SUMMARY PLAN DESCRIPTION

of the

NEBRASKA BANKERS ASSOCIATION
VEBA GROUP INSURANCE PLANS

SUMMARY PLAN DESCRIPTION

Introduction

Nebraska Bankers Association Voluntary Employees Beneficiaries Association (the "Sponsor") sponsors the Nebraska Bankers Association VEBA Group Insurance Plans (the "Plan").

The Plan provides benefits through Component Benefit Programs. The names of the Component Benefit Programs are listed in Section 3. They may change from time to time. This Summary, along with the insurance booklets and summary plan descriptions for the various types of benefits provided by the Plan, is the Summary Plan Description ("Summary") for the Plan. These documents describe the Plan in effect as of June 1, 2016. The Sponsor may change the Plan from time to time.

This Summary of the Plan explains its basic features. It is only a summary. You should keep this Summary with the summary plan descriptions, insurance booklets and other documents you received regarding the Component Benefit Programs. The separate plan document, insurance contract or other governing document of each Component Benefit Program and this Plan contain the actual terms of the Plan. If anything in this Summary or the insurance booklets or summary plan descriptions of the Component Benefit Programs is different than the actual terms of the Component Benefit Programs or the Plan, the Component Benefit Programs or Plan control. Please contact Nebraska Bankers Insurance and Services Co., Inc. at (402) 474-1555 if you have any questions.

1. General Information. The legal name, address, and Federal employer identification number of the Plan Sponsor are –

Nebraska Bankers Association Voluntary Employees Beneficiary Association
233 S. 13th Street, Suite 700
Lincoln, NE 68508
Employer Identification No.: 47-6092059

2. Identification of Plan. The Plan is known as the –

Nebraska Bankers Association VEBA Group Insurance Plans.

The Sponsor has assigned Plan Number 501 to this Plan. The Plan keeps its records on a 12-month period from January 1 through December 31. It calls this period the "Plan Year."

3. Type of Plan. The Plan is a wrap plan that provides benefits through several Component Benefit Programs. The Plan incorporates the following Component Benefit Programs:

- Nebraska Bankers Association VEBA Group Insurance PPO Plans;
- Nebraska Bankers Association VEBA Vision Plan;

- Nebraska Bankers Association VEBA Dental Plan;
- Nebraska Bankers Association VEBA Life Insurance Plan;
- Nebraska Bankers Association VEBA Temporary Disability Plan; and
- Nebraska Bankers Association VEBA Long-term Disability Plan.

The Sponsor may include other plans as a Component Benefit Program from time to time. All of these plans are treated as one Plan for Form 5500 and other ERISA compliance purposes.

4. Plan Administrator. Nebraska Bankers Insurance and Services Co., Inc. is the Plan Administrator. Its telephone number is (402) 474-1555. The Plan Administrator provides information about your rights and benefits under the Plan. It has the primary authority to file various reports, forms, and returns with the U.S. Department of Labor and the Internal Revenue Service. The summary plan descriptions, insurance policies, or plan documents identify the plan administrator of each Component Benefit Program. The plan administrator of each Component Benefit Program also makes decisions regarding eligibility of individuals to participate and receive benefits from the program. If a Component Benefit Program does not identify a plan administrator, the Plan Administrator of this Plan shall be the plan administrator for the Component Benefit Program.

The Plan Administrator has full power to interpret and apply the terms of the Plan. The Plan Administrator also makes decisions regarding eligibility of individuals to participate and receive benefits from the Plan.

5. Agent for Service of Legal Process. The Plan must designate an agent for service of legal process. The agent for service of legal process is –

Nebraska Bankers Insurance and Services Co., Inc.
233 S. 13th Street, Suite 700
Lincoln, NE 68508.

6. Funding. Some Component Benefit Programs are funded through contracts or policies of insurance purchased from one or more insurance carriers. The Plan refers to these benefits as Insured Benefits. Other Component Benefit Programs are funded through the Nebraska Bankers Association Voluntary Employees Beneficiary Association Trust (the "Trust"). The Plan refers to these benefits as Self-Insured Benefits. Section 8 has more information about the benefits provided by the Component Benefit Programs.

7. Eligibility to Participate. You are eligible to participate in this Plan if you are eligible to receive benefits under one or more Component Benefit Programs. The terms and conditions of the Component Benefit Programs will tell you whether you participate in this Plan. Please read the eligibility conditions that are part of each summary plan description, insurance booklet, or other governing document of the Component Benefit Programs. You may need to sign

a Salary Reduction Agreement before you can participate in some of the Component Benefit Programs.

(a) **Termination of Participation**. Your participation in the Plan will end on the later of the last day of the month in which you terminate employment with a Member Employer or you stop receiving benefits under all Component Benefit Programs. The same rule applies for participation of your Spouse and Dependents. Some Component Benefit Programs may also terminate coverage if you fail to pay your share of the applicable premiums. Your coverage may end if you fail to work the number of hours required for participation. Please read the summary plan description, insurance booklet, or other governing document for each Component Benefit Program for more information regarding events that terminate your participation. You may also contact the Plan Administrator.

(b) **Coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA")**. Some Component Benefit Programs provide coverage required by COBRA. You may qualify for COBRA if you experience certain qualifying events. The following COBRA procedures apply to the extent that COBRA rights are not set forth in the SPD or plan documents for the Component Benefit Programs. If you have any questions, please refer to the appropriate summary plan descriptions, insurance booklets or other documents. You may also contact the Plan Administrator.

i. *Qualifying Events*. Certain individuals may be eligible for COBRA if coverage is lost for any of the following reasons, called Qualifying Events. A loss of coverage occurs when coverage ceases to be available under the same terms and conditions that applied immediately before the Qualifying Event.

- Your employment with a Member Employer ends for any reason (including retirement and layoffs) other than gross misconduct;
- Your scheduled hours of work are reduced;
- You die while employed and your dependents are covered by one or more of the Component Benefit Programs;
- You and spouse legally separate or divorce, causing your spouse and/or children to lose coverage under one or more of the Component Benefit Programs;
- You become entitled to Medicare (date of enrollment in Part A or Part B, whichever occurs earlier). This allows eligible dependents to elect COBRA coverage for up to 36 months from the date you enroll in Medicare.
- Your dependent children no longer meet the Component Benefit Program's eligibility requirements.

- In certain circumstances, a proceeding in bankruptcy under Title 11. Special rules apply to this type of event governing who may elect to continue coverage and how long that coverage lasts.

If one of the above events occurs, eligible individuals may continue the same coverage they had when the event occurred, subject to any future Component Benefit Programs changes.

ii. *Qualified Beneficiaries*. Only Qualified Beneficiaries may elect continued coverage. Qualified Beneficiaries include you (for termination of employment and reduction of hours), your spouse and any dependent children who are enrolled in one or more of the Component Benefit Programs at the time of the Qualifying Event in addition to any children who are born to or placed for adoption with you if you are participating in COBRA during the COBRA continuation period, provided they are enrolled within 60 days of the date of birth or date of placement.

A domestic partner is not eligible to elect COBRA as a Qualified Beneficiary unless he or she qualifies as a tax dependent within the meaning of Internal Revenue Code Section 152 (determined without regard to sections 152(b)(1), (b)(2), or (d)(1)(B)). However, if you and a domestic partner have coverage under the group health plan and together lose coverage due to a Qualifying Event, the Qualified Beneficiary may elect COBRA for himself or herself and the domestic partner.

Qualified Beneficiaries have the same right to change coverage under any Component Benefit Program for which coverage has been continued and add or drop dependents as active employees.

iii. *COBRA Coverage – Time Limits*. For the Group Insurance PPO Plans, Vision Plan, and Dental Plan, continued coverage is limited to the following specific periods of time:

- You and your dependents may continue coverage for up to 18 months, if:
  - Your employment with a Member Employer is terminated (including retirement and layoff); or
  - Your regularly scheduled work hours are reduced.
- A spouse and dependent children may continue coverage for up to 36 months, if they lose coverage:
  - Because of your death, divorce or legal separation or because you become entitled to Medicare; or
  - Because a dependent child no longer meets a Component Benefit Program's eligibility requirements.

If you become entitled to Medicare before retirement, your entitlement to Medicare is not a Qualifying Event unless your spouse or dependent child loses coverage as a result. If no such loss of coverage occurs (before retirement), at retirement, the maximum COBRA coverage period for your spouse and dependent children ends on the later of these two dates:

- 18 months from your date of retirement
- 36 months from the date you became covered by Medicare.

For Qualified Beneficiaries who are determined to be disabled by the Social Security Administration or who are dependents of a disabled Qualified Beneficiary at the time employment ends (or hours are reduced), or become disabled during the first 60 days of continuation of coverage, coverage may continue for up to 29 months. Each Qualified Beneficiary may separately elect the additional continuation coverage for up to 29 months. You must notify the Plan Administrator of a Social Security award or appeal notice within 60 days of the Social Security determination but no later than the end of the 18th month of COBRA coverage. If you or your family member received a determination of disability before COBRA continuation coverage began and did not receive a subsequent determination that you are no longer disabled, a copy of the determination of disability must be furnished within 60 days of the loss of coverage.

A Qualified Beneficiary may be subject to more than one Qualifying Event. For example, subsequent Qualifying Events may occur as the result of death, divorce, legal separation, or a child losing Component Benefit Program eligibility. A second Qualifying Event may extend coverage for your dependents to a maximum of 36 months from the date of the original Qualifying Event.

A Qualified Beneficiary's COBRA continuation coverage will end before the maximum time period is reached if:

- Payments are not made on a timely basis (within the 30-day grace period);
- The Qualified Beneficiary becomes entitled to Medicare after COBRA continuation coverage is elected;
- In the case of an 11-month extension (up to a total of 29 months) due to certain disabilities, a final determination is made that the individual is no longer disabled (after the first 18 months);
- After the COBRA continuation coverage is elected, the Qualified Beneficiary who elects COBRA coverage under a Component Benefit Program becomes covered under another group health plan, unless the other plan contains a pre-existing condition exclusion or limitation applicable to the Qualified Beneficiary. COBRA coverage will not terminate unless or until the individual is not or is no longer affected by the pre-existing condition exclusion or limitation under the other plan (for example, if the new plan gives credit for prior coverage, it may eliminate all or part of the pre-existing condition exclusion period and COBRA coverage may be terminated);

- All employer-provided health care plans are terminated;

- Coverage ceases for any other generally applicable reason under the Component Benefit Program.

iv. *COBRA Notification/Cost*. The Plan Administrator will provide enrollment information for COBRA continuation coverage at the time of a Qualifying Event. It is the enrolled participant's responsibility to provide an accurate address for mailing purposes.

It is also the enrolled participant's responsibility to notify the Plan Administrator or the COBRA Administrator of a loss of health coverage as a result of a:

- Divorce;

- Legal separation; or

- Child's loss of dependent status under a health plan.

This notice must be provided within 60 days of the date of the event (or, if later, the date the dependent would lose coverage because of the event).

The Plan Administrator or the COBRA Administrator must also be notified if:

- A dependent has a second Qualifying Event that would allow coverage to be extended to a total maximum of 36 months. This notice must be provided within 60 days of the second Qualifying Event (or the date it would have resulted in a loss of coverage if it had been the first Qualifying Event).

- An enrolled participant is determined by the Social Security Administration to have a disability that would allow the extension of coverage from 18 months to a total maximum of 29 months. This notice must include a copy of the Social Security Administration's determination letter and be provided within 60 days of that determination and no later than the end of the original 18-month of COBRA continuation coverage.

- The Social Security Administration has determined that an enrolled individual is no longer disabled, ending entitlement to continue coverage. This notice must be provided within 30 days of the Social Security Administration's determination.

All of the notices provided under COBRA must include: the name of the employee, the name of each affected dependent, the Qualifying Event, and the date of the Qualifying Event.

If an individual fails to provide an appropriate notice on time, the right to COBRA continuation coverage will be lost.

The cost of continued coverage is 102% of the total cost for the coverage, including the Member Employer and employee contributions. For disabled Qualified Beneficiaries and their family members who have elected COBRA who are continuing coverage beyond 18 months, the monthly cost will be increased to 150% of the cost for the remaining 11 months. The cost will be adjusted annually each January 1 to reflect any changes in the total cost.

To elect COBRA continuation coverage, Qualified Beneficiaries are given 60 days after they receive the election form or, if later, 60 days after coverage under the Component Benefit Program would otherwise end if COBRA coverage is not elected. Each Qualified Beneficiary is entitled to make his or her own coverage election. When coverage is elected, there is 45 days from the date of election to make the initial payment. After that, payments must be made monthly and there is a 30-day grace period.

(c) **Coverage under the Uniformed Services Employment and Reemployment Rights Act ("USERRA")**. Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services under USERRA. Please review the summary plan description, insurance booklet, or other document for each Component Benefit Program for more information about coverage under USERRA. You may also contact the Plan Administrator.

8. Summary of Plan Benefits. If you meet the eligibility conditions stated above, the Plan provides you an opportunity to participate the Component Benefit Programs. Each program has its own summary plan description, insurance booklet, or other governing document. These documents contain more information about the benefits provided by the Component Benefit Programs.

The Component Benefit Programs provide Insured Benefits and Self-Insured Benefits. The Insured Benefits are provided through one or more insurance contracts with an insurer. The Insured Benefits include the Vision Plan, Dental Plan, Life Insurance Plan, Temporary Disability Plan, and Long-term Disability Plan. The Self-Insured Benefits are funded through the Trust. The Self-Insured Benefits include the Group Insurance PPO Plans. The Sponsor may add or remove any Component Benefit Plan at any time.

The Plan Administrator will provide a schedule of the applicable premiums upon request for each of the Component Benefit Programs and will provide the schedule to Member Employers for dissemination to Participants during the initial and subsequent open enrollment periods for each of the Component Benefit Programs. The cost of the benefits provided through the Group Insurance PPO Plans, Vision Plan, Dental Plan, Life Insurance Plan, Temporary Disability Plan, and Long-term Disability Plan will be funded by Member Employer and Employee contributions.

Each Member Employer decides how much it will contribute to the Plan. It will contribute enough money to pay for the benefits or portion of the benefits that it has agreed to pay for. For the Insured Benefits, your Employer will pay its contributions and your contributions to the Trust, which will pay the contributions to the insurer. For Self-Insured Benefits, your Employer will pay its contributions and your contributions to the Trust, which will pay benefits to or on behalf of

participants and eligible family members. The Plan will use all of your contributions toward the cost of a benefit before it uses Employer contributions to pay for the cost of such benefit.

9. Qualified Medical Child Support Orders. The Plan will also provide benefits under the Component Benefit Programs that provide health benefits as required by any qualified medical child support order ("QMCSO"). A QMCSO has to satisfy certain specific conditions to be qualified. The Plan Administrator will notify you if it receives a QMCSO that applies to you. It will then provide you with a copy of the Plan's procedures for determining whether the medical child support order is qualified. The Plan will also provide benefits to dependent children placed with participants or beneficiaries for adoption. The Plan will provide these benefits under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries.

10. Circumstances that May Cause a Loss of Benefits. The Plan contains many restrictions on the type, amount, and circumstances under which it will pay benefits. You should read the summary plan description, insurance booklet, or other governing document of each Component Benefit Program for more information. You may lose coverage under the Plan if the Sponsor terminates the Plan. You may also lose coverage if the Sponsor amends the Plan to reduce or eliminate your coverage. Your coverage under this Plan generally terminates when you terminate employment with a Member Employer. It will also terminate if you otherwise are no longer eligible for benefits under all Component Benefit Programs. Your coverage may also terminate if you fail to make a contribution under the Component Benefit Program or it you waive coverage under one of the Component Benefit Programs. Eligibility for some benefits may terminate if you are not activity at work, or if you switch from full-time to part-time employment status.

11. Amendment and Termination. The Sponsor hopes to continue the Plan indefinitely but, as with all of the Component Benefit Programs, the Sponsor may change or discontinue the Plan. The Sponsor may make changes to all or any class of employees, at any time and for any reason, without notice. If the Sponsor amends, alters, discontinues, or terminates the Plan, the Plan will only be liable for previously incurred claims that are filed within the time period set forth in the applicable Component Benefit Program.

12. Claims Procedure for Benefits. This Section applies if you have not received benefits under the Plan that you believe the Plan should pay.

(a) **Claims for Insured Benefits**. The insurance contracts, booklets or other documents explain how to make a claim for an Insured Benefit. To obtain benefits from the insurer, you must follow the insurer's claims procedure. That procedure may require you to complete, sign, and submit a written claim on the insurer's form. You may obtain a copy of the form from the insurer or the Plan Administrator.

The insurer will decide your claim according to its reasonable claims procedures. These procedures may be subject to ERISA. The insurer may request independent medical advice and such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim, in whole or in part, you will receive written notification of the reason(s) for the denial. If

your claim is denied, you may appeal to the insurer for further review. The insurer will decide your appeal in accordance with its reasonable claims procedures. These procedures may be subject to ERISA. If you do not appeal on time, you may lose your right to file suit in federal or state court. The court may find that you failed to exhaust your administrative appeal rights.

You can find more information about the claims procedure for each Insured Benefit in its insurance contract, booklet, or other document.

(b) **Claims for Self-Insured Benefits**. For claims under the Self-Insured Benefits, the following procedures apply to the extent the Component Benefit Program does not have its own claims procedure. These claims procedures are established in accordance with ERISA.

If there are any inconsistencies between the information set forth below and the claims procedures set forth in the appropriate provider or insurer's information or the SPD, the provider or insurer's claims procedure or the procedure in the SPD will control.

Filing an Initial Claim. To file an initial claim under the Component Benefit Program, a claimant should submit his or her claim as set forth in the SPD.

Initial Claim Determinations. Claims will be evaluated and processed within a time frame that depends upon the nature of the claim. Different time frames for determining claims will apply depending on whether the claim is urgent, pre-service but not urgent, or post-service. With the exception of the section labeled "Disability Claim," all of the descriptions below relate to claims for health benefits. Determinations will be made in accordance with the terms of the Component Benefit Program and applicable law.

Urgent Care Claim. A claim is considered an urgent care claim if delaying the decision of the claim beyond the urgent time frames could seriously jeopardize life or health or the ability to regain maximum function, or in the opinion of the claimant's physician, would subject the claimant to severe pain that could not be adequately managed without the care that is the subject of the claim.

Urgent care claim determinations will be made as soon as possible. Notice of the determination will be provided within 72 hours of the claim unless more information is required to process the claim. If more information is required, notification will be provided within 24 hours and the claimant will have 48 hours to make a submission. The claimant will be notified of the decision within 48 hours of that submission.

If a claim is improperly filed, the notification of the proper filing procedure will be provided within 24 hours. This notice will be provided only if the claim identified the name of the claimant, the specific medical condition or symptom, and the treatment, service, or product for which approval is sought and only if the claim was submitted to a person or unit customarily responsible for handling benefit matters relating to the option elected.

Concurrent Care. If the claimant has been approved for an ongoing course of treatment and the Component Benefit Program reduces the treatment before the end of the pre-approved period of time or number of treatments, the reduction will be considered an adverse benefit determination. Notification of the reduction or termination will be provided sufficiently in advance in order to allow the claimant to appeal the determination and obtain a review of the claim before treatment is disrupted.

If the claimant requests to extend a course of treatment for an urgent care claim at least 24 hours before approval for treatment will lapse, the claimant will be notified whether the extension is granted or denied as soon as possible, but in any event, within 24 hours after receipt of the claim.

Pre-Service Claim. A pre-service claim is a claim that must be filed before receiving medical care (other than an urgent care claim) to be eligible for full benefits under the Component Benefit Program. In the case of a pre-service claim, notification of the Component Benefit Program's benefit determination will be provided within a reasonable period of time, but no later than 15 days after the Component Benefit Program receives the claim. This period may be extended by the Component Benefit Program for an additional 15 days, provided that the Component Benefit Program administrator determines that the extension is necessary due to matters beyond the control of the Component Benefit Program, and provides timely notification of the circumstances requiring the extension of time and the date by which a decision can be expected. If an extension is necessary because of a failure to submit information necessary to decide the claim, the notice of extension will specifically describe the required information. The claimant will have 45 days to provide that information.

If a claim is improperly filed, notification will be provided within 5 days.

Post-Service Claim. A post-service claim is a claim under the Component Benefit Program that is not a pre-service or urgent care claim and can be filed after medical care is received. For a post-service claim, notification of an adverse benefit determination will be provided within a reasonable period of time, but no later than 30 days after the Component Benefit Program receives the claim. This period may be extended by the Component Benefit Program for an additional 15 days, provided the Component Benefit Program administrator determines that the extension is necessary due to matters beyond the control of the Component Benefit Program, and the Component Benefit Program administrator provides timely notification of the circumstances that require the extension of time and the date by which a decision can be expected. If an extension is necessary because of a failure to submit information necessary to decide the claim, the notice of extension will specifically describe the required information. The claimant will have 45 days to provide that information.

Disability Claim. For a disability benefits claim, notification of an adverse benefit determination will be provided within a reasonable period of time, but no later than 45 days after the Component Benefit Program receives the claim. This period may be extended for an additional 30 days (up to two times), provided that the Component Benefit Program administrator determines that the extension is necessary due to matters beyond the control of the Component Benefit Program, and the Component Benefit Program administrator provides timely notification of the

circumstances requiring the extension and the date by which a decision can be expected. The notice will also explain the standards for being entitled to a benefit and issues that need to be resolved before a decision can be made. If an extension is necessary because of a failure to submit information necessary to decide the claim, the notice of extension will specifically describe the required information. The claimant will have 45 days to provide that information.

Notification. Written or electronic notification of any adverse benefit determination will be provided. If a claim is denied, in whole or in part, the notice will set forth:

- The specific reason or reasons for the denial;
- A reference to the specific Component Benefit Program provisions on which the denial is based;
- A description of any additional material or information necessary for the benefit to be paid and an explanation of why such material or information is necessary;
- An explanation of the Component Benefit Program's review procedures and time limits (including expedited review procedures in the case of an urgent care claim) and a statement of the right to bring a civil action following the claim denial on review;
- In the case of a claim denial by a Component Benefit Program providing health or disability benefits:
    - If the decision relied on a claims administrator's internal rules, a copy of the applicable rule or a statement that the rule will be provided free of charge upon request; or
    - If the decision is based on a limit or exclusion for medical necessity or experimental treatment or a similar exclusion or limit, an explanation of the clinical or scientific judgment for the determination or a statement that such explanation will be provided free of charge upon request;
- In the case of a claim denial by a Component Benefit Program involving urgent care, the information described above may be provided orally within the prescribed time frames, with written confirmation within 3 days.

Appeal of Adverse Benefit Determinations. If a claim is denied, the claimant is entitled to a full and fair internal review. The claimant will have 180 days after receiving a claim denial notice to file an appeal. The request for review must be written and should include an explanation of why the claimant believes he or she is entitled to benefits and any supporting evidence or documentation, including testimony. The claimant has the right to request, free of charge, reasonable access to and copies of documents, records, and other information relevant to the claim, including the claim file. The Sponsor will not charge or otherwise unduly inhibit or hamper submission or processing of an appeal. Subject to reasonable verification procedures, a personal representative may act on a claimant's behalf in filing or pursuing an appeal. The review of a denied claim will be conducted by a fiduciary of the Component Benefit Program who is not the

individual who made the initial claim decision and is not a subordinate of such individual. Appropriate medical experts will be consulted where medical judgment is required.

For group health plans that are not excepted benefits, the plan or insurer must provide any new or additional evidence considered, relied upon, or generated by the plan or insurer (or at the direction of the plan or insurer) in connection with a claim. This evidence must be provided as soon as possible, and sufficiently in advance of the due date for the notice of final internal adverse benefit determination so that the claimant has a reasonable opportunity to respond prior to the due date. If the final internal adverse benefit determination will be based on new or additional rationale, the plan or insurer must provide the claim, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the due date for the notice of final internal adverse benefit determination to provide the claimant a reasonable opportunity to respond prior to the due date.

The plan or insurer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. This means that (a) the named fiduciary deciding an appeal be different from (and not subordinate to) the individual who decided the initial claim; (b) any medical expert consulted regarding an appeal be different from (and not subordinate to) the expert consulted in connection with the initial claim; and (c) decisions involving hiring, compensation, termination, promotion, or related matters regarding any individual (e.g., a claims adjudicator or medical expert) must not be based on the likelihood that the individual will support the benefits denial.

The various insurers maintain their own procedures for appeals of adverse benefit determinations. Claimants should contact the provider for information about the applicable provider's appeal procedures. If there are any inconsistencies between the information set forth above and the claims procedure in the appropriate provider's information, the provider's procedure will control.

Assistance Regarding a Claim or Appeal. Some states have established an office of health insurance customer assistance or ombudsman under PHS Act Section 2793 to assist individuals with internal claims and appeals and external review process. Please contact the Plan Administrator for a current list of states that offer this assistance.

The chart below sets forth the timing of decisions upon appeal. The decision on appeal will be final and binding.

Procedure	**Health Benefits**			**Disability Benefits**	**Other Benefits**
	Urgent	**Pre-Service Non-Urgent**	**Post-Service**		
Notice of Improper Filing	24 hours	5 days	N/A	N/A	N/A

Procedure	Health Benefits			Disability Benefits	Other Benefits
	Urgent	Pre-Service Non-Urgent	Post-Service		
Notice of Incompleteness	24 hours	N/A	N/A	N/A	N/A
Notice of Initial Determination or Need for Extension (Measured from Filing)	72 hours (no extensions)	15 days	30 days	45 days	90 days
Claimant's Provision of Additional Information (where required)[1]	48 hours	45 days	45 days	45 days	Not Specified
Notice of Initial Determination after Commencement of Extension or Receipt of Additional Information, as applicable	48 hours	15 days[2]	15 days	30 days (may be repeated once)	90 days
Request by Claimant for Review after Claim Denial	180 days	180 days	180 days	180 days	60 days
Notice of Determination of Appeal (or Need for Extension, if applicable)	72 hours	30 days	60 days	45 days	60 days

External Review Procedure. The external review procedures apply to group health plans that are not excepted benefits. If a claim is denied following a full and fair internal review, the claimant is entitled to a full and fair external review, except that a denial, reduction, termination or failure to provide payment based on a determination that the participant or beneficiary fails to meet the requirements for eligibility under the terms of the group health plan is not eligible for external review. Generally, this means that external review only applies to claims involving the following: (a) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer; or (b) rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time). The claimant will have 4 months after receiving the final internal claim denial notice to file an appeal.

Within 5 business days after receipt of a request for External Review, the Component Benefit Program administrator or its designee will determine whether the claim is eligible for review under the external review procedure. This determination is based on whether:

- The claimant is or was covered under the Component Benefit Program at the time the claim was made or incurred;

[1] Measured from the notice of incompleteness for urgent health claim or the notice of a need for extension where more information is required.

[2] May be increased by unused time from period for providing notice of extension or need for additional information. May be delayed to extent plan waits for claimant to provide information.

- The denial relates to the claimant's failure to meet the Component Benefit Program's eligibility requirements;

- The claimant has exhausted the Component Benefit Program's internal claims and appeal procedures; and

- The claimant has provided all the information required to process an external review.

Within 1 business day after completion of this preliminary review, the Component Benefit Program administrator or its designee will provide written notification to the claimant of whether the claim is eligible for external review.

If the request for review is complete but not eligible for external review, the Component Benefit Program administrator or its designee will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the United States Department of Labor Employee Benefits Security Administration at its toll free number 866.444.3272.

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for external review, the Component Benefit Program will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for external review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Component Benefit Program within 1 business day. The Component Benefit Program may consider this information and decide to reverse its denial of the claim. If the denial is reversed, the Component Benefit Program will notify the claimant in writing and the external review process will end.

If the Component Benefit Program does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

- The claimant's medical records;

- The attending health care professional's recommendation;

- Reports from appropriate health care professionals and other documents submitted by the Component Benefit Program or issuer, claimant, or the claimant's treating provider;

- The terms of the Component Benefit Program;

- Appropriate practice guidelines, which must include applied evidence-based standards;

- Any applicable clinical review criteria developed and used by the Component Benefit Program; and

- The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Component Benefit Program and the claimant of its final decision within 45 days after the IRO receives the request for the external review. The IRO's decision notice must contain:

- A general description of the reason for the External Review, including information sufficient to identify the claim;

- The date the IRO received the assignment to conduct the review, the date the external review was conducted, and the date of the IRO's decision;

- References to the evidence or documentation, including the evidence-based standards, the IRO considered in reaching its decision;

- A discussion of the principal reason(s) for the IRO's decision, including what applicable, if any, evidence-based standards were a basis for its decision;

- The rationale for the IRO's decision;

- A statement that the determination is binding and that judicial review may be available to the claimant; and

- Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act.

The decision of the IRO is binding on the Component Benefit Program, as well as the claimant, except to the extent other remedies are available under state or federal law. The Component Benefit Program will provide any benefits (including making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Component Benefit Program intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Generally, a claimant must exhaust the Component Benefit Program's claims and appeal procedures in order to be eligible for the external review process. However, in some cases the Component Benefit Program provides for an expedited external review if:

- The claimant receives an adverse benefit determination that involves a medical condition for which the time for completion of the Component Benefit Program's internal claims and appeal procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

- The claimant receives a final adverse benefit determination that involves a medical condition where the time for completion of a standard external review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the Component Benefit Program must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for external review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Component Benefit Program.

Legal Action. All claim and appeal opportunities available must be exhausted before any lawsuit may be filed with respect to a claim. If a lawsuit with respect to a claim denial is filed, it must be filed no later than 3 years after the date of the final Component Benefit Program decision (including all appeals) regarding the claim.

13. General Information.

(a) **No Guarantee of Employment**. The Plan is not an employment contract. Nothing contained in this Summary or the Component Benefit Programs gives you the right to be retained in the service of a Member Employer. This Plan does not interfere with the right of a Member Employer to discharge you or to terminate your service at any time.

(b) **Coordination of Benefits**. Your benefits under this Plan and the Component Benefit Programs may be coordinated with other plans. This means that in some cases, your coverage may be reduced or not provided if you have coverage from another source. This prevents duplicate benefits. Please refer to the summary plan descriptions, insurance booklets, or other governing documents for more information about coordination of benefits.

(c) **Subrogation**. Your benefits under this Plan and the Component Benefit Programs may be subject to subrogation. This means that you may be required to reimburse the Plan for benefits you receive as a result of an injury or illness for which a third party is, or may be, held responsible. This prevents duplicate benefits. Please refer to the summary plan descriptions, insurance booklets, or other governing documents for each Component Benefit Program for more information about subrogation.

(d) **Documents of Component Benefit Programs Control**. The summary plan descriptions, insurance booklets, or other governing documents of the Component Benefit Programs contain the terms of your right to receive benefits. If there is a conflict among the plans,

the terms of the Component Benefit Programs will control the interpretation, unless otherwise required by law.

(e) **Assignment of Benefits**. Your benefits under the Plan cannot be used as collateral for loans or be assigned in any other way, except as required by federal law. The Plan shall not be liable for or subject to debts, contracts, liabilities or torts of any person entitled to benefits under the Plan. To the extent permitted by law, neither the benefits nor payments under the Plan will be subject to the claim of creditors or to any legal process. Notwithstanding the above statements, you may assign benefits directly to a health care provider or facility. Otherwise, benefits will be paid according to the terms of the summary plan descriptions, insurance booklets, or other governing documents of the Component Benefit Programs.

14. Statement of ERISA Rights. The Employee Retirement and Income Security Act of 1974 ("ERISA") grants certain rights to Participants under the Plan. ERISA entitles all Plan Participants to the following:

(a) You may examine all documents governing the Plan without charge. These include the insurance contracts, summary plan descriptions, or other plan documents, and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor. The Sponsor will make the documents available at the Plan Administrator's office. They may also be available at other specified locations.

(b) You may obtain copies of all Plan documents and other Plan information. These include the insurance contracts, summary plan descriptions, or other plan documents, copies of the latest annual report (Form 5500 series), and the updated Summary Plan Description. The Plan Administrator will provide them upon written request. It may charge a reasonable amount for the copies.

(c) You will receive a copy of the Plan's annual financial report from the Plan Administrator.

(d) You may continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event under COBRA. You or your dependents may have to pay for such coverage. Please review the portion of the Summary Plan Description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

ERISA also imposes duties upon the people responsible for the operation of the Plan. These individuals are called "fiduciaries" of the Plan. Fiduciaries have a duty act prudently. They must act in the interest of you, other Participants and Beneficiaries. No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or from exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done. You may also obtain copies of documents relating to the decision without charge. You have the right to have the Plan review and reconsider your claim.

ERISA provides several steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials. It may also order the Plan Administrator to pay you up to $110 a day until you receive the materials. The court may decide not to enforce a penalty if the Plan Administrator did not send the materials because of reasons beyond its control. You may file suit in state or Federal court if you have a claim for benefits that is wholly or partially denied or ignored. You may file suit in Federal court if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or qualified medical child support order. The Plan's fiduciaries may not misuse the Plan's money or discriminate against you for asserting your rights. If they do, you may seek assistance from the U.S. Department of Labor. You may also file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Please contact the Plan Administrator if you have any questions about the Plan. You may have questions about this statement or your rights under ERISA. If so, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor. Your telephone directory should list the address. You may also ask the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

15. Conclusion. This Summary Plan Description is intended to briefly highlight the provisions of the Plan. The Sponsor intends this Summary to be accurate. However, the Plan will control any conflict between this Summary and the Plan. You should consult with the Plan Administrator concerning the actual Plan provisions if you have questions.

4828-5229-5468, v. 1