DIOCESE of LA CROSSE

PRIEST GROUP MEDICAL BENEFIT PLAN

GROUP NUMBER: 8236

Effective Date: July 1, 2015

Original Effective Date: January 1, 1992

Administrative Service Manager:
Custom Benefit Plan Administrators, a Benefit Plan Administrators of Eau Claire, Inc. affiliate
305 5th Avenue South, Suite 206
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GRANDFATHERED HEALTH PLAN NOTICE

This Diocese of La Crosse Priest Group Medical Benefit Plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to Other Plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of Lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the Diocese of La Crosse. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans

IMPORTANT MESSAGE

It is important that ANY CHANGE OF ELIGIBILITY for You be reported to Your Employer, as soon as possible.

Changes of eligibility include:

- Total Disability
- Retirement
- Change of address
- Medicare eligibility

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

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SECTION 4 GENERAL PLAN INFORMATION

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SECTION 1

MEDICAL BENEFITS

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

PREFERRED PROVIDER ORGANIZATION PROVISIONS

WHAT IS A PREFERRED PROVIDER ORGANIZATION?

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

REASONS TO USE A PPO PROVIDER

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

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

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

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

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

HOW TO SELECT A PROVIDER

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

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

TRAVEL/COMPLIMENTARY/WRAP PPO NETWORK

This network is available for you when you travel outside your primary network area. This does not include charges incurred if You traveled to such location for the purpose of obtaining medical services, drugs or supplies. The Complimentary/travel network identifier is on the back of your ID card. If you access a provider within this network, your benefits will be paid at the PPO level of benefits. For providers within the Multiplan Complimentary network, contact Multiplan, Inc. at 1-800-546-3887 or via their website at www.Multiplan.com.

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

SCHEDULE OF BENEFITS

OUTLINE OF MEDICAL COVERAGE

Benefit	PPO Providers	Non-PPO Providers
Annual Maximum	Unlimited	
Deductible	$500 per person per Contract Year	$500 per person per Contract Year
Coinsurance Percentage Payable (except as noted)	90%	80%
Maximum Out-of-Pocket (includes deductible)	$900 per person per Contract Year	$1,300 per person per Contract Year
Physician/Clinic Office Calls*	Covered Expenses subject to a $25 copayment per visit for office visit charges only, then 100%.	Covered Expenses subject to Deductible and reimbursed at coinsurance percentage.
Laboratory/X-ray Charges	Covered Expenses subject to Deductible and reimbursed at coinsurance percentage.	Covered Expenses subject to Deductible and reimbursed at coinsurance percentage.
Preventive Care Benefit	Covered Expenses are payable at 100% to $700 per Contact Year then subject to Deductible and reimbursed at coinsurance percentage.	Covered Expenses subject to Deductible and coinsurance, payable to a $700 Maximum per Contact Year.
Physician/Clinic Other Services Including: - Durable Medical Equip. - Home Health Care	Covered Expenses subject to Deductible and reimbursed at coinsurance percentage.	Covered Expenses subject to Deductible and reimbursed at coinsurance percentage.
Hospital Services - Inpatient Charges - Outpatient Charges	Covered Expenses subject to Deductible and reimbursed at coinsurance percentage.	Covered Expenses subject to Deductible and reimbursed at coinsurance percentage.
Chiropractic Care	Covered Expenses subject to Deductible and reimbursed at coinsurance percentage.	Covered Expenses subject to Deductible and reimbursed at coinsurance percentage.
Emergency Room Charges* (Copayment waived if admitted on inpatient basis within 24 hours for same condition.)	Covered Expenses subject to a $50 copayment, then subject to PPO Deductible and PPO coinsurance percentage.	
Prescription Drugs*	*Retail*: $10 copayment for generic Drugs or $25 copayment for brand name Drugs, 100% thereafter, for up to a 34-day supply. *Mail Order*: $20 copayment for generic Drugs or $50 copayment for brand name Drugs, 100% thereafter, for a 90-day supply.	
Mental or Nervous Conditions and Substance Abuse	*Inpatient:* Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. *Outpatient:* $25 copayment per visit, 100% thereafter	*Inpatient and Outpatient:* Covered Expenses subject to Deductible and reimbursed at coinsurance percentage.

* Copayments for physician/office calls, Emergency room charges, prescription Drugs and Mental or Nervous Conditions and Substance Abuse are not credited to Deductible, coinsurance or maximum out-of-pocket expense.

Schedule of Benefits (continued)

MEDICAL BENEFITS

Annual Maximum Unlimited per Covered Person

Deductible per Contact Year 1-8

PPO Providers	$500
Non-PPO Providers	$500

If You use a combination of PPO and Non-PPO Providers, the amount of Deductible You have paid will be credited to both Deductibles.

Coinsurance 1-8

PPO Providers	90% (You pay 10%)
Non-PPO Providers	80% (You pay 20%)

After You satisfy the deductible for the Contact Year, the Plan will then pay the applicable percentage shown for Covered Expenses up to the out-of-pocket limit listed below, and 100% thereafter for the remainder of the same Contact Year, subject to Plan maximums.

Out-of-Pocket Limit 1-8

PPO Providers	$ 900
Non-PPO Providers	$1,300

Any copayments associated with this Plan will not accrue toward satisfaction of these out-of-pocket limits.

The out-of-pocket limit amounts represent the total dollars paid by You toward satisfaction of the Deductible and coinsurance provisions. When You reach the limit, the Plan will then pay 100% of Covered Expenses, subject to Plan Maximums, for the remainder of the same Contact Year. If You use a combination of PPO and Non-PPO Providers, the amount of Deductible and eligible coinsurance You have paid for PPO Providers will also be credited to the out-of-pocket limit for Non-PPO Providers, so that the combined out-of-pocket amounts will not exceed the Non-PPO Provider out-of-pocket limit.

COVERED EXPENSES

The benefits under this Plan are intended to cover a wide range of services. In the section, "Medical Covered Expenses," You will find important additional information on the types of services covered under this Plan. Please also refer to the section, "Limitations and Exclusions" for information on expenses not covered. In addition, You may find the "Definitions" section helpful in understanding the terms used in this Summary Plan Description.

Information in this section is intended to give You a convenient outline of the Plan provisions and is not all-inclusive. Unless otherwise stated, all Covered Expenses are subject to the Deductible and coinsurance shown in the Schedule of Benefits. Charges for services received from Non-PPO Providers are subject to Usual and Customary guidelines.

Hospital Benefits 1-11

Semi-private room and board, intensive care or coronary care and miscellaneous charges.

Assisting the Primary Surgeon 1-11

Subject to applicable deductible and coinsurance provisions based on the CMS Physician Fee Schedule and NCCI guidelines

Pre-admission Testing 1-11

Payable at 100% when in lieu of testing on admission.

Qualified Practitioner's Benefits 1-11

PPO Providers

Outpatient Charges (Office Visits) – $25 copayment per visit, then 100%. This $25 copayment is not applied towards the deductible, coinsurance or out-of-pocket limits. X-ray, laboratory and other services when obtained

Schedule of Benefits (continued)

or performed during a Qualified Practitioner's office visit are subject to the Deductible and coinsurance listed above.

Inpatient Charges –Subject to applicable deductible and coinsurance provisions.

Non-PPO Providers

Outpatient Charges –Subject to applicable deductible and coinsurance provisions.

Inpatient Charges –Subject to applicable deductible and coinsurance provisions.

Oral Surgery and Other Dental Services 1-12

Subject to applicable deductible and coinsurance provisions.

Preventive Care Benefit..... 1-12

PPO Providers

Payable at 100% up to a $700 Maximum per person per Contact Year then subject to deductible and coinsurance

Non-PPO Providers

Subject to deductible and coinsurance provisions Payable to a $700 Maximum per person per Contact Year.

Prescription Drug Benefits 1-12

Retail (Pharmacy)

$10 copayment for generic Drugs or $25 copayment for brand name Drugs per prescription, 100% thereafter, up to a 34-day supply. The copayment is not applied towards the deductible, coinsurance or out-of-pocket limits.

Mail Order

$20 copayment for generic Drugs or $50 copayment for brand name Drugs per prescription, 100% thereafter, for a 90-day supply. The copayment is not applied towards the deductible, coinsurance or out-of-pocket limits.

Outpatient Hospital Benefits 1-14

Subject to applicable deductible and coinsurance provisions.

Emergency Room Medical Care 1-14

$50 copayment per visit, then subject to the PPO Deductible and PPO coinsurance. (Copayment is waived if You are admitted on an inpatient basis within 24 hours of Emergency care for the same condition.) This $50 copayment is not applied towards the Deductible, coinsurance or out-of-pocket limits.

Ambulatory Surgical Center/Free Standing Surgical Facility 1-14

Subject to applicable deductible and coinsurance provisions.

X-ray and Laboratory Tests..... 1-14

Subject to applicable deductible and coinsurance provisions.

Ambulance Service Benefit..... 1-15

Subject to applicable deductible and coinsurance provisions.

Skilled Nursing Home Benefit 1-15

Subject to-applicable deductible and coinsurance provisions and a Maximum of 30 days per Confinement.

Home Health Care Benefit 1-15

Subject to applicable deductible and coinsurance provisions Benefits are available for up to 40 visits per Contact Year when visits are in lieu of a covered Confinement in a Skilled Nursing Home or Hospital.

Hospice Care Benefit..... 1-16

Subject to applicable deductible and coinsurance provisions. Benefits are available when Hospice Care is in lieu of a covered Confinement in a Hospital or Skilled Nursing Home.

Schedule of Benefits (continued)

Mental or Nervous Conditions, Substance Abuse Benefit 1-17

Inpatient Treatment

Subject to applicable deductible and coinsurance provisions.

Outpatient Treatment

PPO Providers

$25 copayment per visit, then 100%. This $25 copayment is not applied towards the Deductible, coinsurance or out-of-pocket limits. X-ray, laboratory and other services when obtained or performed during a Qualified Practitioner's office visit are subject to the Deductible and coinsurance listed above.

Non-PPO Providers

Subject to applicable deductible and coinsurance provisions.

Chiropractic Care Benefit..... #9 under Other Covered Expenses

Subject to applicable deductible and coinsurance provisions.

Virtual Care Benefit 1-20

PPO Providers

Subject to applicable deductible and coinsurance provisions.

Non-PPO Providers

Not covered.

Other Covered Expenses 1-17

Subject to applicable deductible and coinsurance provisions.

For information on other types of services and supplies, please see the Medical Covered Expense section and the Exclusions and Limitations section.

HOW TO FILE A MEDICAL CLAIM

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

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

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

Attention: Claim Department
Custom Benefit Plan Administrators, a Benefit Plan Administrators of Eau Claire, Inc. affiliate
P.O. Box 1385
La Crosse, WI 54602-1385

Phone: 608-784-2442 or 800-944-2188
Fax: 608-782-3280

E-mail: info@custombenefit.net

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

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

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

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

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

PAYMENT OF CLAIMS

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

ASSIGNMENTS

The Plan will make direct payment to the provider of service, unless the claim has already been paid, in which case payment will be made to the covered Employee or such other person determined by the Plan Administrator to be the appropriate recipient. Such claim must contain adequate documentation of the prior payment, and the payment will discharge the Plan from any further liability with respect to the claim.

Benefits for medical expenses covered under this Plan may be assigned by a Covered Person to the provider; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

CLAIM FILING LIMIT

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

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

PRESCRIPTION DRUG CHARGES

Retail Pharmacy

Present Your CBA ID card and the prescription to a participating pharmacy. Then sign the pharmacist's voucher and pay the pharmacist the copayment for each prescription You receive as shown on the Schedule of Benefits. The balance of the transaction will be handled by Your pharmacy.

If You are without Your CBA ID card or are at a non-participating pharmacy, You must pay for the prescription and submit a claim for reimbursement to:

Express Scripts
P.O. Box 14711
Lexington, KY 40512

Claim forms are available from Express Scripts. For more information regarding Your benefits or to check for a participating pharmacy, please contact Express Scripts at 1-800-818-0093.

Mail Order

The mail service program provides participants with an easy and convenient way to obtain Your maintenance medical. An order form, which explains the mail service program is greater detail, is available. Please contact Your Human Resource Department or Express Scripts at the number on the order form if You have any questions regarding this program.

RIGHT TO CONSIDER SUBSTITUTION FOR COVERED CHARGES

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

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

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

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

4. Must be Medically Necessary.

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

MEDICAL BENEFITS

DEDUCTIBLE AND COINSURANCE INFORMATION

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

Individual Deductible

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

Coinsurance

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

Out-of-Pocket Limit

Except as noted below, when the combined Covered Expenses You must pay for Yourself to satisfy the Plan's Deductible and coinsurance provisions equals the amount shown in the Schedule of Benefits, the Plan will reimburse additional Covered Expenses Incurred during the remainder of the Contact Year at 100%. There are different limits for individual maximum out-of-pocket and family maximum out-of-pocket that applies to Covered Expenses for PPO Providers and for Non-PPO Providers. The total You pay for both PPO Provider Out-of-Pockets and Non-PPO Provider Out-of-Pockets will not exceed the maximum for Non-PPO Provider Deductible expense. The out-of-pocket limits are shown in the Schedule of Benefits.

Any copayments associated with this Plan will not apply to out-of-pocket limits, nor will the penalty for failure to comply with the Utilization Review Plan.

UTILIZATION REVIEW PLAN

Throughout this booklet the terms Health Tradition or "Custom Medical Care" will be referenced. Both are Utilization Management, Cost Containment Program staffed by licensed professional nurses who have years of experience in health care. They understand the importance of minimizing the intrusion into the Qualified Practitioner/patient relationship and rely on their ability to promote health care alternatives that are acceptable to everyone: patients, Qualified Practitioners and Employers.

HOW THE PROGRAM WORKS

When Your Qualified Practitioner recommends an inpatient Confinement for a Covered Person, Your pre-certification company must be called (Health Tradition at 781-2118, toll-free 1-888-758-7848 or Custom Medical Care toll-free at 1-866-898-9351) at least 72 hours prior to the admission.

When You or Your Qualified Practitioner call Your pre-certification company for Pre-admission Certification, You will be asked for the following information:

1. Group name and number
2. Name of Employee
3. Employee's Social Security Number
4. Name of patient
5. Patient's birthday
6. Patient's address
7. Admitting Hospital
8. Phone number of admitting Hospital
9. Qualified Practitioner's name and phone number
10. Reason for admission
11. Admission date

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

PRE-ADMISSION REQUIREMENTS

"Pre-admission Certification" means approval by Your pre-certification company of the Medical Necessity for a proposed Confinement in a Qualified Treatment Facility, and the appropriate length of stay.

You or Your Qualified Practitioner must contact Your pre-certification company at least 72 hours before admission in order to avoid incurring a penalty to benefits otherwise payable under the Plan (see "Pre-admission Certification Penalty" in this section). **Special rules apply to Emergency admissions, explained further in this section.** Your Qualified Practitioner, the Qualified Treatment Facility or any other person who can provide the necessary information may make contact; however You are responsible for making sure that Your pre-certification company has been contacted. Upon notification, Your pre-certification company will contact Your Qualified Practitioner for all pertinent details concerning the admission. This is only the first step in the certification procedure. In order to certify Your admission, Your pre-certification company will:

1. Review Your Qualified Practitioner's treatment plan;
2. Advise You and Your Qualified Practitioner if the proposed Confinement is certified as Medically Necessary; and
3. Advise You and Your Qualified Practitioner for how many days the Confinement is certified.

This Pre-admission Certification is valid for 30 days from the scheduled date of admission. If the patient does not enter the Qualified Treatment Facility within 30 days or enters for a different reason, another request for Pre-admission Certification must be made.

Emergency Admissions

Do not delay seeking medical care for any Covered Person who has a serious condition that may jeopardize his life or health because of the requirements of this program. You may contact Your pre-certification company after admission as described below and You will not incur a penalty.

If You must be admitted on an emergency basis, follow the physician's instructions carefully and contact Your pre-certification company by telephone within 48 hours or the first business day after the admission date.

The Plan does not require You to obtain approval of a medical service prior to getting treatment for an urgent care or Emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. In an urgent care or emergency situation, You simply follow the Plan's procedures after receipt of treatment, and file the claim as a Post-Service Claim.

"Emergency", for purposes of this program, 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. An Emergency may or may not be life threatening. The Plan Administrator may, in its discretion, request satisfactory proof that an Emergency or acute condition did exist.

Weekend Admissions

Weekend Qualified Treatment Facility admissions (Friday, Saturday, or Sunday) will not be certified as Medically Necessary unless You are admitted on an Emergency basis, or treatment or surgery is performed on the day You are admitted.

Extension of a Certified Admission

Your attending Qualified Practitioner may, at any time, initiate by telephone a request for re-evaluation or extension from Your pre-certification company. Following a review, Your attending Qualified Practitioner has the right to appeal any decision. It is important to remember that, at no time, will the decision-making authority for treatment be taken out of Your Qualified Practitioner's hands. Your pre-certification company will not, under any circumstances, interfere with the Qualified Practitioner-patient relationship or the course of treatment.

IF AN EXTENSION IS NOT CERTIFIED, BENEFITS OTHERWISE PAYABLE FOR THE EXTENSION PERIOD WILL BE TREATED AS DESCRIBED UNDER "PRE-ADMISSION CERTIFICATION PENALTY".

PRE-ADMISSION CERTIFICATION PENALTY

If You fail to notify Your pre-certification company of a Confinement within the time limits specified, the benefits otherwise payable under this Plan will be reduced by **$100**. This penalty will be applied to Covered Expenses before application of any Deductibles and coinsurance, and will not contribute to out-of-pocket limits.

CASE MANAGEMENT

If You become seriously or chronically ill or Injured, this Plan provides for case management services to help You use Your benefits under the Plan in the most effective manner. This is accomplished by working with You and Your Qualified Practitioner in planning and implementing health care alternatives to meet Your needs. The case management staff will try to conserve Your benefit dollars by making sure that Your case is handled as efficiently as possible.

Case management services are provided by Your pre-certification company. The case management staff at Your pre-certification company consists of licensed, professional nurses who have many years of experience in health care. They understand the importance of minimizing intrusion into the Qualified Practitioner-patient relationship. The case management staff relies on its ability to promote health care alternatives that are acceptable to everyone: patients, Qualified Practitioners and Plan Administrators.

By promoting health care alternatives that are acceptable to You, Your Qualified Practitioner and Your Plan Administrator, case management helps to control health care costs and helps You use Your benefits more efficiently.

MEDICAL COVERED EXPENSES

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

HOSPITAL BENEFITS

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

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

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

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

2. Professional services of an anesthesiologist.

PRE-ADMISSION TESTING

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for Pre-admission testing. Benefits are payable at 100% when pre-admission testing is performed in a Qualified Practitioner's office or the outpatient department of a Hospital, within seven days of a covered inpatient Confinement and accepted by the inpatient facility in lieu of like tests performed after Your admission.

QUALIFIED PRACTITIONER BENEFITS

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

1. Home and office calls;

2. Administration of anesthesia:

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

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

   The Plan will follow CMS Physician Fee Schedule and NCCI guidelines in determining procedures subject to multiple surgical procedure reductions. This includes

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

c. If an assistant surgeon is required, the assistant surgeon's covered charge will be allowed based on the CMS Physician Fee Schedule and NCCI guidelines.

5. Second surgical opinions.

ORAL SURGERY

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

1. Surgical removal of unerupted teeth;

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

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

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

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

PREVENTIVE CARE BENEFIT

Covered Expenses will be reimbursed, as shown in the Schedule of Benefits, for the following services for Covered Persons.

Check-ups or routine examinations include the office visit and related charges for:

1. Routine x-ray and laboratory tests, including routine prostate exams;

2. One routine colonoscopy every 5 years for Covered Persons age 50 and over;

3. Routine immunizations; and

4. Routine vision including refraction and hearing exams limited to one per Contract Year.

You must not be confined in a Hospital or Qualified Treatment Facility and such expenses must not be for the diagnosis or treatment of a specific Injury or Sickness.

No benefits are payable under this provision for:

1. Medical examinations for Injury or Sickness; or

2. Any dental examinations.

PRESCRIPTION DRUG BENEFIT

Covered Expenses will be payable as shown in the Schedule of Benefits. Your identification card shows Your name, ID number and group number.

Covered Drugs
Benefits are payable for the following covered drugs:

1. All Federal Legend Drugs;

Medical Covered Expenses (continued)

2. All compounded prescriptions in which at least one ingredient is a covered Federal Legend Drug;

3. Legend Bulk Powders are covered unless specifically excluded;

4. Insulin;

5. AIDS related drugs;

6. Insulin syringes/needles including OTC and disposable needles, reusable syringes with or without needles, disposable syringes with or without needles;

7. Legend Hematinics;

8. Diabetic supplies (lancets, alcohol swabs, test strips, test tape);

9. OTC and Legend Meclizine tablets

Limitations and Exclusions
The following are not Covered Expenses under the Plan:

1. Drugs which are taken by or administered to a member while a patient is in a licensed Hospital, Nursing Home, or similar institution, which operates or allows to be operated on its premises a facility for dispensing pharmaceuticals. This includes take home prescription drugs.

2. Drugs which are entirely consumed at the time and place of prescribing.

3. Refills in excess of the number specified or authorized by the prescriber or any refill dispensed after one year from the prescribers original order.

4. Over-the-counter (non-legend) medicines, drugs, supplies and vitamins (except as listed above), even with a prescription.

5. State Restricted Drugs

6. Nutritional supplements/Vitamins except as listed above

7. Drugs requiring prior authorization that was not obtained.

8. Drugs used for cosmetic purposes

9. Investigational and/or experimental Drugs with the exception of investigational Drugs used for the treatment of HIV which have reached a Phase 3 clinical investigation.

10. Drugs which were distributed by the manufacturer as samples.

11. Charges for injection or administration of a drug

12. Drugs labeled "Caution-limited by Federal law to investigational use", or experimental drugs even though a charge is made to the member.

13. Self prescribed medications.

14. Prescription Drugs which are covered under workers' compensation law or which are covered without charge under any government program.

15. Topical Fluoride Products

16. Dexedrine—age 15 and above

17. Ostomy Supplies
18. Therapeutic devices or appliances
19. Serums, Toxoids, and Allergens
20. Diagnostic Agents except listed above
21. Enteral and Parenteral Formula and Supplies
22. Drugs used to enhance athletic performance.
23. Prescription products which are not dispensed by a licensed pharmacist or Physician
24. Anorectics (any drug used for the purpose of weight loss) or Antiobesity agents
25. Dermatologicals, hair growth stimulants
26. Blood Glucose Monitors
27. Glucowatch Products
28. Smoking Deterrents
29. Growth Hormones
30. MS Agents

OUTPATIENT HOSPITAL BENEFIT

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

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

EMERGENCY ROOM MEDICAL CARE

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

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

AMBULATORY SURGICAL CENTER

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

X-RAY AND LABORATORY TESTS

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

AMBULANCE SERVICE BENEFIT

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

SKILLED NURSING HOME BENEFIT

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

1. Begins within 14 days after discharge from an inpatient Hospital Confinement of at least three consecutive days or prior Skilled Nursing Home Confinement of at least three consecutive days. If the Covered Person is Medicare eligible, the Confinement must meet Medicare guidelines;

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

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

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

HOME HEALTH CARE BENEFIT

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

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

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

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

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

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

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

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

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

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

The home health care plan may consist of:

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

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

3. Physical, respiratory, occupational or speech therapy;

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

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

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

Specifically excluded from coverage under this benefit are the following:

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

2. Transportation services.

HOSPICE CARE BENEFIT

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

For hospice care only, Your immediate family is considered to be Your parent.

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

1. Room and board and other services and supplies;

2. Part-time nursing care by or supervised by a registered nurse (RN);

3. Counseling services by a licensed clinical social worker or pastoral counselor for the hospice patient and immediate family;

4. Medical social services provided to You or Your immediate family under the direction of a Qualified Practitioner. Services include:

    a. assessment of social, emotional and medical needs, and the home and family situation,
    b. identification of the community resources available and assisting in obtaining those resources;

5. Dietary counseling;

6. Consultation and case management services by a Qualified Practitioner;

7. Physical or occupational therapy;

Medical Covered Expenses (continued)

8. Part-time home health aide service; and

9. Medical supplies, Drugs and medicines prescribed by a Qualified Practitioner.

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

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

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT

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

1. Charges made by a Qualified Practitioner;

2. Charges made by a Qualified Treatment Facility;

3. Charges for Drugs which may be obtained only on the written prescription of a Qualified Practitioner.

Inpatient Benefits
Covered Expenses while confined as a registered bed patient in a Qualified Treatment Facility. Treatment includes residential treatment services.

Outpatient Benefits
Covered Expenses for outpatient treatment received while not confined in a Hospital or Qualified Treatment Facility. Treatment includes partial confinement and psychological testing when obtained or performed during the outpatient treatment.

Special Limitations on Nervous Conditions, Substance Abuse and Alcoholism
Covered Expenses for Nervous Conditions, Substance Abuse and alcoholism do not include treatment for nicotine habit or addiction, or court ordered examinations or counseling. Court ordered examinations or counseling are not covered if this is the sole reason for treatment. This limitation does not apply if the treatment would otherwise be covered. The copayment for Covered Expenses for outpatient treatment is not applied towards the Deductible, coinsurance or out-of-pocket limits shown on the Schedule of Benefits.

OTHER COVERED EXPENSES

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

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

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

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

4. Special supplies when prescribed by Your attending Qualified Practitioner, including:
   a. Casts, splints, surgical dressings, trusses, braces and crutches,
   b. Oxygen and other gases, and rental of equipment for their administration,

Medical Covered Expenses (continued)

c. Catheters,
d. Colostomy bags, belts and rings,
e. Ureterostomy bags,
f. Flotation pads,
g. Needles and syringes,
h. Custom molded orthotics (with an exclusion on treating diagnosed flat feet), or
i. Initial contact lenses or eyeglasses following cataract surgery.

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

6. Installation and use of an insulin infusion pump, other equipment and supplies used in the treatment of diabetes, and diabetic self-management education programs. Coverage for an insulin infusion pump is limited to the purchase of one pump per year. The pump must be in use for 30 days before purchase.

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

8. Chiropractic Care for the treatment of an Injury or Sickness. Routine or maintenance Chiropractic Care is not a Covered Expense.

9. Treatment by a licensed physical, speech or occupational therapist to restore loss or to correct impairment due to an Injury or Sickness.

10. Radiation therapy and chemotherapy.

11. Acupuncture and acupressure.

13. Tissue transplants (e.g. arteries or veins, corneas, heart valves, skin) placed in the body to aid the function of a body organ or replace tissue lost due to sickness or injury.

14. Human organ or tissue transplants. The transplant must be provided from a human donor to a living human recipient.
    a. bone marrow transplants;
    b. heart transplants;
    c. heart lung transplants (combined procedures);
    d. kidney transplants;
    e. liver transplants;
    f. lung transplants;
    g. pancreas transplants;
    h. pancreas kidney transplants (combined procedures);
    i. small bowel transplants; and
    j. small bowel liver transplants (combined procedures)

    When both the recipient and donor are covered by this Plan, each is entitled to benefits.

    When only the recipient is covered by the Plan, both the donor and the recipient are entitled to benefits. The donor's benefits are limited to those not available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any government program. Benefits for the donor are charged against the recipient's coverage under the Plan.

    When only the donor is covered by the Plan, the donor is entitled to benefits. The benefits are limited to only those not available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any governmental program. No benefits are provided to the non-covered transplant recipient.

    If any organ or tissue is sold rather than donated, no benefits are payable for the purchase or removal of such organ or tissue. Other costs related to the evaluation and procurement are covered for a recipient who is covered under this Plan.

15. Treatment of kidney disease, including dialysis.

Medical Covered Expenses (continued)

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

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

18. Charges for Virtual Care.

LIMITATIONS AND EXCLUSIONS

This Plan does not provide benefits for:

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

2. Eye refractive disorders, vision therapy (orthoptics), radial keratotomy or keratoplasty to correct refractive disorders, cochlear implants, eyeglasses, hearing aids or the fitting or repair of any hearing aid or eyeglasses, except as specified by the Plan. The initial purchase of eyeglasses or contact lenses following cataract surgery is a Covered Expense.

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

4. Exams directed or requested by a court of law; routine physical exams for occupation, sports participants, employment or the purchase of insurance.

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

6. Plastic or Cosmetic Surgery, including any services or supplies related to, resulting from complications of, or for reversal of Cosmetic Surgery, unless for reconstructive surgery due to Injury, infection or other disease of the involved part.

7. Dental care or treatment except as specifically described.

8. Any loss to a Covered Person who is not a member of the armed forces which was caused or contributed to by:

   a. War or any act of war, whether declared or not, or
   b. Any act of international armed conflict, or any conflict involving armed forces or any international authority.

9. Any drug or medicine which is not approved for marketing by United States Food and Drug Administration, by issuance of a New Drug Application or other form of formal approval; or any approved drug which is not used for the specific indication which led to its approval by the United States Food and Drug Administration. This does not include investigational new drugs which have reached a Phase 3 clinical investigation for the treatment of HIV infection.

10. Services that are Experimental or Investigational.

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

12. Custodial Care.

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

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

Limitations and Exclusions (continued)

15. Expenses incurred for which You are entitled to receive benefit during any extension of Your previous medical plan.

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

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

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

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

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

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

22. Expenses in connection with the treatment of developmental delays, including, but not limited to speech therapy, occupational therapy and physical therapy will not be considered eligible. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of ADD or ADHD.

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

24. Educational testing or training, or recreational therapy.

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

26. Treatment programs, services or supplies having to do with the cessation of tobacco usage or nicotine addiction.

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

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

29. Homeopathic medicines and/or supplies.

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

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

32. Genetic testing or counseling.

33. Any human organ or tissue transplant not specifically listed, or any non-human or artificial organ or tissue transplant.

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

Limitations and Exclusions (continued)

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

36. Charges for services or supplies resulting from malpractice, malfeasance or misfeasance.

37. Services, treatments or supplies that are not specified as covered under this Plan.

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

39. Charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak unstable, flat, strained or unbalanced feet, unless an open-cutting operation is performed; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails unless the treatment is medically necessary.

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

41. Services which are required to treat injuries that are sustained or an Sickness that is contracted including infections and complications, while the Plan Covered Person was under, and due to the care of a Provider wherein such Sickness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

42. Expenses actually Incurred by other persons.

43. Benefits that are provided, or which would have been provided had the Covered Person enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled "Coordination of Benefits" and "Medicare".

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

45. Services not actually rendered.

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

47. Required as a result of unreasonable provider error.

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

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

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

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SECTION 2

DEFINITIONS

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DEFINITIONS

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

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

Active:
Active means all non-Retirement Status priests incardinated in the Diocese unless otherwise determined by the Bishop, or all non-incardinated priests assigned in the Diocese by the Bishop unless otherwise determined by the Bishop.

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.

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

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.

Assignment of Benefits:
Assignment of Benefits means an arrangement whereby the Plan Covered Person assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Plan Covered Person, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

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

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

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

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

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

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

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

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

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

Covered Expense:
A Covered Expense is a Medically Necessary service or supply listed for coverage under this Plan which is Usual and Customary and which is not limited or otherwise excluded.

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

Custodial Care:
Custodial Care means care or Confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding,

preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

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

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

Disability Status:
Disability Status means being unable to perform normal duties of an Active priest with an expectation that the priest will return to Active status. A Disability Status priest will remain eligible for benefits under the Plan. If it is determined that the disability is permanent, the priest may be granted Retirement Status by the Bishop.

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

Durable Medical Equipment:
Durable Medical Equipment means equipment which:

1. Can withstand repeated use;

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

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

4. Is appropriate for use in the home.

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

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

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

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

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

Employee:
Employee means:

1. All non-Retirement Status priests Incardinated in the Diocese unless otherwise determined by the Bishop;

2. All non-Incardinated priests assigned in the Diocese by the Bishop unless otherwise determined by the Bishop;

3. All Retirement Status priests incardinated in the Diocese unless otherwise determined by the Bishop; or

4. All Disability Status priests or as otherwise determined by the Bishop.

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

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

Experimental or Investigational:
Experimental or Investigational means services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

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

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

All phases of clinical trials shall be considered Experimental.

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

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

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

3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
   a. maximum tolerated dose;

b. toxicity;
c. safety;
d. efficacy; and
e. efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

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

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

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

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

Family Member:
Family Member means Your parent, grandparent, brother or sister.

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.

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.

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

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

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

Home Health Care Agency:
Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

1. It is primarily engaged in and duly licensed to provide skilled nursing services and other therapeutic services, if such licensing, is required by the appropriate authority where services are provided;

2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one registered nurse (RN) to govern the services provided and it must provide for full-time supervision of such services by a Qualified Practitioner or registered nurse;

3. It maintains a complete medical record on each patient;

4. It has a full-time administrator; and

5. It is approved by Medicare.

Hospice Care Agency:

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

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

Hospice Care Program:

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

Hospice Facility:

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

Hospital:

Hospital means 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.

Incardinated:
Incardinated means ordained for and belonging to the presbyterate of the Diocese of La Crosse.

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

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.

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 and/or Maximum Allowable Charge:
Maximum Amount and/or Maximum Allowable Charge means the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be ~~the lesser of~~:

1. The Usual and Customary amount;

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

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

4. The negotiated rate established in a contractual arrangement with a Provider; or

5. The actual billed charges for the covered services.

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

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

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

2. Its purpose must be to restore health.

3. It must not be primarily custodial in nature.

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

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

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

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

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

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

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

Morbid Obesity:
1. The Participant weighs more than 100 pounds over standard weight for height, sex and age; or

2. The Participant weighs more than 2 times the standard weight for height, sex and age; whichever is less. For a Participant who is less than 19 years of age, Morbid Obesity means that the Participant's weight is 50% greater than ideal body weight.

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

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

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

1. Any primary payer besides the Plan;

2. Any other group health plan;

3. Any other coverage or policy covering the Covered Person;

4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

5. Any policy of insurance from any insurance company or guarantor of a responsible party;

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

7. Worker's compensation or other liability insurance company; or

8. Any other source, including but not limited to crime victim restitution funds, and medical Disability or other benefit payments, and school insurance coverage.

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

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

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

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

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

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

Pre-admission Tests:
Pre-admission Test means those Diagnostic Services done prior to scheduled surgery, provided that:

1. The tests are approved by both the Hospital and the Qualified Practitioner;

2. The tests are performed on an outpatient basis prior to Hospital admission; and

3. The tests are performed at the Hospital into which Confinement is scheduled, or at a Qualified Treatment Facility designated by the Qualified Practitioner who will perform the surgery.

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

Prior to Effective Date or After Termination Date:

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

Psychiatric Hospital:

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

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

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

3. It is licensed as a psychiatric hospital;

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

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

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

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.

Reasonable and/or Reasonableness:

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

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

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

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

Rescission or Rescind:
Rescission or rescind is a cancellation of coverage or discontinuance of coverage under the Plan that has retroactive effect, unless attributable to:

1. Failure to timely pay the cost of coverage; or

2. Fraud or intentional misrepresentation of material fact, as those circumstances are described under Health Care Reform and regulatory guidance.

Retirement Status:
Retirement Status means the priest has been granted retiree status by the Bishop. A Retirement Status priest may not return to an Active status.

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

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

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

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

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

4. A daily record for each patient; and

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

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

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

Special Enrollee:
A Special Enrollee is an eligible Employee who is entitled to and who requests Special Enrollment (as described in Section 3) within 31 days of losing other health coverage.

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

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

2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Substance Abuse Treatment Center:

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

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

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

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

Total Disability or Totally Disabled:

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

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

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.

Usual and Customary:

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

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

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

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

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

Virtual Care:

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

Waiting Period:

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

You and Your:

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

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SECTION 3

ELIGIBILITY

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PLEASE NOTE THAT SECTIONS 3 AND 4 OF THIS DOCUMENT PROVIDE REQUIRED LANGUAGE DUE TO FEDERAL LAWS AND REGULATIONS AND THIS LANGUAGE HAS BEEN INCLUDED IN ITS ENTIRETY.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

These provisions apply to Employees 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.

EMPLOYEE COVERAGE

Employee Eligibility

You are eligible for coverage under the Plan if You are an Employee of the Employer and You are Legally Employed.

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

Employee Effective Date

Your effective date will be 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 effective date, 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.**

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.

SPECIAL AND LATE ENROLLMENT

SPECIAL 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 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 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.

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.) or

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

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

Special Enrollment Period (Time Frames for Enrollment)

"Special Enrollment Period" shall mean, with respect to "Special Enrollment for Individuals Losing Coverage", the period which ends 31 days after:

1. The date on which the coverage is exhausted, if the coverage was COBRA continuation coverage; or

2. 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.

Late Enrollment

An enrollment is "late" if it is not made on a "timely basis" or during a special enrollment period.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The Enrollment Date for a Late Enrollee is the first day of coverage. Thus, the time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

Effective Date of Coverage; Conditions

All conditions for effectiveness of coverage under the Plan which are set forth in "Employee Coverage" will apply to persons enrolling during a Special Enrollment Period. Coverage for Employees enrolling during a Special Enrollment Period will become effective at 12:01 AM on the date following the loss of coverage or the first day of the month following the receipt by the Plan of the required enrollment forms. Enrollment must be in writing in a form furnished and accepted by the Plan Administrator, and must be received by the Plan Administrator within 31 days of the eligibility date under "Special Enrollment Period". If You enroll for coverage more than 31 days after the date of qualifying event under the Special Enrollment Period, You will be considered a Late Enrollee under the Plan.

GINA

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

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

1. Such individual's genetic tests;

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

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

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

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

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

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

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

RETURNING EMPLOYEES

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

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

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

For an approved leave of absence, an Employee will remain eligible for coverage under the Plan as long as the Employee is otherwise eligible (and enrolled) under the Plan. Note that for an approved leave of absence, an Employee will be treated as an Ongoing Employee, even if the Employee's absence was longer than one year.

TERMINATION OF COVERAGE

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

1. The date of termination of the Plan;

2. The last 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 the termination of employment occurs; or

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

7. The date You die.

TERMINATION DUE TO FRAUD

Eligibility and Effective Date of Coverage (continued)

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.

RETIREE CONTINUATION

Retirement Status priests over 65 must elect Medicare Parts A & B, and coverage will continue with Medicare as the primary payor. Retirement Status priests are those priests who have been granted Retirement Status by the Diocesan Bishop.

IMPORTANT NOTICE FOR ACTIVE EMPLOYEES AGE 65 AND OVER

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

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

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

Contact Your Plan Administrator for further information.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

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

1. They were 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, 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.

Uniformed Services Employment & Reemployment Rights Act (USERRA) (continued)

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

SECTION 4

GENERAL PLAN INFORMATION

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PLEASE NOTE THAT SECTIONS 3 AND 4 OF THIS DOCUMENT PROVIDE REQUIRED LANGUAGE DUE TO FEDERAL LAWS AND REGULATIONS AND THIS LANGUAGE HAS BEEN INCLUDED IN ITS ENTIRETY.

ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by St. Ambrose Financial Services, Inc., the "Plan Sponsor" as of July 1, 2015 hereby amends and restates the Diocese of La Crosse Priest Group Health 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.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

St. Ambrose Financial Services, Inc.

By: _____

Name: _____

Title: _____

Date: _____

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, 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 Priest Group Medical Benefit Plan
TYPE OF PLAN	A self-funded welfare benefit plan providing certain medical benefits to covered Employees. 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	July 1, 2015
GROUP NUMBER	8236
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	501
PLAN SPONSOR IDENTIFICATION NUMBER	39-0807229
ADMINISTRATIVE SERVICE MANAGER	Custom Benefit Plan Administrators, a Benefit Plan Administrators of Eau Claire, Inc. affiliate 305 5th Avenue South, Suite 206 P.O. Box 1385 La Crosse, WI 54602-1385 (800) 944-2188 (Toll-free) or (608) 784-2442
AGENT FOR SERVICE OF LEGAL PROCESS	Mr. Dennis Herricks St. Ambrose Financial Services, Inc. 3710 East Avenue South P.O. Box 4004 La Crosse, WI 54602-4004 (608) 791-2669

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

PLAN ADMINISTRATION

Plan Administrator

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

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

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a 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

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

Excess Insurance

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

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

1. any primary payer besides the Plan;

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

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

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

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

Vehicle Limitation

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

Allowable Expenses

"Allowable Expenses" shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service, rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

Claim Determination Period

"Claim Determination Period" shall mean each Calendar Year.

Effect on Benefits:

Application to Benefit Determinations

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

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

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

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

Coordination of Benefits (continued)

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

Order of Benefit Determination

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

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

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

3. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year falls earlier in the year will be primary, except:
   a. When the parents are separated or divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or
   b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan; which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

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

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

Right to Receive and Release Necessary Information

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

Facility of Payment

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

Right of Recovery

In accordance with section 9.06C, 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 Article, 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 or her Dependents.

Provision for Coordination of Benefits with Medicare

Definitions

1. "Medicare" means that portion of Title 18 of the United States Social Security Act of 1965, as then constituted or as amended in the future.

2. "Fully Covered Person" means any person who is eligible for Medicare Coverage.

3. "Full Medicare Coverage" means coverage for all of the benefits provided under Medicare with the exception of Medicare Part D, including any benefits provided on an optional basis. For the purpose of this Provision, a Fully Covered Person will be considered to have Full Medicare Coverage.

Effects on Benefits

Coordination of benefits does not apply to Medicare Part D.

The benefits payable under this Plan for expenses incurred (as determined by the Benefit Provision of this Plan) by a Fully Covered Person shall be reduced by the amount such Fully Covered Person is eligible for benefits under Full Medicare Coverage. Any benefits received from Full Medicare Coverage not covered by this Plan shall not reduce benefits payable under this Plan.

Except that:

For active Employees age 65 and older who continue to participate in this Plan, this Plan will provide its full regular benefits first and Medicare coverage may provide supplemental benefits for those expenses not paid by this Plan. This provision does not apply to Employees entitled to Medicare because of total Disability or end stage renal disease. This provision intends to comply with the TEFRA Act of 1982.

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.

DISCRETIONARY AUTHORITY

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in

regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participants' rights; and to determine all questions of fact and law arising under the Plan.

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.

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.

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.

MENTAL HEALTH PARITY

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

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:

Custom Benefit Plan Administrators, a Benefit Plan Administrators of Eau Claire, Inc. affiliate
Attn: Claim Appeal Department
P.O. Box 1385
La Crosse, WI 54602-1385

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;

Privacy (continued)

3. Establish safeguards for information, including security systems for data processing and storage;

4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

6. Not use or disclose genetic information for underwriting purposes;

7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

8. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);

10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);

11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);

12. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

13. 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 Custom Benefit Administrators, a Benefit Plan Administrators of Eau Claire, Inc. affiliate, 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.

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. 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.

Privacy (continued)

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:

Custom Benefit Administrators, a Benefit Plan Administrators of Eau Claire, Inc. affiliate
305 5th Avenue South, Suite 206
La Crosse, WI, 54601
Phone: 608-784-2442
Fax: 608-782-3280
Email/Website: www.custombenefit.net

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

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.

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.