Dependent children, the rules stated above will not apply if they conflict with the court decree. Instead, the plan of the parent with financial responsibility, as ordered by the court, will pay benefits first.

5. The plan covering a laid off or retired person, or a person on COBRA or any other form of continuation, or covering the Dependent of such a person, will pay benefits after the plan covering such persons as an active Employee of the Dependent of an active Employee.

6. The plan covering the person under a disability extension of benefits will pay benefits before the plan covering such persons as an active Employee or the Dependent of an active Employee.

If the above rules do not apply or cannot be determined, then the Plan that covered the person for the longer period of time will be primary.

If a plan other than this Plan does not include provisions 3. or 5., then those provisions will be ignored in order to determine benefits with the other plan.

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 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 or instruments as may be necessary to implement this provision.

Facility of Payment

Whenever payments 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 organizations 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 provision, 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 Covered Person or his Dependents.

Coordination of Benefits with Medicare

In all cases, coordination of benefits with Medicare will conform with Federal Statutes and Regulations. In the case of Medicare, each individual who is eligible for Medicare will be assumed to have full Medicare coverage (i.e. Part A Hospital insurance and Part B voluntary medical insurance) whether or not the individual has enrolled for full coverage. Your benefits under this Plan will be coordinated to the extent allowed by Federal Statutes and Regulations.

Coordination of Benefits (continued)

If any Covered Person is eligible for Medicare benefits because of End Stage Renal Disease ("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.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

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 Covered Person(s), and/or their Dependents, beneficiaries, estate, heirs guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

Covered Person(s) his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person(s) agrees the Plan shall have an equitable lien on any funds received by the Covered Person(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 Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

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

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 Covered Person(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

As a condition to participating in and receiving benefits under this Plan, the Covered Person(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 Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan discretion.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(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 Plan may, at its discretion, in its own name or in the name of the Covered Person(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.

If the Covered Person(s) fails to file a claim or pursue damages against:

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. 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;

the Covered Person(s) authorizes the Plan to pursue sue, compromise and/or settle any such claims in the Covered Person(s) and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(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

The Plan shall be entitled to recover 100% of the benefits paid, without deductible 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 Covered Person(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. IF the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

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

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 Covered Person(s), whether under the doctrines or causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction status, 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.

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 Covered Person(s).

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.

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 settlement(s), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

1. the responsible part, 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. 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.

Separation of Funds

Benefits paid by the Plan, funds, recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(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 Covered Person(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third part or any Coverage, the Plan's subrogation and reimbursement right shall still apply, and the entity pursing said claim shall honor and enforce the Plan rights by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations

It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. 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;

2. 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;

3. to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

4. to do nothing to prejudice the Plan's rights of subrogation and reimbursement;

5. to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

6. to not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.

If the Covered Person(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 Covered Person(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 Covered Person(s).

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

Offset

If timely repayment is not made, or the Covered Person and/or his/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 Covered Person'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 Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan.

Minor Status

In the event the Covered Person(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.

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

AMENDMENTS TO OR TERMINATION OF THE PLAN

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust Agreement (if any).

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his own discretion.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Plan assets will be allocated and disposed of for the exclusive benefit of Covered Persons, except that any taxes and administration expenses may be paid from the Plan's assets.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A Covered Person is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Administrative Service Manager. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as his authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

AUTOPSY

The Plan reserves the right to have an autopsy performed upon any deceased Covered Person whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

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 Covered Persons 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 shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated Maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document. It is intended that the Plan will conform to any applicable law.

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.

FREE CHOICE OF PROVIDER

Any Covered Person 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.

HEADINGS

The headings used in this Plan Document are used for convenience of reference only. Covered Persons are advised not to rely on any provision because of the heading.

LIMITATION ON ACTIONS

No action at law or in equity shall be instituted to recover under this Plan prior to the expiration of 90 days after a claim for benefits has been filed in accordance with the requirements of this Plan. Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within one year after the expenses due to Injury or Sickness are incurred or are alleged to have been incurred. Any limitation on actions regarding claims for benefits shall be as provided in Section, "General Provisions", "Claims Procedures; Payment of Claims", heading "Decision on Review to be Final".

MEDICAID COVERAGE

A Covered Person'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 Covered Person. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, 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.

NO WAIVER OR ESTOPPEL

No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or 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 the one specifically waived.

NON-U.S. PROVIDERS

Medical expenses for care, supplies, or services which are rendered by a Qualified Practitioner 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 Covered Person 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.

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.

PHYSICAL EXAMINATION

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person 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 Covered Person must comply with this requirement as a necessary condition to coverage.

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 Covered Person.

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 Covered Person's contribution (if any) will be determined from time to time by the Plan Administrator.

PRONOUNS

All personal pronouns used in the Plan shall include either gender unless the context clearly indicates otherwise.

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 Covered Person. Such payment will fully discharge the Plan's liability to the extent of the payment.

RIGHT OF RECOVERY PROVISION

Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the Covered Person on whose behalf the payment was made.

A Covered Person, Provider, another benefit plan, insurer, or any other person or entity who receives a payment for expenses exceeding the amount of benefits available under the terms of the Plan or on whose behalf such payment to the Plan was made, shall return the amount of such erroneous payment to the Plan Sponsor 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 Sponsor for an erroneous payment and such payment shall be reimbursed in lump sum or deducted from future claims presented for processing.

Health care providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree 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-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the Plan shall be entitled to recover its litigation cost and actual attorney's fees incurred.

RIGHT TO RECEIVE AND RELEASE INFORMATION

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Covered Person for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

SECURITY

The Employer, who is the sponsor of this Plan, will receive electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the Employer certifies to the Plan that it agrees to:

1. Take appropriate and reasonable safeguards (administrative, physical and technical) to protect the confidentiality, integrity, and availability of the information it creates, receives, maintains or transmits;

2. Require that nay agent or subcontractor of the Employer agrees to the same requirements that apply to the Employer under this provision;

3. Report to the Plan any security incident that the Employer becomes aware of; and

4. Apply reasonable and appropriate security measures to maintain adequate separation between the Plan and itself.

STATEMENTS

In the absence of fraud, all statements made by a Covered Person 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 Covered Person or, if deceased, to his beneficiary.

WRITTEN NOTICE

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

CLAIM PROCEDURES; PAYMENT OF CLAIMS

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. However, as noted below, because of this Plan's design, there are no Pre-service Urgent Care Claims which may be filed with the Plan.

1. Pre-service Claims. A "Pre-service Claim" is a claim for a 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. However, if the Plan does not require the Covered Person to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The Covered Person 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.

   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 Covered Person or the Covered Person's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

   It is important to remember that, if You need medical care for a condition which could seriously jeopardize Your life, there is no need to contact the Plan for prior approval. You should obtain such care without delay.

   The Plan does not require the Covered Person to obtain approval of any urgent care or Emergency medical services or admissions prior to getting treatment for an urgent care or Emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Covered Person 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.

   Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants inpatient Confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Covered Person has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. 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:

   a. The Plan determines that the course of treatment should be reduced or terminated; or

   b. The Covered Person requests extension of the course of treatment beyond that which the Plan has approved.

   If the Plan does not require You 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. You simply follow 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.

3. 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

Health claims must be filed with the Administrative Service Manager within 365 days of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date 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 Administrative Service Manager in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Administrative Service Manager, together with a Form HCFA or Form UB92:

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.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Administrative Service Manager 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 Administrative Service Manager within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the Covered Person of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

TIME OF CLAIM DETERMINATION

You will be notified, 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 Non-urgent Care Claims:

    a. If You have 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 You have not provided all of the information needed to process the claim, then You will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. You 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 You (if additional information was requested during the extension period).

2. Concurrent Claims:

    a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying You of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. You will be notified sufficiently in advance of the reduction or termination to allow an appeal and to obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

    b. Request by a Covered Person Involving Urgent Care. If the Plan Administrator receives a request from a Covered Person 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 Covered Person makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Covered Person 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 a Covered Person Involving Non-urgent Care. If the Plan Administrator receives a request from the Covered Person 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).

3. Post-service Claims:
   a. If You have provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 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 You have not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then You 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 You will be notified of the determination by a date agreed to by the Plan Administrator and You.

4. 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 You, 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.

5. 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 You, 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.

6. 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 You with a notice, either in writing or electronically, containing the following information:

1. A reference to the specific portion(s) of the Plan Document upon which a denial is based;

2. Specific reason(s) for a denial;

3. A description of any additional information necessary for You to perfect the claim and an explanation of why such information is necessary;

4. A statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to Your claim for benefits;

5. 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, upon request);

6. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to You, free of charge, upon request); and

7. 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 Your medical circumstances, or a statement that such explanation will be provided to You, free of charge, upon request.

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 You believe the claim has been denied wrongly, You may appeal the denial and review pertinent documents. The claims procedures of this Plan provide You with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. You at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;

2. You 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 benefit 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 You relating to the claim, without regard to whether such information was submitted or considered in the 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 advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and

7. That You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim for benefits in possession of the Plan Administrator or the Administrative Services Manager; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances.

Requirements for Appeal

You must file an appeal of a post-service claim in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, Your appeal must be addressed as follows:

For Pre-service and Post-service Claims:

Delta Dental of Wisconsin, Inc.
Attn: Claim Appeal Department
PO Box 828
Stevens Point, WI 54481

It shall be Your responsibility 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/Dependent;

2. The Employee/Dependent'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, You will lose the right to raise factual arguments and theories which support this claim if You fail 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 You have which indicates that You are entitled to benefits under the Plan.

If You provide 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 You of the Plan's benefit determination on review within the following timeframes:

1. 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.

2. 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.

3. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

4. Calculating Time Periods. 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 on Review

The Plan Administrator shall provide You with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;

2. Reference to the specific portion(s) of the Plan Document on which the denial is based;

3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;

4. A statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim for benefits;

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to You upon request;

6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, will be provided free of charge upon request; and

7. 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 Documents 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 items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review to be Final

If, for any reason, You do not receive a written response to the appeal within the appropriate time period set forth above, You may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and 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. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.**

A complaint may also be submitted to non-binding arbitration upon mutual agreement with the Employer and other parties involved pursuant to the rules of the American Arbitration Association. The arbitrator cannot award any punitive damages or ignore or vary the provisions of the Plan and must follow all applicable laws.

HIPAA PRIVACY

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 us 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/her about:

1. The Plan's disclosures and uses of PHI;
2. The Participant's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/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. If a Plan engages in underwriting: 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. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
14. Train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
15. 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
16. 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: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
    b. In the event any of the individuals described 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.

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 Delta Dental of Wisconsin, 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/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/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI;
4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;
5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the 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/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.

HIPAA Privacy and Security (continued)

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/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/her personal representative, or treating such person as his/her personal representative could endanger the Participant; and

2. Disclosures to the Secretary of the U.S. Dept 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. If the Plan maintains psychotherapy notes: 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 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/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/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions;
2. Right to Receive Confidential Communication: The Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the 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 Compliance Coordinator;
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six (6) years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (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 Compliance Coordinator;
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/her in certain records maintained by the Plan. If the Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI, or to have a copy of your PHI transmitted directly to another designated person, contact the Privacy Compliance Coordinator. 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/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request; 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/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/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 Compliance Coordinator Contact Information:
St .Ambrose Financial Services, Inc.
3710 East Avenue South
P.O. Box 4004
La Crosse, WI 54602-4004
(608) 791-2669

Additional Contact Information for HIPAA Questions:

Delta Dental of Wisconsin, Inc.
PO Box 828
Stevens Point, WI 54481
800-236-3712 or 715-344-6087
www.deltadentalwi.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 Participant (or next of kin) at last known address or, if specified by Participant, e-mail;
    b. If 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, Plan may contact the Participant by telephone.
        i. The Breach Notification will have the following content:
            1. Brief description of what happened, including date of breach and date discovered;
            2. Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
            3. Steps Participant should take to protect from potential harm;
            4. What the Plan is doing to investigate the branch, 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;
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.