BCU WELFARE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

In the event of an inconsistency between the terms of this Summary Plan Description and the applicable Plan document, insurance contracts, certificates, or other documentation, the insurance contracts, certificates, and other document shall prevail over this Summary Plan Description. This Summary Plan Description and the Plan document, insurance contracts, certificates, and other documentation may be amended at any time.

Effective January 1, 2024
(except as otherwise noted herein)

BCU Welfare Benefit Plan
Summary Plan Description

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I. INTRODUCTION

At BCU (the "Company" or the "Plan Sponsor"), we believe that flexibility in our benefits program is important, so we've designed the BCU Welfare Benefit Plan ("Plan") to allow employees of the Company or Affiliated Employers to select the types and levels of coverage that are appropriate for themselves and their family. This "wrap" summary plan description ("SPD") describes the provisions of the Plan as of January 1, 2024.

The Plan includes the following component benefits:

- Medical and Prescription Drug Benefits
    - PPO option
    - HDHP option with a health savings account
- Fertility Treatment Benefits
- Dental Benefits
    - Basic dental benefit option
    - Enhanced dental benefit option
    - DHMO dental benefit option
- Vision Benefits
- Life, Accidental Death and Dismemberment and Supplemental Life and Accidental Death and Dismemberment Benefit
- Disability Benefits
    - Long-Term Disability Benefits
    - Short-Term Disability Benefits
- Flexible Spending Account Benefits and Transportation Benefits (health care spending accounts, limited purpose health care spending accounts, dependent care flexible spending account), which are described in a separate summary plan description
- Business Travel Accident Benefits
- Critical Illness Benefits
- Hospital Indemnity Benefits
- Health Accident Benefits
- Employee Assistance Plan Benefits
- Legal Services Benefits

Each of these component Benefit Plans is summarized in documents, which may include an insurance contract, a certificate of coverage, benefit summaries, or another governing document prepared by the Company or an insurance carrier ("Booklets"). The Booklets, which have been/will be provided to you and are also available upon request, provide specific information for the benefits. This document is intended to provide you with additional information regarding the Plan and, along with the Booklets, constitute the "summary plan description" for the Plan.

NOTE: Certain other benefits made available by the Plan Sponsor are not part of the Plan and are not included in this SPD. These benefits include health savings account, dependent care spending account, commuter benefits, pet health insurance, identity theft insurance, and certain employee discounts.

II. IMPORTANT DEFINITIONS

This SPD uses a number of defined terms to describe the benefits available under the Plan. The following list explains the meaning of these terms.

AD&D "AD&D" means accidental death and dismemberment insurance.

Affordable Care Act "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010, as amended, as in effect from time to time.

Booklets "Booklets" mean the booklets, certificates, and/or policies that describe the Benefits and have been previously distributed or are attached hereto. The Booklets are an integral part of this Plan.

Benefits or Benefit Plans "Benefits" or "Benefit Plans" means the benefits provided under the Plan, which are listed in the chart under Section III of this SPD.

Claims Administrator "Claims Administrator" means the person(s) or entity(ies) appointed by the Plan Administrator to make an initial benefit determination or to determine a subsequent appeal with respect to a "claim" for benefits (under DOL Regs. 2590.503-1(e)) under a coverage option thereunder, as listed in Supplement A of the Plan.

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

Code "Code" means the Internal Revenue Code of 1986, as amended.

Company "Company" means BCU or any successor thereto.

Coverage Option "Coverage Option" means an employee benefit plan that forms a part of this Plan as set forth in the documents incorporated by reference in the Benefit Plans chart below.

Domestic Partner "Domestic Partner" means a person of the same or opposite sex that is unrelated to you where the relationship satisfies one of the following requirements and the required documentation has been submitted to the Plan Sponsor:

(a) You and domestic partner have registered the domestic partnership with a governmental body according to state or local law (including formalization of a same-sex or civil union, if recognized in the state where you reside); or

(b) You and the domestic partner are in a committed long-term relationship and both you and the domestic partner:

(i) Share a single permanent residence, and have done so continuously for the past 12 months;

(ii) Are financially interdependent;

(iii) Are not related by blood in any degree which would prevent marriage to each other in their state of residence;

(iv) Are not married to another person or in a domestic relationship or civil union with another person; and

(v) Are both at least 18 years of age and under no legal disability which would prevent them from entering into a domestic partnership.

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

GINA "GINA" means the Genetic Information Nondiscrimination Act of 2008.

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

Insurer "Insurer" means an insurance company that has issued an insurance contract through which one or more Benefits are provided. The name, address and phone number of each Insurer providing a benefit is described in the Benefit Plan chart below and in the applicable coverage Booklet. The Insurers are responsible for financing all insured Benefits in exchange for payment of insurance premiums, and are also responsible for processing and deciding all claims for insured Benefits.

Medical Coverage "Medical Coverage" means major medical and prescription coverage provided through the Plan.

MHPA "MHPA" means the Mental Health Parity Act, as amended by the Mental Health Parity and Addiction Equity Act of 2008.

NMHPA "NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

Plan "Plan" means the BCU Welfare Benefit Plan.

Plan Administrator "Plan Administrator" means the BCU Health and Welfare Benefits Committee.

Plan Sponsor "Plan Sponsor" means BCU and any Affiliated Employers that participate in the Plan.

USERRA "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

WHCRA "WHCRA" means the Women's Health and Cancer Rights Act of 1998.

III. GENERAL INFORMATION ABOUT THE PLAN

Plan Name	BCU Welfare Benefit Plan
Primary Sponsor	BCU 340 N. Milwaukee Avenue Vernon Hills, IL 60061 Federal EIN: 23-7250155
Plan Number	501
Plan Year	January 1 – December 31
Effective Date	January 1, 2024
Plan Administrator	BCU Health and Welfare Benefits Committee BCU 340 N. Milwaukee Avenue, Vernon Hills, IL 60061 Telephone: (877) 810-9712

The Plan Administrator has delegated administrative authority to determine all claims to the Claims Administrators (which shall be the Insurers for insured benefits and the entities listed under the Benefit Plans chart below for the self-insured benefits). Such discretionary authority is intended to include, but is not limited to, the determination of whether a person is entitled to benefits under the applicable Benefit Plans and the computation of any and all benefit payments under such Benefit Plans.

Except with regard to administrative authority delegated above, the Plan Administrator shall have the sole discretionary authority to construe the terms of the Plan and all facts surrounding claims under the Plan (such as whether an individual is eligible for coverage under the Plan), and shall determine all questions arising in the administration, interpretation, and application of the Plan. All determinations of the Plan Administrator shall be conclusive and binding on all parties.

Please note that the Insurers are the claim fiduciaries for all fully insured Benefits under the Plan, which are provided through contracts of insurance. The name, address, and phone number of the Insurers are described in the Benefit Plans chart below and in the applicable coverage Booklet.

Agent for Service of Legal Process	BCU 340 N. Milwaukee Avenue Vernon Hills, IL 60061

Type of Plan Benefit	Welfare benefit plan providing medical, fertility treatment, dental, vision, life and accidental death and dismemberment, supplemental life and accidental death and dismemberment, long-term disability, short-term disability, business travel accident, hospital indemnity, health accident, employee assistance program, legal services, and critical illness. Includes Code Section 125 benefits via the health flexible spending account and the limited purpose health flexible spending account permitting elective employee salary deferrals to fund unreimbursed qualifying health expenses.
Types of Administration	Some of the Benefits under the Plan are fully insured and some are paid from the general assets of the Company. The fully insured benefits are administered by the Insurer. The self-funded benefits are administered by a third-party administrator.
Claims Administration	The Claims Administrator receives, processes, and pays for benefits under the Plan. Refer to the Benefit Plans chart below for the Claims Administrators of the Benefit Plans (which are the Insurers for the insured Benefit Plans and are the entities listed for the self-insured Benefit Plans). Claims for benefits under the applicable Benefit Plan should be directed to the applicable Claims Administrator. In the event authority to administer the Plan is delegated to the Claims Administrator, the Claims Administrator shall have sole discretionary authority to construe the terms of the Plan and all facts surrounding claims under the Plan and shall determine all questions arising in the administration, interpretation, and application of the Plan. All determinations of the Claims Administrator shall be final and binding, except where the Plan Administrator has retained discretionary authority to make final claims determinations.
Funding	The Benefit Plans chart below shows what benefits under the Plan are fully insured and what benefits are self-insured. For the fully insured benefits, the Insurers, not the Plan Sponsor, are responsible for paying claims with respect to these benefits. For the self-insured benefits, benefits are self-funded by the Plan Sponsor and claims for these benefits are administered by third-party claims administrators retained by the Company. The cost of coverage for benefits are paid in part by the Plan Sponsor out of its general assets and in part by employees' payroll deductions.
Important Notice	Certain Benefit Plans provided under the Plan are made available through various insurance contracts between the Company and the Insurers. If the terms of this SPD conflict with the terms of such insurance contracts, the terms of the insurance contracts or governing plan document will control, rather than this SPD. For further information about benefits under the Plan, refer to the applicable Booklet, plan document, certificate of coverage, or insurance contract for each separate benefit or contact the Plan Administrator. For information about reimbursement benefits, refer to the flexible spending account summary plan description.

Benefit Plans

Benefit Plans	Insured Benefits – Insurer/Claims Administrator	Self-Insured Benefits - Claims Administrator	Incorporated Document(s)	Contact Information
Medical Benefits (PPO and HDHP options)		Aetna	Booklet	Aetna www.aetna.com 800-238-6716
Prescription Benefits		CVS Caremark	Booklet	CVS Caremark www.caremark.com 833-271-9777
Fertility Treatment Benefits		Progyny	Summary	Progyny www.progyny.com 833-233-0874
Menopause Support Benefits (effective January 1, 2025)		Progyny	Summary	Progyny www.progyny.com 833-233-0874
Dental Benefits (Basic, Enhanced, and PPO options)		Cigna	Booklet	Cigna www.mycigna.com 800-244-6224
Dental Benefits (DHMO option)	Cigna		Insurance Certificate	Cigna www.mycigna.com 800-244-6224
Vision Benefits	Aetna		Booklet	Aetna www.aetna.com 800-238-6716
Employee Assistance Program		ComPsych	Booklet	ComPsych www.guidanceresources.com 800-344-9752
Life and Accidental Death and Dismemberment, Supplemental Life and Accidental Death and Dismemberment, Long-Term Disability, and Short-Term Disability	NY Life		Insurance Certificate	NY Life www.mynylgbs.com 888-842-4462
Flexible Benefit Plan (including Health Care Flexible Spending Account, Limited Purpose Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Commuter (Transit)		Inspira Financial	Booklet	Inspira Financial www.inspirafinancial.com 888-678-8242

Benefit Plans	Insured Benefits – Insurer/Claims Administrator	Self-Insured Benefits - Claims Administrator	Incorporated Document(s)	Contact Information
Business Travel Accident Benefits	NY Life		Insurance Certificate	NY Life www.mynylgbs.com 888-842-4462
Health Accident Plan, Critical Illness Plan, and Hospital Indemnity Plan	Aetna		Insurance Certificate	Aetna www.aetna.com 800-238-6716
Pre-paid Legal Services Plan	MetLife		Booklet	MetLife www.legalplans.com 800-821-6400
Executive Physical Program (Effective January 1, 2025)		Northwestern Medicine	Summary Plan Description	Northwestern Medicine https://www.northwesternexecutivehealth.com 312-926-1300

IV. ELIGIBILITY AND PARTICIPATION REQUIREMENTS

Eligibility for Employees

You and your eligible dependents eligibility to receive benefits under the Plan will be dictated by and limited based on your eligibility to receive benefits under each Coverage Option and as otherwise dictated by a collective bargaining agreement.

In general, you and your eligible dependents are able to participate in the Plan if you are scheduled to work 20 or more hours per week.

In general, you, and your eligible dependents, are able to participate in the Plan on your first day of employment, provided that you enroll within 31 days of that date.

Any other provision of the Plan or a Coverage Option to the contrary notwithstanding, no individual will be considered an eligible employee nor will such individual be otherwise eligible to participate in or receive benefits under the Plan during any period in which such individual is a (1) leased employee or person classified as a leased employee by the Plan Sponsor regardless of whether such person is later determined, whether by the Plan Sponsor or otherwise, to be a common law employee of the Plan Sponsor; (2) covered by a collective bargaining agreement that does not provide for coverage under the Plan; (3) temporary or contract employee; (4) person performing services for the Plan Sponsor under an independent contractor or consultant agreement or arrangement; (5) nonresident alien; or (6) person who is providing services to the Plan Sponsor pursuant to an agreement between the Plan Sponsor and a third party or who is treated for payroll purposes as other than an employee of the Plan Sponsor (even if such person is later determined, whether by the Plan Sponsor or otherwise, to be a common law employee of the Plan Sponsor).

Medical Coverage Rule. You are also eligible for Medical Coverage if you are:

- A variable hour, temporary, or seasonal employee of a Plan Sponsor (employee who does not work a fixed schedule) who averages 30 or more hours a week during the applicable measurement period (with entry following applicable measurement period). You will be advised if you become eligible for Medical Coverage due to your averaging 30 or more hours during a measurement period.

You are not an eligible employee if you are not classified as a common law employee of a Plan Sponsor (such as an independent contractor), even if you are subsequently determined by a court or government agency to have actually been common law employees as of an earlier date. If you are a reclassified worker, you may be eligible to enroll prospectively but do not have any retroactive rights to enroll in this Plan. Whether you are an eligible employee is determined in the sole discretion of the Plan Administrator.

The Executive Physical Program is part of the Plan's Medical Benefits but is available only to certain executives of the Plan Sponsor. Accordingly, if you are designated by the Plan Sponsor as eligible for the Executive Physical Program, you must be enrolled in the Plan's Medical Coverage to access the Executive Physical Program benefit.

Eligibility for Dependents

Your eligible dependents are your:

- Spouse or Domestic Partner
- Dependent children (through the end of the year in which they turn 26 years old for medical, dental, and vision benefits, and until they turn age 26 for life and accidental death and dismemberment, voluntary life and accidental death and dismemberment, and critical illness benefits). Dependent children include:
    - Biological children
    - Stepchildren
    - Legally adopted children (including children placed for adoption)
    - Any children under court-ordered legal guardianship
- Disabled dependent children (proof of disability is required), provided the disability occurred prior to age 26.
- Children of your spouse or Domestic Partner (meeting the description of children above) until the end of the plan year in which they turn 26 years old.
- Children covered by a Qualified Medical Child Support Order.

Note:

- Certain Benefit Plans may have additional eligibility requirements (such as financial dependency), which will be referenced in the Booklets.

Special Enrollment Rights

As required by law, the Plan complies with the applicable provisions of HIPAA. HIPAA provisions apply to group health plans only, not all benefits offered under the Plan.

HIPAA requires a group health plan to provide special mid-year enrollment opportunities to certain employees and/or their dependents in two circumstances: (1) loss of other coverage, or (2) acquisition of a new dependent. As discussed below, certain other circumstances relating to the loss of eligibility for coverage under Medicaid or a state-sponsored children's health program or a determination of eligibility for a subsidy under either of these programs may also provide special enrollment rights.

If you are covered under another group medical plan and involuntarily lose that coverage (due to expiration of COBRA, loss of eligibility under the other group plan, or termination of employer contributions), you or your dependents may enter the Plan under the special mid-year enrollment rights. You must request enrollment in writing within 31 days after the loss of other coverage or the company's cessation of contributions for such other coverage. Coverage will begin on the date of the event that caused you to involuntarily lose coverage.

If you as an employee acquire a new dependent, by marriage, birth, adoption, or placement for adoption, you have a right to enroll yourself and the new dependent in the group health plan. You must request enrollment in writing within (a) 60 days of the birth, adoption, or placement for adoption, or (b) 31 days of the marriage.

You will also have a special enrollment right under the Plan in the following circumstances:

- If you, your spouse, or your dependents experience a loss of eligibility for Medicaid or Children's Health Insurance Program ("CHIP") coverage; or
- If you, your spouse, or your dependents become eligible for premium assistance under an optional state Medicaid or CHIP program that would pay your portion of the applicable insurance premium for Plan coverage.

Special timing rules apply for the two circumstances above. To exercise your special enrollment rights in these circumstances, you must notify the Plan Administrator within 60 days of the loss of coverage or 60 days of when eligibility for the Medicaid or CHIP subsidy is determined.

Please refer to the applicable Booklets and other documentation relating to the Benefit Plans for additional information about your special enrollment rights.

Nondiscrimination

For group health benefits under the Plan, HIPAA prohibits the Plan from discriminating on the basis of health factors. The Plan may not impose evidence of insurability or underwriting requirements, or otherwise determine eligibility for health coverage, on the basis of an individual's health status. HIPAA prohibits discrimination among similarly situated Plan participants and their dependents (including late enrollees) based on health status or health claims experience.

The Genetic Information Nondiscrimination Act of 2008 supplements HIPAA's nondiscrimination requirements to regulate the use of genetic information about Plan participants and their dependents and other family members (as defined by GINA). GINA precludes the Plan from setting premiums or contribution levels based on genetic information, requiring mandatory genetic testing, or requesting, requiring, or purchasing genetic information for underwriting purposes. Under GINA, "genetic information" refers to any information about an individual's genetic tests, any genetic tests of the individual's family members and relatives, and any manifestation of a disease or disorder in the individual's family members but does not include gender or age. A "genetic test" includes any analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes. Tests that do not detect abnormalities and those that are directly related to manifested disease or disorder or pathological conditions that could reasonably be detected by a health care professional with appropriate training and expertise are not encompassed within this definition. GINA defines "underwriting purposes" to mean rules for eligibility for coverage, computation of premiums or contribution amounts, application of pre-existing condition limitations, and other activities relating to the creation, renewal, or replacement of an insurance contract or health benefits.

Please refer to the applicable Booklets and other documentation relating to the Benefit Plans for additional information.

Termination of Participation

Your participation and the participation of your eligible family members in all Benefit Plans of the Plan will continue until the earlier of

(1) the termination of the Plan;

(2) the end of the month in which you cease to be an eligible employee (for medical/dental/vision benefits) or the date you cease to be an eligible employee (for all other benefits under the Plan); or

(3) the date you terminate employment with a Plan Sponsor or otherwise lose coverage.

Coverage also may terminate if you fail to pay your share of an applicable premium, if your hours drop below any required hourly threshold, if you submit false claims, or for any other reason as set forth in the certificates of coverage for the applicable component Benefit Plans. You should consult these materials for specific termination events and information.

Other circumstances can result in the termination, reduction, or denial of benefits. The Booklets and other governing documents provide additional information.

If your or your eligible family member's coverage under a Benefit Plan that is a group health plan ceases because of certain "qualifying events" specified in COBRA, then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time.

In general, a qualifying event under COBRA includes the following events that result in your loss of coverage:

- termination of your employment (other than by reason of gross misconduct), or reduction of your work hours;
- your death;
- divorce or legal separation from your spouse;
- your becoming eligible to receive Medicare benefits; or
- when a dependent of yours ceases to be a dependent.

For a qualifying event that is a divorce or legal separation from your spouse, or your dependent ceasing to be eligible to participate in the Plan, it will be your obligation to inform the Plan Administrator of the event in writing within 60 days of its occurrence. The Plan Administrator, in turn, has a legal obligation to furnish you, your spouse, or your dependent as the case may be, with a notice of your rights under COBRA and with the option to elect to continue the applicable coverage provided at stated premium costs. Qualified beneficiaries have 60 days following receipt of the notice regarding their COBRA rights to elect to continue coverage under COBRA. The notification you will receive regarding your rights under COBRA will explain all the terms and conditions of the continued coverage in detail.

For purposes of COBRA continuation coverage, group health plan benefits will be subject to separate elections because they are subject to separate requirements under COBRA. Your COBRA election for group health plan coverage will be applicable only for the coverage you had in effect at the time of your qualifying event. Accordingly, if you had group health plan coverage in effect prior to your termination of employment and then elect COBRA continuation coverage, you must pay the applicable premium for the coverage.

Your health care flexible spending account is subject to somewhat different requirements under COBRA; please refer to the summary plan description for the flexible spending accounts for additional information.

Continuation of Coverage under USERRA

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to USERRA. If you are absent from work for less than 31 days due to your active military service, your Plan participation will not be interrupted.

If you are absent from work for more than 30 days due to service in the uniformed services, you and your covered family members will have the opportunity to elect continuation group health coverage for the 24 month period that begins on the first day of your leave of absence. You must pay the premiums for continuation coverage with after-tax funds.

USERRA continuation coverage is considered to be alternative coverage for COBRA purposes. As a result, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Please refer to the applicable Booklet for more information about continuation coverage available under USERRA.

Continuation of Coverage under

If you take a leave of absence for your own serious health condition or for family members with a serious health condition or to care for a newborn or adopted child, you may be able to continue your health coverage under the

FMLA and Other Laws

Plan under the FMLA. If you drop your health coverage during the leave, you will generally be able to reinstate it as of the date you return to active employment, assuming you pay any contributions required for coverage. In addition, to the extent required under and in accordance with the FMLA, and the regulations thereunder, any Plan Sponsor contributions made under the terms of the Plan will continue to be made on your behalf during an FMLA leave.

Please refer to the applicable Booklet for more information about continuation coverage available under FMLA and other applicable state laws or contact the Benefits Department at bcubenefits@bcu.org.

Conversion and Portability Privileges

Life insurance and disability benefits are not subject to the COBRA continuation provisions. However, in certain circumstances an existing life insurance conversion or portability privilege may be exercised within a specified period of time following the date of termination. If you wish to exercise this conversion or portability privilege, please refer to the applicable Booklet for specific requirements.

V. SUMMARY OF PLAN BENEFITS

Benefits and Contributions

The Plan provides you and your eligible dependents with medical, fertility treatment, dental, vision, long-term disability, business travel accident, group life and accidental death and dismemberment, supplemental life and accidental death and dismemberment, short-term disability, critical illness, employee assistance program, commuter benefits, health flexible spending account, limited purpose health flexible spending account, dependent care flexible spending account, and pre-paid legal services plan. A summary of each benefit provided under the Plan is set forth in the applicable Booklet.

The cost of the benefits provided through the Plan is funded in part by Plan Sponsor contributions and in part by both pre-tax employee contributions (for medical, dental, vision, transportation benefits, health flexible spending account, limited purpose health flexible spending account, dependent care flexible spending account) and after-tax employee contributions (for supplemental life and accidental death and dismemberment benefits, hospital indemnity, health accident, critical illness, and legal services benefits). The Plan Sponsor will determine and periodically communicate your share of the cost of the benefits provided through each component Benefit Plan, and it may change that determination at any time.

In general, you will be notified about your portion of monthly contributions for premiums each year prior to open enrollment. New hires eligible for the Plan will be given this information during new hire orientation.

The Plan Sponsor will make contributions in an amount that (in its sole discretion) is needed to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Plan Sponsor will pay its contribution and your contributions to the applicable insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to or on behalf of you or your eligible family members from the Plan Sponsor's general assets. Your contributions toward the cost of a

particular benefit will be used in their entirety prior to using Plan Sponsor contributions to pay for the cost of such benefit.

VI. IMPORTANT DISCLOSURES

QMCSO Procedures

With respect to the component Benefit Plans that provide group health benefits, the Plan will furnish benefits as required by any qualified medical child support order ("QMCSO") (defined in Section 609(a) of ERISA).

As part of a divorce action, a court, domestic relations magistrate, or administrator can enter an order (a "Medical Child Support Order" or "MCSO") that grants a child the right to receive health benefits under one of his or her parent's group health plans, regardless of whether the parent is the custodial parent of the child. However, to be valid or "qualified" (a "QMCSO"), the Medical Child Support Order must meet certain statutory requirements that are identified below.

Upon receipt of a notice of a Medical Child Support Order and request for group health coverage for one or more children of an employee or covered spouse, the following will occur:

- The Plan Administrator will send a letter acknowledging receipt of the Medical Child Support Order. The letter will be sent to the employee and to each child affected by the order.
- The Plan Sponsor will review the order to make certain that it:
  - was issued pursuant to a valid state domestic relations law;
  - specifically provides for a dependent (or dependents) to receive group health benefits;
  - provides the name and last known mailing address of the employee and each child covered by the order;
  - provides a reasonable description of the group health coverage to be provided by the Plan or the manner in which the coverage can be determined. The order cannot require a Plan to provide any benefit or option that is not otherwise provided;
  - specifies the time period to which the order applies;
  - names each group health benefit to which the order applies.

The employee may be required to provide necessary identifying information about the child(ren), such as social security number(s), so that the Plan Sponsor can comply with the requirements of the order.

Upon completion of its review, the Plan Administrator will notify the employee and each affected child advising whether or not the order has been determined to be qualified. If the order is determined to be qualified, each child affected by the order will be permitted to submit a written designation to the Plan Administrator nominating a representative to receive copies of any notices regarding any coverage or benefits matters.

Special Rights Relating to Childbirth

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

Coverage of Reconstructive Surgery

The federal Women's Health and Cancer Rights Act of 1998 requires coverage of treatment related to mastectomy. If you are eligible for mastectomy benefits under your group health plan and you elect breast reconstruction in connection with such mastectomy, you are also covered for the following:

- Reconstruction of the breast on which mastectomy has been performed;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all states of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under the Plan. Coverage is subject to applicable deductibles, copayments and coinsurance payments.

Mental Health Parity

Except in limited circumstances, Federal law requires that any mental health care coverage provided by a group health plan generally be comparable to the coverage available for other types of illness or disease. In particular:

- The financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to mental health and substance abuse benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits;
- Mental health benefits and substance abuse benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to such benefits;
- Out-of-network mental health and substance abuse benefits must generally be made available to covered persons;
- Standards for medical-necessity determinations and reasons for any denial of benefits relating to mental health benefits and substance abuse benefits must be made available upon request to plan participants; and

- The requirements imposed by the MHPA (regarding annual and lifetime dollar limits) will continue and will be extended to substance abuse benefits.

VII. CLAIMS AND APPEALS PROCEDURES

Important Note

Depending on the Benefit Plan at issue, different claims and appeals procedures may be applicable under the Plan. The following explanation summarizes the key aspects of the claims and appeals procedures that are generally effective. You should refer to the applicable Booklets and other documentation for the particular Benefit Plan at issue for additional information about how to submit claims and appeals to the appropriate Claims Administrator.

Claims for Fully Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits of the fully insured component benefits available under the Plan, the respective Claims Administrator is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the Claims Administrator of a fully insured Benefit Plan, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign, and submit a written claim on the Insurer's form.

The relevant Claims Administrator will decide your claim in accordance with its reasonable claims procedures, in accordance with ERISA. The Claims Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide a claim. If the Claims Administrator denies a claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Claims Administrator for a review of the denied claim. Any such appeal will be decided in accordance with the Claims Administrator's reasonable claims procedures, in accordance with ERISA. If you do not appeal on time, then you may lose the right to file suit in a state or federal court, as the internal administrative appeals will not have been exhausted (which generally is a prerequisite to bringing a suit in state or federal court).

For Medical Coverage, you may also have an external review right if you appeal a determination based on: (a) medical judgment, as determined by the external reviewer, or (b) a rescission of coverage.

Refer to the applicable Booklet and other documentation for more information about how to file a claim and details regarding claims procedures applicable to each component benefit available under the Plan. If your Booklet does not have claims information, refer to the claims procedures referenced below.

Claims for Self-Funded Benefits

Benefits for medical, fertility treatment, dental, health flexible spending account, and limited purpose health flexible spending account are provided on a self-funded

basis (*i.e.*, paid out of the Plan Sponsor's general assets), and the claims procedures for these benefits are set forth in the applicable Booklet.

Applicability of General Claims Procedures

To the extent not otherwise provided under the applicable Booklet or other documentation for a Benefit available under the Plan, the following claims and appeals procedures shall be applicable.

If you have any questions about the procedures that are applicable to a particular Benefit, please contact the Claims Administrator for more information. Claims Administrator information (including address and telephone number) for a specific Benefit Plan is contained in the Benefit Plan chart in Section III of this Summary.

Filing a Claim for Benefits

In order to submit a claim for benefits, you must complete and submit the necessary forms to the designated Claims Administrator (or to the Plan Administrator if no Claims Administrator has been appointed for a particular benefit).

Forms are available from the Claims Administrator found on the benefits website www.bcubenefits.com. If you do not use the prescribed procedures for filing a claim, then your inquiry will not be treated as a claim for benefits and the procedures summarized here will not apply.

What is a Claim for Benefits?

A claim for benefits includes the following requests:

- A request for reimbursement of expenses already incurred, and
- A request for pre-approval of an expense where the Plan requires pre-approval as a condition of reimbursement of the expense.

How are Claims Processed?

Your claim for benefits will be decided by the Claims Administrator for a particular type of benefit. The Claims Administrator will provide a response to your claim within the applicable time period described below. If you do not receive a response within the applicable time period, please contact the Claims Administrator. (Alternatively, you may assume that the claim has been denied and submit an appeal).

Authorized Representative

You may be represented by an authorized representative (such as your spouse, other family member, physician, or attorney) when you initially file your claim or appeal the initial denial of your claim. The Claims Administrator may require that the person you select provide evidence (such as a signed authorization) that you have authorized him or her to represent you in connection with your claim for benefits. However, please note that generally the fact that you have assigned your right to payment to a health care provider will not be sufficient evidence that the health care provider is authorized to represent you in connection with a claim for benefits.

Legal Action

If you believe your claim under the Plan is being improperly denied in whole or in part, you have the right to bring a legal action. However, no legal action can be brought until you have exhausted all the steps in the appeal process provided in the Plan. You must bring any such legal action within one year of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action unless the insurance contract provides for a different period of time for bringing suit. However, the one-year period is tolled for any period during which an external review is pursued, and such tolling will end as of the date of a notice of a final external review decision.

Health Claims: The claims procedures described in this section will apply to any claim for health benefits under the Plan to the extent that claims procedures for health benefits are not provided in the Booklets or such claims procedures do not comply with ERISA or other applicable law.

Types of Health Claims The applicable time period for responding to a claim for health benefits depends on the type of claim at issue:

- *Concurrent Care Claim* – A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously approved benefit claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.
- *Pre-Service Care Claim* – A pre-service claim is a claim for a benefit under the Plan with respect to which the terms of the Plan require approval (usually referred to as pre-certification) of the benefit in advance of obtaining medical care.
- *Post-Service Care Claim* – A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim.
- *Urgent Care Claim* – An urgent care claim is any claim for medical care or treatment with respect to which, in the opinion of the treating physician, lack of immediate processing of the claim could seriously jeopardize the life or health of you or your dependent or subject you or your dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies and is determined by the attending provider.

Notification of Initial Decision If your claim is an **urgent care claim**, you or your authorized representative will be notified of the Claims Administrator's initial decision on the claim, whether adverse or not, as soon as is feasible, but in no event more than 72 hours after its receipt of the claim. If the claim does not include sufficient information for the Claims Administrator to make a decision, you or your representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. You will have at least 48 hours to respond to this request; the Claims Administrator then must inform you of its decision within 48 hours of receiving the additional information.

If your claim is a **concurrent care claim**, the Claims Administrator will notify you of its decision, whether adverse or not, within 24 hours after receiving the claim. You will be given time to provide any additional information required to reach a decision.

If you seek authorization for a **pre-service care claim**, the Claims Administrator will notify you of its initial determination, whether adverse or not, as soon as possible, but not more than 15 days from the date it receives the claim. This 15-day period may be extended by the Claims Administrator for an additional 15 days if the extension is required due to matters beyond the Claims Administrator's control.

If you have filed a **post-service claim** for reimbursement of medical care services that already have been rendered, you will receive a response within 30 days after your claim is received by the Claims Administrator. The Claims Administrator may notify you in writing before the end of the normal 30-day review period that it needs an additional 15 days to review your claim because of circumstances beyond its control.

If the Claims Administrator extends its review period, you will be notified in writing. The notice will inform you of the following:

- The special circumstances requiring the extension of time;
- The date by which you can expect a decision;
- The standards for determining your entitlement to a benefit;
- The unresolved issues that prevent a decision on your claim; and
- A description of any additional information that you need to submit.

You will have at least 45 days to provide the requested information (this will have the effect of suspending the time for a decision on your claim until the specified information is provided). The Claims Administrator will have up to 30 days to respond to your claim after you respond to the request for additional information.

The Claims Administrator may notify you in writing before the end of the first 30-day extension that it needs a second 30-day extension to review your claim because of circumstances beyond its control. The notice of the second extension also will indicate the circumstances requiring the extension, when the Claims Administrator expects to be able to respond to your claim, and the other information noted above. You will have at least 45 days to provide the requested information. The Claims Administrator may delay responding to your claim for benefits until you respond to any request (in the notice of the second 30-day extension) for additional information. The Claims Administrator will have up to 30 days to respond to your claim after you respond to the request for additional information.

Notice of Denial

If your claim is denied in whole or in part, you will receive a written or electronic response from the Claims Administrator. The Claims Administrator's response will include the following information:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning);
- The specific reason(s) for the denial, including the denial code and its corresponding meaning and a description of the standard, if any, that was used in denying the claim;
- Reference to the specific Plan provisions upon which the denial was based;
- A description of any additional material or information that is necessary for your appeal of the denied claim to be successful, and an explanation of why this information is necessary;

- An explanation of the available internal and external review procedure summarized below, including the time limits applicable to the review procedures and your rights to submit written comments, evidence, and testimony and have them considered, your right to review (upon request and at no charge) relevant documents and other information, including your claim file;
- A statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793 to assist individuals with the internal claims and appeals and external review process;
- A statement that you have a right to bring a civil action under ERISA following a denial of an appeal of your claim; and
- For urgent care claims, a description of the Plan's Expedited Review Process.

The Claims Administrator will also provide you with the following additional information:

- If the Claims Administrator relied on an internal rule, guideline, protocol, or other similar criterion in denying your claim, then the Claims Administrator either will provide you with a copy of that criterion or will notify you that it relied on such a criterion and inform you that you may request a copy of the criterion free of charge.
- If the Claims Administrator based the claims denial on a medical exclusion or limit, then the Claims Administrator either will provide you with an explanation of the scientific or clinical judgment underlying the claims denial, as applied to your medical circumstances, or will notify you that an explanation will be provided free of charge upon request.

To request a copy of the criterion or medical judgment summary, please contact the Claims Administrator. If the Claims Administrator's response does not include the information noted above, please contact the Claims Administrator and request the missing information.

How Do I Appeal a Denied Claim?

If your initial claim is denied, then you may submit an appeal, requesting that the Claims Administrator review your claim. Your request for a review must be in writing unless your claim involves urgent care, in which case the request may be made orally, by telephone, fax, email, or other reasonable method.

Upon your written request and free of charge, you will be given reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits or appeal. If the advice of a medical or vocational expert was obtained in connection with the initial benefit decision, the names of each such expert shall be provided to you, regardless of whether the advice was relied upon in making the benefit determination. All necessary information in connection with an urgent care appeal shall be transmitted between the Plan and you by telephone, fax, or e-mail.

In connection with your appeal, you may submit written comments, documents, records, or other information relating to your claim. Upon request and free of

charge, the Claims Administrator will provide you with reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

Deadline for Submitting an Appeal

You must submit your appeal to the Claims Administrator within 180 days after you receive the notice from the Claims Administrator denying your initial claim for benefits.

If you do not submit your appeal by this deadline, then you lose your right to file an appeal and you may be precluded from filing a lawsuit contesting your claims denial.

Review of Appeals

Your appeal will be decided by someone who is different from, and who is not a subordinate of, the individual who made the initial decision on your claim. Also, if a decision is based in whole or in part on a medical judgment, then the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will not be the same as any health care professional who was consulted in connection with the initial claims denial, nor a subordinate of that professional. If your appeal is denied, you will be advised if any medical or vocational expert's advice was obtained on behalf of the Plan in connection with your appeal, regardless of whether the advice was relied on by the Plan.

Timing of Notification of Decision on Appeal

The Claims Administrator will provide a response to your claims within the time periods noted below. If you do not receive a response within the applicable time period, please contact the Claims Administrator.

The Claims Administrator must issue a review decision on your appeal according to the following timetable:

- *Urgent Care Claims* – not later than 72 hours after receiving your request for a review.
- *Pre-Service Claims* – not later than 30 days after receiving your request for a review.
- *Post-Service Claims* – not later than 60 days after receiving your request for a review.

Under special circumstances, an extension of time may be needed. For post-service claims, the Claims Administrator may notify you in writing before the end of the normal 60-day review period that it needs an additional 60 days (two 30 day periods if the Plan has two appeal levels) to review your claim because of special circumstances. For pre-service claims, the Claims Administrator may notify you in writing before the end of the normal 30-day review period that it needs an additional 30 days (two 15 day periods if the Plan has two appeal levels) to review your claim because of special circumstances. That notification will indicate the special circumstances requiring the extension (for example, the lack of required information) and when the Claims Administrator expects to be able to respond to your claim.

The Claims Administrator will consider your appeal, taking into account all comments, documents, records, and other information submitted, including

information not submitted or considered in the initial decision on your claim. The Claims Administrator will not defer to the initial decision to deny your claim. Except to the extent a decision is subject to external review as required by law, any decision made by the Claims Administrator on appeal will be final and conclusive.

Notice of Appeal Denial

If your appeal is denied in whole or in part, you or your beneficiary will receive a written or electronic response from the Claims Administrator. The Claims Administrator's response will include the following information:

- Information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason(s) for the denial, including the denial code and its corresponding meaning and a description of the standard, if any, that was used in denying the claim;
- Reference to the specific Plan provisions upon which the denial was based;
- A statement that upon request you are entitled to receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claims for benefits;
- A statement describing any other voluntary appeal procedures offered by the Plan and your right to obtain information about those procedures.
- A statement that you have a right to bring a civil action under ERISA following an adverse determination on your appeal;
- Contact information for any applicable office of health insurance consumer assistance; and
- Any other information required by law.

The Claims Administrator will also provide the following additional information if your claim was denied:

- If the Claims Administrator relied on an internal rule, guideline, protocol, or other similar criterion in denying your appeal, then the Claims Administrator either will provide you with a copy of that criterion or will notify you that it relied on such a criterion and inform you that you may request a copy of the criterion free of charge; and
- If the Claims Administrator based the appeal denial on a medical necessity, experimental treatment, or similar exclusion or limit, then the Claims Administrator either will provide you with an explanation of the scientific or clinical judgment underlying the appeal denial, as applied to your medical circumstances, or will notify you that such an explanation will be provided free of charge upon request.
- If, during the course of the Claims Administrator's review, additional evidence or facts that form an additional rationale for denial are identified, the Claims Administrator will provide you with the evidence or rationale, and provide you with a reasonable opportunity to respond.

To request a copy of the criterion or medical judgment summary, please contact the Claims Administrator. If the Claims Administrator's response does not include all of this information, please contact the Claims Administrator and request the missing information.

External Review

For Medical Coverage, including prescription drug coverage, you have an external review right if you appeal a determination based on: (a) medical judgment, as determined by the external reviewer, or (b) a rescission of coverage. If not addressed in the Booklets, refer to the information below for information on external review:

External review (the "External Review Program") offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after you have exhausted the appeals process described above, provided your claim meets one of the following requirements:

- Your appeal relates to a rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- You have received an unfavorable (or adverse) decision on appeal based on a medical judgment – e.g., based on clinical reasons (such as the requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or the exclusions for experimental or investigational services.

The External Review Program does not apply if the adverse benefit determination is based on an administrative determination, such as:

- your eligibility;
- explicit benefit exclusions (except where medical judgment is involved); or
- defined benefit limits.

Deemed Exhaustion of Internal Claims Procedures & De Minimis Exception to Deemed Exhaustion Rule

You will not be required to exhaust the internal claims and appeals processes described above if the Plan fails to adhere to the claims procedure requirements. In such an instance, you may proceed immediately to the External Review Program or make a claim in court. However, the internal claims and appeals process will not be deemed exhausted (meaning you must adhere to them before participating in the External Review Program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to you as long as the Claims Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you, and the violation is not reflective of a pattern or practice of non-compliance.

If you believe the Claims Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, you may request that the Plan provide a written explanation of the violation, including a description of the Plan's bases for asserting that the violation should not result in a "deemed

exhaustion" of the claims procedures. The Plan will respond to this request within 10 days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide you with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

Standard External Review

Under the External Review Program, after you have exhausted your internal appeals, you may request an independent review of an adverse benefit determination. An adverse benefit determination related to your failure to meet the Plan's eligibility requirements is not eligible for external review.

All requests for an external review must be made within 4 months of the date you receive the adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. You, your treating physician, or an authorized designated representative may request an external review by writing the Claims Administrator.

For external review relating to prescription drug coverage, the request should include the member's name and ID, member contact information, a copy of the adverse benefit determination letter along with any documentation to support the appeal, and should be mailed or faxed to the Claims Administrator.

The Claims Administrator will review your request for external review within five (5) business days of its receipt of the request to determine whether:

- you were covered under the Plan at the time the service was requested or provided;
- the adverse determination was based on medical judgment and does not relate to eligibility;
- you have exhausted the Plan's internal appeals process, unless you are not required to exhaust the internal appeals process due to the deemed exhaustion rule described above; and
- you have provided all paperwork necessary to complete the external review.

The Claims Administrator will notify you in writing within one (1) business day of the completion of its review, whether your adverse benefit determination is eligible for external review, and if any additional information is required. If the request is not eligible for external review, the notification will include the reasons why it is not eligible and contact information for the Employee Benefits Security Administration (866-444-EBSA). If the request was incomplete, the notification will state the information or materials needed to complete the request, and you must supply the information by the later of:

(a) the last day of the 4-month filing period described above; or

(b) 48 hours after receipt of the Claims Administrator's notification.

If your adverse benefit determination is eligible for external review, the Claims Administrator will forward your request to an Independent Review Organization (IRO) with which the Plan has contracted. The IRO will be chosen based on a rotating list of at least three approved IROs. The IRO acts as a fiduciary of the Plan with respect to the external reviews that are delegated to the IRO.

The IRO will provide you with a written notification that it has received and accepted your request for external review, and give you the opportunity to submit additional information within 10 business days. The Claims Administrator will provide the IRO any information and documentation it considered in making its adverse benefit determination. If you supply additional information to the IRO, the IRO will forward that information to the Claims Administrator, at which point the Claims Administrator may reconsider its adverse benefit determination.

The IRO will review your claim without giving deference to the Claims Administrator's prior decisions, and will take into account any additional information you have supplied. In addition, in making its determination, the IRO may consider all documents and information provided, including, but not limited to, your medical records, your physician's recommendations, the terms of the Plan, appropriate practice guidelines, and the opinion of the IRO's clinical reviewer(s).

The IRO will render its decision within 45 days of its receipt of the request for review and will provide written notification to both you and the Plan. This notification will include:

- a general description of the reason for the request for external review, including sufficient information to identify the claim;
- the date the IRO received the request for external review and the date of its decision;
- reference to the evidence or documentation considered in reaching its decision;
- the reason(s) for its decision, including any evidence-based standards that were relied on;
- a statement that the determination is binding except to the extent other remedies are available under state or federal law;
- a statement that judicial review may be available; and
- current contact information for any applicable office of health insurance consumer assistance or ombudsman.

If the decision of the IRO reverses the adverse benefit determination, the Plan will accept the decision and provide benefits for the service or procedure in accordance with the terms and conditions of the Plan. If the decision of the IRO confirms the Claims Administrator's adverse benefit determination, the Plan will not be obligated to provide benefits for the service or procedure.

After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for 6 years, and make them available for review by you and the Claims Administrator upon request, except if the disclosure would violate State or Federal privacy laws.

Expedited External Review

Your adverse benefit determination may be eligible for an expedited external review if:

- you have received an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal (as described above) would seriously jeopardize your life or health, or your ability to regain maximum function and you have filed a request for an expedited internal appeal, or
- you have received an adverse benefit determination involving a medical condition for which the timeframe or completion of a standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, or if the adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

If you make a request for an expedited external review, the Claims Administrator will immediately review your request and provide you with written notice of whether your adverse benefit determination is eligible for external review. If your adverse benefit determination is eligible for external review, the Claims Administrator will forward your request to an IRO (electronically, by telephone or fax, or by other similar manner) as described above under the Standard External Review Procedures, along with all documents and information it considered in making its adverse benefit determination.

The IRO will follow the review process described above, and render a decision within 72 hours after it receives the request for review. The IRO will provide a written confirmation of its decision to both you and the Plan within 48 hours thereafter.

Disability Claims

Claims for Disability Benefits

The claims procedures described in this section will apply to claims for a disability benefit made under the Plan to the extent that disability claims procedures are not provided in the Booklets or such claims procedures do not comply with ERISA or other applicable law.

Filing a Benefit Claim

To be eligible to file a disability benefit claim under the Plan, you or your authorized representative must first comply with the reporting, communication, and treatment requirements described in the applicable Booklet and comply with the administrative requests of the Claims Administrator.

Notification of Initial Decision

The Claims Administrator shall render a decision within 45 days after receipt of the claim unless special circumstances beyond the control of the Claims Administrator require an extension of time for processing the claim. If such an extension of time for processing is required, this 45-day period may be extended up to an additional 30 days (for a total of 75 days) if the Claims Administrator notifies you prior to the expiration of the original 45 day period of (i) the circumstances requiring the extension, and (ii) the date by which the Claims Administrator expects to render its decision.

In the event that the Claims Administrator determines (during the 30-day extension period) that due to matters beyond the control of the Claims Administrator, a

decision on the claim for disability benefits cannot be rendered within the 30-day extension period, the seventy-five (75) day period may be extended up to an additional 30 days (for a total of 105 days) if the Claims Administrator notifies you prior to the expiration of the first 30-day extension period of (i) the circumstances requiring the additional extension, and (ii) the date by which the Claims Administrator expects to render its decision.

The extension notice provided by the Claims Administrator for the first extension period or the second extension period must include (i) an explanation of the standards on which entitlement to disability benefits is based, (ii) any unresolved issues that prevent the Claims Administrator from rendering a decision on the claim for disability benefits, and (iii) the additional information required to resolve such issues (you must provide the additional information to the Claims Administrator required to resolve such issues within 45 days of the date of the extension notice).

In the event that period of time is extended for the Claims Administrator to render its decision on a claim for disability benefits due to your failure to submit information necessary to decide a claim for disability benefits, the period of time for the Claims Administrator to render a decision for such a claim shall be tolled from the date on which the extension notice is sent to you until the date on which you respond to the request for additional information.

If a claim for disability benefits is denied or if you believe that disability benefits under the Plan to which you are entitled have not been provided, you may appeal the denial as provided below.

Notice of Denial

A notice of a claim denial will be provided in a culturally and linguistically appropriate manner and will include the following:

- the specific reason(s) for the adverse determination;
- reference to the specific Plan provisions on which the determination is based;
- an explanation of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- either the internal rules, guidelines, protocols, standards, or other similar criteria that was relied upon for the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of:
    - healthcare professionals treating you and vocational professionals who evaluated you;
    - the advice of medical or vocational experts obtained on behalf of the Plan in connection with the decision; and/or
    - a disability determination presented by the claims to the Plan made by the Social Security Administration; and

- 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.

How to Appeal A Denied Claim

All disability claims will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions such as claims adjudicators and medical/vocational experts (i.e., not based on the likelihood that the individual will support the denial of benefits).

You will have an opportunity for a full and impartial appeal of a claim denied or adversely impacted by the Claims Administrator or its designated representative. The appeal will be made to the Claims Administrator or its designated representative and processed in accordance with the Plan's appeal procedures and rules, which include:

- you will have 180 days after receipt of the notification of the adverse benefit determination by the Claims Administrator to appeal the decision to the Claims Administrator in writing;
- you will have the opportunity to present written comments, documents, records, and other specific additional information relative to the claim;
- you will be provided upon request and free of charge, reasonable access to, and copies of, all information relevant to the claim, and will receive notice of the identity of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination; and
- the Claims Administrator or its designated representative will take into account all comments, documents, records and other specific information submitted by you relating to the claim, even if such items were not submitted or considered in the initial benefit determination by the Claims Administrator. You may present evidence and testimony to support your claim during the appeal process. You will be given a fair opportunity to respond to new or additional evidence or rationales before they become a basis for denials and filing an appeal.

The Claims Administrator shall conduct a full and fair review of the entire claim taking 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 initial benefit determination. Further, to the extent that the initial adverse determination was based upon a medical judgment, the Claims Administrator shall consult with an independent health care professional who has appropriate training and experience in the requisite field and who is neither the health care professional who was consulted in connection with the initial adverse benefit determination that is the subject of that appeal nor the subordinate of such individual.

The medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Before the Claims Administrator issues an adverse benefit determination on appeal, the Claims Administrator shall provide you, free of charge, with any new or

additional rationale or evidence considered, relied upon, or generated by the Plan or Insurer, in connection with the claim, with such information to be provided as soon as possible and sufficiently in advance of the date on which a determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

Timing of Notification of Decision on Appeal

The Claims Administrator will provide a written response to the appeal within 45 days after it is received. In the event that an extension of time is needed due to special circumstances by the Claims Administrator to render its decision for an appeal of a denied claim for disability benefits, this 45 day period may be extended up to an additional 45 days (for a total of 90 days) if the Claims Administrator notifies you prior to the expiration of the original 45 day period of (i) the special circumstances requiring the 45 day extension, and (ii) the date by which the Claims Administrator expects to render its decision. The Claims Administrator will send you written notification of the Plan's final position on the appealed negative determination.

Notice of Appeal Denial

The Claims Administrator will provide you with written notice of its adverse benefit determination on your appeal of the claim. The notice will be written in a culturally and linguistically appropriate manner and in a manner calculated to be understood by you and shall include:

- specific reasons for the adverse determination;
- specific reference to Plan provision on which the determination is based;
- 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 the claim;
- a description of any additional material or information needed and why such material or information is necessary;
- a description of the review procedures and time limits (including a statement of your right to bring a civil action under Section 502(a) of ERISA and a description of any limitation period that applies to bringing an action including the date the period expires;
- a discussion of the decision with an explanation for disagreeing with the following views (a) your health care professionals, or vocational professionals evaluating you, (b) the advice of medical or vocational experts obtained on behalf of the Plan (whether or not relied upon), and (c) any Social Security Administration disability determination;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other criteria do not exist; and
- a statement describing any other voluntary appeal procedures offered by the Plan and your right to obtain information about those procedures.

Claims other than Health and

The claims procedures described in this section will apply to any benefits to the extent that the claims procedures are not provided in the Booklets or such claims procedures do not comply with ERISA or other applicable law; provided, the claims

Disability Claims (*e.g.*, life insurance)

procedures described in this section will not apply to health and disability claims (described above).

Claims for Benefits

To be eligible to file a benefit claim for other than health benefits or disability benefits under a Plan, you or your authorized representative must first comply with the reporting, communication and treatment requirements described in the applicable Booklet and comply with the administrative requests of the Claims Administrator.

Notification of Initial Decision

The Claims Administrator shall render a decision within 90 days after the receipt of the claim, unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing a claim is required or additional information is required to process the claim, the Claims Administrator may extend this 90-day period for up to an additional 90 days (for a total of 180 days) if the Claims Administrator notifies you prior to the expiration of the original 90-day period of (i) the special circumstances requiring the additional processing time, and (ii) the date by which the Claims Administrator expect to render a decision will be reached.

Notice of Denial

The Claims Administrator or its designated representative will transmit a written notice of any denial or adverse determination of a benefit claim. This notice will include:

- the specific reason(s) for the adverse determination;
- references to the specific Plan provisions on which the determination is based;
- a description of any additional information required for you to complete the claim and an explanation of why the additional information is needed; and
- an explanation of the Plan's appeal procedures and the time frames for the procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA after any adverse determination on the appeal.

How to Appeal A Denial Claim

You will have an opportunity for a full and impartial appeal of a claim denied or adversely impacted by the Claims Administrator. The appeal will be made to the Claims Administrator and processed in accordance with the Plan's appeal procedures and rules, which include:

- you will have 60 days after receipt of the notification of the adverse benefit determination by the Claims Administrator or its designated representative to appeal the decision to the Claims Administrator;
- you will have the opportunity to present written comments, documents, records, and other specific additional information relative to the claim;
- you will be provided upon request and free of charge reasonable access to and copies of all information relevant to the claim; and
- the Claims Administrator will take into account all comments, documents, records and other specific information submitted by you relating to the

claim, even if such items were not submitted or considered in the initial benefit determination by the Claims Administrator

Timing of Notification Decision on Appeal

The Claims Administrator shall render a decision within 90 days after the receipt of the claim unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing a claim is required or additional information is required to process the claim, the Claims Administrator may extend this 90-day period for up to an additional 90 days (for a total of 180 days) if the Claims Administrator notifies you prior to the expiration of the original 90-day period of (i) the special circumstances requiring the additional processing time, and (ii) the date by which the Claims Administrator expect to render a decision will be reached. The Claims Administrator will provide a written response to the appeal within 60 days after it is received unless special circumstances beyond the control of the Claims Administrator require an extension of time for processing the claim. If such an extension of time for processing is required, the Claims Administrator may extend this 60-day period for up to an additional 60 days (for a total of 120 days) if the Claims Administrator notifies prior to the expiration of the original 60-day period of (i) the special circumstances requiring the additional processing time, and (ii) the date by which the Claims Administrator expect to render a decision will be reached. The Claims Administrator will send you written notification of the Plan's final position on the appealed negative determination.

Notice of Appeal Denial

The Claims Administrator will provide you with written notice of its adverse determination on your appeal of the claim. The notice will:

- set forth the specific reason for the adverse determination;
- detail the specific Plan provision on which the determination is based;
- notify you that upon request and free of charge, you will be provided reasonable access to, and copies of, all information relevant to the claim;
- describe any voluntary appeal procedures offered by the plan; and
- state your right to bring a civil action under Section 502(a) of ERISA.

VIII. PLAN ADMINISTRATION

Plan Administrator

The administration of the Plan is under the supervision of the Company acting as the Plan Administrator. The Plan Administrator is responsible for the day-to-day administration of the Plan. The Plan Administrator has delegated administrative authority and the authority to determine claims to the various Claims Administrators identified in the Benefit Plan chart of Section III of this SPD.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing,

expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

The Plan Administrator has the discretionary authority to interpret and construe the terms of the Plan in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Powers and Authority of Insurers

Certain benefits under the Plan are fully insured. The Insurers are responsible for (1) determining eligibility for and the amount of any benefits payable under their respective policies; and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective policies. The Insurers, not the Plan Sponsor, are responsible for paying claims with respect to these programs. The Plan Sponsor shares responsibility with the Insurers for administering these program benefits.

No Plan Assets

The benefits provided under the Plan will be paid solely by the applicable Insurers or, in the case of self-insured benefits, from the general assets of the Plan Sponsor, and nothing in this SPD (including any of its supplemental documentation) creates or should be construed to create a trust of any kind. Nothing herein will be construed to require the Plan Sponsor to maintain any fund or segregate any amount for the benefit of any participant or other person, and no participant or other person has any claim against, right to, or security or other interest in, any fund, account or asset of a Plan Sponsor from which any payment under the Plan or its component Benefit Plan may be made except as may otherwise be provided by applicable law.

Reliance on Opinions, etc.

The Plan Administrator (and any duly appointed Claims Administrators) shall be entitled to rely upon (a) any tables, valuation, computations, estimates, certificates, and reports furnished by a Claims Administrator or any consultant, or firm or corporation that employs one or more consultants, and (b) any opinions furnished by legal counsel. The Plan Administrator shall be fully protected and shall not be liable in any manner whatsoever for anything done or action taken or suffered in reliance upon any such information, opinions, or reports. Any and all things done or actions taken or suffered by the Plan Administrator shall be conclusive and binding on all employees and any other persons whomsoever, except as otherwise provided by law. The Plan Administrator and any Claims Administrators may, but are not required to, rely upon all records of the Plan Sponsor with respect to any matter or thing whatsoever, and may likewise treat those records as conclusive with respect to all employees and any other persons whomsoever, except as otherwise provided by law.

Limitation of Liability

Except as provided in Part 4 of Title I of ERISA, no person shall be subject to any liability with respect to his or her duties under the Plan unless he or she acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated, except as provided in Part 4 of Title I of ERISA. No action or responsibility shall be deemed to be a fiduciary action or responsibility except to the extent required by ERISA.

Plan Records The Plan Administrator (or Claims Administrator, as applicable) shall cause to be kept all books, accounts, records or other data as may be necessary or advisable in its judgment for the administration of the Plan and its component Benefit Plans and properly to reflect the affairs thereof.

Indemnification To the extent permitted by law, the Plan Sponsor shall indemnify each employee of the Plan Sponsor with duties under the Plan against expenses (including any amount paid in settlement of claims) reasonably incurred by him or her in connection with any claims against him or her by reason of his or her conduct or actions taken in good faith in the performance of his or her duties under the Plan, except in relation to matters resulting from willful misconduct, breach of good faith, or gross negligence in the performance of those duties. The preceding right of indemnification shall be in addition to any other right to which any such employee may be entitled as a matter of law or otherwise.

Costs of Plan Administration The Plan Sponsor will bear its incidental costs of administering the Plan.

IX. AMENDMENT OR TERMINATION OF THE PLAN

Although the Company expects to maintain the Plan indefinitely, it is not legally required to do so, and it reserves the right, as Plan Sponsor, to amend or terminate the Plan or any of its component benefits at any time and without liability. In addition, the BCU Health and Welfare Committee has been delegated the right to amend and/or terminate any provision of the Plan or the Benefit Plans at any time, in accordance with its charter, provided that if any amendment or modification will materially increase the cost with respect to the Plan, the Committee must first obtain authorization of the Company's Board of Directors. No provision of the Plan or any of its related documents shall create any vested rights in any employee, participant, or other person. The Plan may be amended or terminated only by a written instrument duly adopted by the Company or any of its delegates.

X. MISCELLANEOUS PROVISIONS

Controlling Documents Notwithstanding any provision herein to the contrary, benefits are provided under the Plan pursuant to various insurance policies and other plan documents. If the terms of this SPD conflict with the terms of any such insurance policies or plan documents, then the terms of such policies, contracts, or documents shall control, unless otherwise required by applicable law.

Limitations on Benefits No annual or lifetime limit on the dollar amount of "essential health benefits" will be imposed under the Plan. Non-essential health benefits may be subject to a lifetime limit on the dollar amount of such benefits. The Plan Administrator will determine whether or not a particular benefit is essential using good faith efforts to comply with a reasonable interpretation of the term "essential health benefits" as that term is used in the Affordable Care Act and regulations issued under that Act.

Limitation on Rescission of Coverage

The Plan cannot rescind your Medical Coverage unless you perform an act, practice, or omission that constitutes fraud, or unless you make an intentional misrepresentation of a material fact. The Plan reserves the right to rescind Medical Coverage if you commit such fraud or make such a misrepresentation. The Plan will provide you with at least 30 days' advance written notice if the Plan will rescind your Medical Coverage. "Rescission" is a cancellation or discontinuance of Medical Coverage that has retroactive effect. Note, the Plan may still cancel or discontinue Medical Coverage effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Nothing in this Section will prohibit the Plan or any component benefit from cancelling or discontinuing such coverage prospectively for any reason provided under the Plan or any applicable coverage Benefit Plan.

No Guarantee of Employment

Nothing in the benefit plans gives you the right to remain in employment or affects the Plan Sponsor's right to terminate your employment at any time, with or without cause, and that right is hereby reserved. The adoption and maintenance of the Plan does not constitute a contract between the Plan Sponsor and any employee, or consideration for, or inducement to or condition of, the employment of any employee.

Coordination with Medicare

As applicable, the Plan will be administered to comply with mandated federal standards effected through the Tax Equity and Fiscal Responsibility Act of 1982 and the Consolidated Omnibus Budget Reconciliation Act of 1985 with respect to proportioning benefits provided by this Plan and the benefits provided through Medicare.

When an individual covered under the Plan becomes eligible for Medicare, the Plan will pay benefits in accordance with the Medicare Secondary Payer requirements of federal law. In general, this means the Plan will be primary and Medicare will be secondary if:

- You or your spouse is eligible for Medicare because of having reached age 65 but you are still an active employee (Medicare becomes primary when you retire),
- You are entitled to Medicare because of disability but you still have "current employment status," as determined by Medicare rules (Medicare becomes primary when you cease to have "current employment status"), or
- You are entitled to Medicare because you have End Stage Renal Disease ("ESRD") but you are still in the first 30 months of the ESRD coordination of benefits period (Medicare becomes primary after 30 months).

Please refer to the applicable Booklet or other documentation for additional information about the coordination of particular Plan benefits with Medicare.

Refund of Overpayments

If you receive benefits under this Plan, you (or any other person or organization that was paid) may be required to make a refund to the Plan if:

- All or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment made under this Plan exceeded the benefits available under this Plan for the services at issue.
- The refund will equal the amount of benefits paid in excess of the amount that should have been paid under this Plan.
- If the refund is due from another person or organization, you agree to help the Plan Sponsor get the refund when requested.

If you (or any other person or organization that was paid) do not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable to you under this Plan. Future benefits under any other group benefits plan maintained by the Plan Sponsor are also subject to reduction. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

The Insurers providing benefits under the Plan may impose similar requirements relating to the payments they make. Please refer to the applicable Booklet or other documentation for further information.

Subrogation and Right of Reimbursement

The Plan reserves the right to seek reimbursement on its own behalf through subrogation and/or reimbursement upon the receipt of a recovery, settlement, judgment, award, or other payment by you, your spouse, or dependents (collectively, "covered persons") for covered expenses payable by the Plan which result from illness or injury caused by a third-party. The Plan will be reimbursed from the first monies recovered as the result of judgment, settlement, or otherwise regardless of whether the covered person has been fully compensated or "made whole" and regardless of the "Rimes Doctrine," "Common Fund Doctrine," "Attorneys' Fund Doctrine," or contributory or comparative negligence rules or statutes. This right includes the Plan's right to receive reimbursement from uninsured or underinsured motorist coverage and no-fault coverage.

Benefits will not be paid under the Plan unless and until you, your spouse, and dependents timely notify the Plan Administrator, in writing, of whatever benefits are paid under this Plan that may be subject to reimbursement or subrogation by the Plan, and that (a) you, your spouse and/or your dependents have made a claim for damages or insurance proceeds against such third party; (b) you, your spouse and/or your dependents cooperate with the Plan so as not to prejudice the Plan's reimbursement for benefits; and (c) you, your spouse and/or dependents execute and deliver any documents or agreements required by the applicable Claims Administrator. You also must keep the Plan Administrator informed in advance of any settlement proposals advanced or agreed to by the third party or the third party's insurer.

The Insurers providing benefits under the Plan may impose similar requirements relating to the payments they make. Those requirements are incorporated by reference into this document with respect to each of the applicable benefits. Please refer to the applicable Booklet or other documentation for further information.

To the extent a Benefit Plan also contains provisions regarding subrogation and reimbursement or right to recovery of expenses, the terms of this Plan and the applicable Benefit Plan shall both apply such that the Plan has the greatest possible rights with respect to subrogation, reimbursement, recovery of expenses or benefits.

Compliance with Federal and State Mandates

With respect to the Plan and its component benefits, the Plan Sponsor will comply, to the extent applicable, with the requirements of all applicable laws including but not limited to USERRA, the Affordable Care Act, COBRA, GINA, HIPAA, NMHPA, WHCRA, MHPA, and FMLA (and any state laws of similar effect).

Tax Consequences and Withholding

The Plan Sponsor does not guarantee the federal, state, or local tax treatment of any benefits provided under the Plan. Benefits provided under the Plan shall be subject to federal, state, or local income tax withholding or employment tax withholding in accordance with the rules applied to such benefits as interpreted by the Plan Sponsor under applicable federal, state, or local laws.

Facility of Payment

If the Plan Administrator determines that any person to whom any amount is payable under the Plan is unable to care for his or her affairs because of illness or accident, or is a minor, or has died, then any payment due him or her or his or her estate (unless a prior claim therefore has been made by a duly appointed legal representative) may, if the Plan Administrator so elects, be paid to his or her spouse, child, relative, an institution maintaining or having custody of such person, or any other person deemed by the Plan Administrator to be a proper recipient on behalf of such person otherwise entitled to payment. Any such payment will be a complete discharge of the liability of the Plan Administrator and the Plan.

If the Plan Administrator is unable to make payment to any participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such participant or other person shall be forfeited two (2) years after the date any such payment first became due.

Effect of Error

In the event of an error as to the eligibility or participation of a participant, or the allocations made to the account of any participant, or the amount of benefits paid to a participant or other person, the Plan Sponsor shall, to the extent it deems administratively possible and otherwise permissible under Section 125 of the Code or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as such participant is properly entitled to under the Plan. Such action by the Plan Sponsor may include withholding of any amounts due the Plan or the Plan Sponsor from compensation paid by the Plan Sponsor.

Headings

The titles and headings used in this SPD are included herein solely for the convenience of reference. If there is any conflict between such titles and headings and the text of the SPD, the text will control.

Successors and Assigns

Except as otherwise provided in the Plan or under applicable law, all benefits, rights, or interests of participants under the Plan are expressly non-assignable,

non-transferable, including to any health care provider, and shall not be subject to anticipation, alienation, sale, transfer, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities, or other obligations of such participants, and accordingly the right of any participant to receive any benefits under the Plan shall not be subject to any claims by any creditor of or claimant against the participant. Any attempt to assign, transfer, anticipate, alienate, sell, pledge, encumber, charge, garnish, execute, or levy upon, or otherwise dispose of any rights, benefits, or causes of action under the Plan shall be void and unenforceable. This prohibition applies to all rights and interests under the Plan, including rights to benefits, claims for fiduciary breach, claims for statutory penalties, and any other rights that may be asserted by a participant under or related to the Plan. Nothing in this provision prevents a Claims Administrator, in its sole discretion, from paying medical benefits directly to a health care provider that provides services to a participant, but a participant has no authority or right to obligate the Claims Administrator to make direct payment to a medical provider and any attempt to obligate a Claims Administrator to make direct payment to a health care provider is void and unenforceable. Further, the Plan does not create any right or legal relationship or third-party beneficiary status between the Plan Sponsor or any Claims Administrator and any health care providers.

XI. YOUR RIGHTS UNDER ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plans and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and copies of the latest annual reports (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage:

Continue coverage under the health plan components of the Plan for yourself, your spouse, or your eligible dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible dependents may have to pay for such coverage. Review the rules covering your COBRA continuation coverage rights in the applicable summary plan description.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on the people responsible for the operation of employee benefit plans. These people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time limits.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report and do not receive them within 30 days, you may file suit in a federal court within one year of your request for documentation. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive them, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's claims procedures. Any legal action must be brought within one year from the date you are notified of a final decision on your appeal or you lose any rights to bring such legal action unless the insurance contract provides for a different period of time for bringing suit. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court after exhausting the Plan's claims procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or 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.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, including COBRA, HIPAA and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 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: (866) 444-EBSA. You may visit their website at www.dol.gov/ebsa.