NEBRASKA BANKERS ASSOCIATION VEBA

GROUP INSURANCE PLANS

and

SUMMARY PLAN DESCRIPTION

Introduction

Nebraska Bankers Association Voluntary Employees Beneficiary Association (the "Sponsor") sponsors the Nebraska Bankers Association VEBA Group Insurance Plans (the "Plan"). This document (this "Summary") sets forth the terms of the amended and restated Plan as of January 1, 2022. The Plan provides benefits through each of the separate plans listed in the Appendix (the "Component Benefit Programs"). Applicable written plan documents, insurance contracts, and/or other governing documents contain the actual terms of each Component Benefit Program. The Plan incorporates these documents by reference. Together, this Summary and the written plan documents, insurance contracts, and other governing documents of each Component Benefit Program constitute the written plan document for the Plan, as required by the Employee Retirement Income Security Act of 1974 ("ERISA").

Separate summary plan descriptions, insurance booklets, and other similar documents summarize the terms of each Component Benefit Program. This Summary incorporates those applicable summary plan descriptions, insurance booklets, and/or other documents by reference. The Sponsor intends this document, together with those summaries, booklets, and similar documents, to constitute the Plan's Summary Plan Description.

If anything in this Summary is different than the actual terms of a Component Benefit Programs, the Component Benefit Programs control. The Sponsor may change the Plan and any Component Benefit Program from time to time.

You should keep this Summary with the summary plan descriptions, insurance booklets and other documents you received regarding the Component Benefit Programs. Please contact the Plan Administrator at 402-474-1555 if you have any questions.

1. General Information. The Sponsor is the Plan Sponsor. Its legal name, address, and federal employer identification number are:

Nebraska Bankers Association Voluntary Employees Beneficiary Association
233 S. 13th Street, Suite 700
P.O. Box 80008
Lincoln, NE 68508
EIN: 47-6092059

The Sponsor permits Participating Employers to elect to participate in the Plan, and permits the eligible employees of Participating Employers to receive benefits under the Plan. Section 6 contains more information about Participating Employers.

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

Nebraska Bankers Association VEBA Group Insurance Plans

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

3. Type of Plan. The Plan is a welfare benefits plan that provides benefits through several Component Benefit Programs. The Plan incorporates the Component Benefit Programs listed in the Appendix. As indicated in the Appendix, the Plan includes some Component Benefit Programs even though they are not subject to the requirements of ERISA. The Sponsor may include other plans as a Component Benefit Program from time to time. All of the Component Benefit Programs are treated as one Plan for Form 5500 and other ERISA compliance purposes.

4. Plan Administrator. The Sponsor is the Plan Administrator. The Sponsor may delegate its responsibilities as Plan Administrator to a committee or other person or persons in writing. The Sponsor's telephone number is 402-474-1555. The Plan Administrator provides information about your rights and benefits under the Plan. It has the primary authority to file various reports, forms, and returns with the U.S. Department of Labor and the Internal Revenue Service. The summary plan descriptions, insurance policies, or plan documents identify the plan administrator of each Component Benefit Program. The plan administrator of each Component Benefit Program also makes decisions regarding eligibility of individuals to participate and receive benefits from the program. If a Component Benefit Program does not identify a plan administrator, the Plan Administrator of this Plan shall be the plan administrator for the Component Benefit Program.

The Plan must designate an agent for service of legal process. The agent for service of legal process is –

Chair, Board of Trustees
Nebraska Bankers Association Voluntary Employees Beneficiary Association
233 S. 13th Street, Suite 700
Lincoln, NE 68508

Legal process may also be served on the Plan Administrator.

The Plan Administrator has full power to interpret and apply the terms of the Plan. The Plan Administrator's decisions are final and binding. The Plan Administrator also makes decisions regarding eligibility of individuals to participate and receive benefits from the Plan. The Plan Administrator may make and enforce rules to help it administer the plan. The Plan Administrator has all other powers necessary and appropriate to carry out its obligation to administer the Plan.

The Sponsor agrees to indemnify and defend, to the fullest extent permitted by law, any employee serving as the Plan Administrator or as a member of a committee designated as the Plan Administrator, with respect to liabilities, damages, costs and expenses including attorneys' fees, and settlements approved by the Sponsor, that occur because of a good faith act or omission in connection with the Plan.

5. Named Fiduciary. The law requires the Plan to identify a named fiduciary with authority to control and manage plan operation and administration. For Insured Benefits, the insurance company issuing the applicable policy constitutes the named fiduciary with the full power to interpret and apply the terms of the applicable Component Benefit Program as those terms relate to benefits under the applicable insurance contract, and to determine the eligibility of participants based on information provided by the Sponsor. For Component Benefit Programs that are Self-Insured Benefits, the plan administrator of the applicable Component Benefit Program constitutes the named fiduciary for purposes of determining the amount of, and entitlement to, benefits under the

Appendix. If the Component Benefit Program does not identify a plan administrator, the Plan Administrator of this Plan shall be the plan administrator for the Component Benefit Program. The respective plan administrator has full power and authority to make factual determinations, to interpret, and to apply the terms of the Plan.

6. Participating Employers. A "Participating Employer" means an organization whose Application and Participating Employer Agreement (the "Participating Employer Agreement") has been accepted by the Board of Trustees of the Sponsor or a committee of the Board which is authorized by and acting by the Sponsor (the "Board"). An employer that meets the requirements of the terms and conditions of the Participating Employer Agreement may submit a Participating Employer Agreement on behalf of itself and any Qualifying Affiliates (as defined in the Appendix), seeking participation and membership in the Sponsor, or renewal of the same.

Upon acceptance by the Board, the employer becomes or renews its status as a "Participating Employer" and the terms of the Participating Employer Agreement, together with the terms of the NBA VEBA Trust Agreement, become a binding contract between the Participating Employer and the Sponsor, subject to the coverage elections and terms and conditions that follow. The Sponsor may add Participating Employers from time to time.

A Participating Employer has all the duties and responsibilities of the Sponsor under the Plan, unless the Sponsor delegates duties differently in a written agreement. However, the Sponsor reserves to itself the responsibility to determine the terms of the Plan including eligibility and benefits; to appoint, remove, or replace the Plan Administrator; to exercise all administrative functions and powers related to the Plan, unless delegated to the Plan Administrator; to amend or terminate the Plan; and to establish and maintain the Plan.

7. Eligibility to Participate. You are eligible to participate in this Plan if you are eligible to receive benefits under one or more Component Benefit Programs. The terms and conditions of the Component Benefit Programs will tell you whether you participate in this Plan. The Appendix summarizes these terms. You become a participant in this Plan automatically when you become a participant in a Component Benefit Program. In general, a Participating Employer must treat you as an Active Employee or a Director (each, as defined in the Appendix) for you to be eligible. For more information about eligibility, please read the eligibility conditions that are part of each summary plan description, insurance booklet, or other governing document of the Component Benefit Programs. You may need to sign a salary contribution agreement before you can participate in some of the Component Benefit Programs.

8. Funding. Some Component Benefit Programs are funded through contracts or policies of insurance purchased from one or more insurance carriers. The Plan refers to these benefits as Insured Benefits. Other Component Benefit Programs are funded through the assets of the Nebraska Bankers Association Voluntary Employees' Beneficiary Association Trust (the "Trust"). The Plan refers to these benefits as Self-Insured Benefits. Nothing in this Plan provides a right to any fund, account, or asset of the Sponsor or Participating Employer from which a payment under the Plan may be made. Unless required to do so by law, the Sponsor generally will not segregate any amount for benefits under the Plan in a separate trust or fund. The Appendix has more information about the benefits provided by the Component Benefit Programs, and which Component Benefit Programs are Insured Benefits and Self-Insured Benefits. The Sponsor will pay the incidental costs of administering this Plan from the assets of the Trust to the extent permitted by ERISA.

The Plan Administrator will provide a schedule of the applicable premiums to participants during the initial and subsequent open enrollment periods and upon request for each of the Component Benefit Programs. The Appendix explains the Component Benefit Programs funded by Participating Employer contributions, employee contributions, or both. Each Participating Employer decides how much it will contribute to the Plan. It will contribute enough money to pay for the benefits or portion of the benefits that it has agreed to pay for. You must contribute the remaining cost of any benefits you elect. For the Insured Benefits, a Participant Employer will pay its contributions and your contributions to the Trust, which will remit those contributions to the insurer. For Self-Insured Benefits, your contributions and the contributions of Participating Employers will be contributed to the Trust in order to pay benefits.

9. Required Information about Component Benefit Programs which are Self-Funded Health Plans. The Nebraska Bankers Association VEBA Group Insurance PPO Plans ("Health Plans") are not insurance. They are not subject to state laws and requirements that apply to health insurance offered by a licensed insurer. Also, they are not covered by the Nebraska Life and Health Guaranty Association. In the event the Health Plans are unable to pay claims, Nebraska law authorizes the Board to assess Participating Employers and Qualifying Affiliates (as defined in the Appendix) for claims under the Health Plans, in addition to other remedies the Plans and Trust may have.

10. Summary of Plan Benefits. If you meet the eligibility conditions stated above, the Plan provides you an opportunity to participate in the Component Benefit Programs. Each program has its own applicable summary plan description, insurance booklet, and/or other governing document. These documents contain more information about the benefits provided by the Component Benefit Programs. You can obtain these documents free upon request by contacting the Plan Administrator. Each Participating Employer may decide which Component Benefit Programs it intends to offer to its participants, and may change its offerings at any time. The Sponsor may change the Component Benefit Programs that it offers under the Plan at any time.

11. Limits on Benefits, Circumstances that May Cause a Loss of Benefits. The Plan contains restrictions on the type, amount, and circumstances under which it will pay benefits. You should read the applicable summary plan description, insurance booklet, and/or other governing document of each Component Benefit Program for more information. You may lose coverage under the Plan if the Sponsor terminates the Plan. You may also lose coverage if the Sponsor amends the Plan to reduce or eliminate your coverage. You may lose coverage under the Plan if the Participating Employer terminates its Participating Employer Agreement or amends the Component Benefit Plans that it offers to its participants. Your coverage under this Plan generally terminates when you terminate employment with the Participating Employer. Coverage will also terminate if you are no longer eligible for benefits under all Component Benefit Programs. Eligibility for some benefits may terminate if you are not actively at work, or if you switch from full-time to part-time employment status.

12. Termination of Participation. Your participation in the Plan will end when you stop receiving benefits under all Component Benefit Programs. The same rule applies for participation of your spouse and dependents. Some Component Benefit Programs may also terminate coverage if you fail to pay your share of the applicable premiums. Your coverage may end if you fail to work the number of hours required for participation. Sections 12 and 13 describe circumstances in which you may be eligible to continue coverage under some of the Component Benefit Programs.

Please read the applicable summary plan description, insurance booklet, and/or other governing document for each Component Benefit Program for more information regarding events that terminate your participation. You may also contact the Plan Administrator.

13. Coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). Some Component Benefit Programs provide continuation coverage required by COBRA. The following COBRA procedures apply to the extent that COBRA applies to a Component Benefit Program and COBRA rights are not set forth in the summary plan description or plan documents for the Component Benefit Programs. If you have any questions, please refer to the appropriate, applicable summary plan descriptions, insurance booklets and/or other documents. You may also contact the Plan Administrator.

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

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

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

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

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

Qualifying Event, the Qualified Beneficiary may elect COBRA for himself or herself and the domestic partner.

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

COBRA Coverage – Time Limits. For the Component Benefit Programs subject to COBRA, continued coverage is limited to the following specific periods of time:

- You and your dependents may continue coverage for up to 18 months, if:
  - Your employment with the Participating Employer is terminated (including retirement and layoff); or
  - Your regularly scheduled work hours are reduced.

- A spouse and dependent children may continue coverage for up to 36 months, if they lose coverage:
  - Because of your death, divorce or legal separation or because you become entitled to Medicare; or
  - Because a dependent child no longer meets the Component Benefit Programs' eligibility requirements.

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

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

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

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

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

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

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

It is the enrolled participant's responsibility to notify the Participating Employer or the Plan Administrator of a loss of health coverage as a result of a divorce, legal separation, or child's loss of dependent status under a health plan. This notice **must be in writing and must be provided within 60 days of the date of the event** (or, if later, the date the dependent would lose coverage because of the event). If your qualifying event is a divorce or legal separation, your notice must include a copy of the divorce decree or legal separation agreement. The Participating Employer or the Plan Administrator must also be notified if:

- A dependent has a second Qualifying Event that would allow coverage to be extended to a total maximum of 36 months. This notice must be provided within 60 days of the second Qualifying Event (or the date it would have resulted in a loss of coverage if it had been the first Qualifying Event).
- An enrolled participant is determined by the Social Security Administration to have a disability that would allow the extension of coverage from 18 months to a total maximum of 29 months. This notice must include a copy of the Social Security Administration's determination letter and be provided within 60 days of that determination and no later than the end of the original 18-month of COBRA continuation coverage.
- The Social Security Administration has determined that an enrolled individual is no longer disabled, ending entitlement to continue coverage. This notice must be provided within 30 days of the Social Security Administration's determination.

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

Notices must be directed to:

Navia Benefit Solutions
600 Naches Ave SW
Renton, WA 98057

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

The cost of continued coverage is 102% of the total cost for the coverage, including the Participating Employer's and employee contributions. For disabled Qualified Beneficiaries and their family members who have elected COBRA who are continuing coverage beyond 18 months, the monthly cost will be increased to 150% of the cost for the remaining 11 months. The cost will be adjusted annually each. January 1 or first day of Plan Year for a non-calendar-year Plan to reflect any changes in the total cost.

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

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

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

16. Claims Procedure for Benefits. This Section applies if you have not received benefits under the Plan that you believe the Plan should pay. All claim and appeal opportunities available must be exhausted before any lawsuit may be filed with respect to a claim.

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

The insurer will decide your claim according to its reasonable claims procedures. These procedures may be subject to ERISA. The insurer may request independent medical advice and such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim, in whole or in part, you will receive written notification of the reason(s) for the denial. If your claim is denied, you may appeal to the insurer for further review. The insurer will decide your appeal in accordance with its reasonable claims procedures. These procedures may be subject to ERISA. If you do not appeal on time, you may lose your right to file suit in federal or state court. The court may find that you failed to exhaust your administrative appeal rights. You can find more information about the claims procedure for each Insured Benefit in its applicable insurance contract, booklet, and/or other document.

(b) **Claims for Self-Insured Benefits**. The applicable summary plan descriptions and/or plan documents explain how to make a claim for a Self-Insured Benefit. The following procedures apply to the extent the Component Benefit Program that is a Self-Insured Benefit does not have its own claims procedure. These claims procedures are established in accordance with ERISA. If there are any inconsistencies between the information set forth below and the claims procedures set forth in the appropriate provider's information or the summary plan description for the Component Benefit Program, the provider's claims procedure or the procedure in the summary plan description will control.

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

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

Urgent Care Claim. A health benefit claim is considered an urgent care claim if delaying the decision of the claim beyond the urgent time frames could seriously jeopardize life or health or the ability to regain maximum function, or in the opinion of the claimant's physician, would subject the claimant to severe pain that could not be adequately managed without the care that is the subject of the claim. Urgent care claim determinations will be made as soon as possible. Notice of the determination will be provided within 72 hours of the claim unless more information is required to process the claim. If more information is required, notification will be provided within 24 hours and the claimant will have 48 hours to make a submission. The claimant will be notified of the decision within 48 hours of that submission. If a claim is improperly filed, the notification of the proper filing procedure will be provided within 24 hours. This notice will be provided only if the claim identified the name of the claimant, the specific medical condition or symptom, and the treatment,

service, or product for which approval is sought and only if the claim was submitted to a person or unit customarily responsible for handling benefit matters relating to the option elected.

Concurrent Care. If the health benefit claimant has been approved for an ongoing course of treatment and the Component Benefit Program reduces the treatment before the end of the pre-approved period of time or number of treatments, the reduction will be considered an adverse benefit determination. Notification of the reduction or termination will be provided sufficiently in advance in order to allow the claimant to appeal the determination and obtain a review of the claim before treatment is disrupted. If the claimant requests to extend a course of treatment for an urgent care claim at least 24 hours before approval for treatment will lapse, the claimant will be notified whether the extension is granted or denied as soon as possible, but in any event, within 24 hours after receipt of the request.

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

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

Disability Claim. For a disability benefits claim, notification of an adverse benefit determination will be provided within a reasonable period of time, but no later than 45 days after the Component Benefit Program receives the claim. This period may be extended for an additional 30 days (up to two times), provided that the Plan Administrator determines that the extension is necessary due to matters beyond the control of the Component Benefit Program, and the Plan Administrator provides timely notification of the circumstances requiring the extension and the date by which a decision can be expected. The notice will also explain the standards for being entitled to a benefit and issues that need to be resolved before a decision can be made. If an extension is necessary because of a failure to submit information necessary to decide the claim, the notice of extension will specifically describe the required information. The claimant will have 45 days to provide that information.

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

- The specific reason or reasons for the denial;
- If the claim is for a disability benefit, the notice will explain the basis for disagreeing with the views presented by the claimant of health care professionals who treated the claimant and of vocational professionals who evaluated the claimant, the views of medical or vocational experts whose advice was obtained by the Plan, or a disability determination presented by the claimant made by the Social Security Administration;
- A reference to the specific Component Benefit Program provisions on which the denial is based;
- A description of any additional material or information necessary for the benefit to be paid and an explanation of why such material or information is necessary;
- An explanation of the Component Benefit Program's review procedures and time limits (including expedited review procedures in the case of an urgent care claim and voluntary appeal procedures in the case of a disability claim) and a statement of the right to bring a civil action following the claim denial on review;
- In the case of a claim denial by a Component Benefit Program providing disability benefits, a description of any applicable contractual limitation period that applies to the claimant's right to bring a civil action following denial upon review, and the calendar date on which the limitations period expires for the claim;
- In the case of a claim denial by a Component Benefit Program providing health or disability benefits:
  - For a health benefit, if the decision relied on a claim's administrator's internal rules, a copy of the applicable rule or a statement that the rule will be provided free of charge upon request;
  - For a disability benefit, the specific internal rules, guidelines, protocols, standards, or other similar criteria relied upon in making the determination, or a statement that the foregoing do not exist;
  - If the decision is based on a limit or exclusion for medical necessity or experimental treatment or a similar exclusion or limit, an explanation of the clinical or scientific judgment for the determination. For health benefits, the notice may include statement that such explanation will be provided free of charge upon request; and
  - If the claim pertains to disability benefits, a discussion that explains the reasons for disagreeing with the views of health care professionals and vocational professionals who treated or evaluated the claimant, and the views of medical or vocational experts whose

advice the claims administrator obtained in connection with the decision. The notice will include this information whether or not the claims administrator relied on those views. It will also explain the reasons for disagreeing with any determination made by the Social Security Administration.

- In the case of a claim denial by a plan involving urgent care, the information described above may be provided orally within the prescribed time frames, with written confirmation within three days.
- In the case of a disability claim denial, a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim.

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

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

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

The various providers maintain their own procedures for appeals of adverse benefit determinations. Claimants should contact the provider for information about the applicable

provider's appeal procedures. If there are any inconsistencies between the information set forth above and the claims procedure in the appropriate provider's information, the provider's procedure will control.

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

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

Procedure	Health Benefits			Disability Benefits	Other Benefits
	Urgent	Pre-Service Non-Urgent	Post-Service		
Notice of Improper Filing	24 hours	5 days	N/A	N/A	N/A
Notice of Incompleteness	24 hours	N/A	N/A	N/A	N/A
Notice of Initial Determination or Need for Extension (Measured from Filing)	72 hours (no extensions)	15 days	30 days	45 days	90 days
Claimant's Provision of Additional Information (where required)[1]	48 hours	45 days	45 days	45 days	Not Specified
Notice of Initial Determination after Commencement of Extension or Receipt of Additional Information, as applicable	48 hours	15 days[2]	15 days	30 days (may be repeated once)	90 days
Request by Claimant for Review after Claim Denial	180 days	180 days	180 days	180 days	60 days
Notice of Determination of Appeal (or Need for Extension, if applicable)	72 hours	30 days	60 days	45 days	60 days

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

Within five business days after receipt of a request for external review, the Plan Administrator or its designee will determine whether the claim is eligible for review under the external review procedure. This determination is based on whether:

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

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

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

- The denial relates to the claimant's failure to meet the Component Benefit Program's eligibility requirements;
- The claimant has exhausted the Component Benefit Program's internal claims and appeal procedures; and
- The claimant has provided all the information required to process an external review.

Within one business day after completion of this preliminary review, the Plan Administrator or its designee will provide written notification to the claimant of whether the claim is eligible for external review.

If the request for review is complete but the claim is not eligible for external review, the Plan Administrator or its designee will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the United States Department of Labor Employee Benefits Security Administration at its toll free number 866.444.3272. If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the four month filing period, whichever is later, to submit the additional information.

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

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

- The claimant's medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Component Benefit Program or issuer, claimant, or the claimant's treating provider;
- The terms of the Component Benefit Program;
- Appropriate practice guidelines, which must include applied evidence-based standards;
- Any applicable clinical review criteria developed and used by the Component Benefit Program; and
- The opinion of the IRO's clinical reviewer.

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

- A general description of the reason for the external review, including information sufficient to identify the claim;
- The date the IRO received the assignment to conduct the review, the date the external review was conducted, and the date of the IRO's decision;
- References to the evidence or documentation, including the evidence-based standards, the IRO considered in reaching its decision;
- A discussion of the principal reason(s) for the IRO's decision, including what applicable, if any, evidence-based standards were a basis for its decision;
- The rationale for the IRO's decision;
- A statement that the determination is binding and that judicial review may be available to the claimant; and
- Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act.

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

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

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

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

Legal Action. If a lawsuit with respect to a claim denial is filed, it must be filed no later than three years after the date of the final Component Benefit Program decision (including all appeals) regarding the claim.

17. Amendment and Termination. The Sponsor hopes to continue the Plan indefinitely but, as with all of the Component Benefit Programs, the Sponsor may change or discontinue the Plan at any time. The Sponsor may amend or terminate the Plan by a written instrument adopted by the Sponsor or by a person authorized by the Sponsor. The Sponsor may make changes to all or any class of Participating Employers or participants, at any time and for any reason, without notice. The Board authorizes the Chair to execute, without further authorization from the Board, amendments to the Plan which counsel to the Sponsor recommends be adopted to comply with applicable law and/or to facilitate Plan administration, and which do not materially increase the cost to the Sponsor of sponsoring and administering the Plan.

If the Sponsor amends, alters, discontinues, or terminates the Plan, the Plan will only be liable for previously incurred claims that are filed within the time period set forth in the applicable Component Benefit Program. If the Sponsor discontinues or terminates the Plan, benefits under the Component Benefit Programs will be governed by the applicable plan document, insurance contract, or other governing document. Unless otherwise specified in the Component Benefit Program or the Trust, any remaining assets of a Component Benefit Program will be distributed to the Participating Employer and participants pro rata according to their respective contributions to the Component Benefit Program.

18. HIPAA Privacy and Security. This Section applies to Component Benefit Programs that are group health plans and that are Self-Insured Benefits, or that are Insured Benefits that provide the Plan or Component Benefit Program with access to Protected Health Information (as defined below) (collectively, the "HIPAA Component Benefit Programs"). The terms of this Section apply to the extent a HIPAA Component Benefit Program does not contain its own HIPAA Privacy and Security provisions.

Purpose: The Sponsor adopts this Section to allow the HIPAA Component Benefit Programs offered under the Plan to disclose Protected Health Information to the Sponsor or the Participating Employer in certain situations, as permitted by HIPAA. References in this Section to disclosures from the Component Benefit Programs made to the Sponsor include disclosures to employees of the Participating Employer, as described below.

Definitions. The following definitions apply for purposes of this Section:

- "Health Information" means any information, including genetic information, whether oral or recorded in any form or medium, that: is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearing house; and relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual.
- "Health Plan" means an individual or group plan that provides or pays the cost of medical care (as defined in Section 2791(a)(2) of the Public Health Service Act, 42 U.S.C. § 300gg-91(a)(2)).

- "HIPAA" means the Health Information Portability and Accountability Act of 1996, as amended, HITECH, and including final regulations promulgated pursuant thereto.
- "HIPAA Component Benefit Program" means any Component Benefit Program that is a group health benefit program to which HIPAA applies. Generally, this means the Component Benefit Programs that provide medical care coverage and are maintained by the Sponsor.
- "HITECH" means the Health Information Technology for Economic and Clinical Health Act enacted as part of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5 (Feb. 17, 2009).
- "Individually Identifiable Health Information" means a subset of Health Information including demographic information collected from an individual, and which: is created or received by a health care provider, Health Plan, employer, or health care clearing house; and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- "Plan Administration Functions" means administration functions performed by the Sponsor on behalf of the HIPAA Component Benefit Program, excluding functions performed by the Sponsor in connection with any other benefit or benefit plan of the Sponsor.
- "Privacy Notice" means the notice of the HIPAA Component Benefit Program's privacy practices distributed to HIPAA Component Benefit Program participants in accordance with 45 C.F.R. § 164.520, as amended from time to time.
- "Protected Health Information" or "PHI" means Individually Identifiable Health Information that is: transmitted by electronic media; maintained in any media described in the definition of electronic media at 42 C.F.R. § 162.103; or transmitted or maintained in any other form or medium. Protected Health Information excludes Individually Identifiable Health Information in education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. § 1232g; records described at 20 U.S.C. § 1232g(a)(4)(B)(iv); employment records held by a covered entity in its role as employer; and records regarding a person who has been deceased for more than 50 years.
- "Secretary" means the Secretary of the U.S. Department of Health and Human Services or his or her designee.
- "Summary Health Information" means information that: summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Health Plan; and from which the information described at 42 C.F.R. § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 C.F.R. § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.
- "Unsecured PHI" means Protected Health Information that has not been secured through the use of technology or by a methodology specified by the Secretary in guidance issued pursuant to 42 U.S.C. § 17932(h)(2). In the absence of guidance from the Secretary, "Unsecured PHI" means Protected Health Information that is not secured by a technology standard that renders PHI unusable, unreadable, or indecipherable to unauthorized persons and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

Terms used, but not otherwise defined in this Section shall have the same meaning as those terms in HIPAA and regulations promulgated thereunder.

Conditions of Disclosure. The Sponsor agrees that with respect to any PHI disclosed to it by the HIPAA Component Benefit Program, a health insurance issuer or an HMO, the Sponsor shall:

- Not use or further disclose the PHI other than as permitted or required by the HIPAA Component Benefit Program documents or as required by law.
- Ensure that any agents, including a subcontractor, to whom it provides PHI received from the HIPAA Component Benefit Program, agree to the same restrictions and conditions that apply to the Sponsor with respect to such PHI.
- Not use or disclose the PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Sponsor.
- Report to the HIPAA Component Benefit Program any access, use or disclosure of PHI that is inconsistent with this Section or the Privacy Rule or Security Rule, including, without limitation, any access, use, or disclosure of Unsecured PHI which could reasonably require the HIPAA Component Benefit Program to undertake an analysis to determine whether a "breach" has occurred (as that term is defined in the regulations and the Secretary's guidance promulgated with respect to HITECH and HIPAA generally), immediately upon becoming aware of an inconsistent use or disclosure. The Sponsor agrees to provide all information reasonably requested by the HIPAA Component Benefit Program in order for the HIPAA Component Benefit Program to fully comply with its obligations under 45 C.F.R. Part 164 including breach notification and security incident obligations. The Sponsor agrees, to the extent practicable, to mitigate the harmful effects of a breach or security incident known to the Sponsor and to document any breach or security incident and the outcome of the same. The Sponsor agrees to reimburse the HIPAA Component Benefit Program for all costs incurred by the HIPAA Component Benefit Program in complying with the breach notification procedures in 45 C.F.R. § 164 Subpart D, provided such costs arise out of a breach for which the Sponsor is required to give the HIPAA Component Benefit Program notice under this Section.
- Provide individuals with access to PHI in accordance with 45 C.F.R. § 164.524 and 42 U.S.C. § 17935(e). The Sponsor agrees to provide access to PHI in a Designated Record Set, as that term is defined in 45 C.F.R. § 164.501, to the HIPAA Component Benefit Program or, as directed by the HIPAA Component Benefit Program, to an individual at the written request of the HIPAA Component Benefit Program within 10 calendar days to allow the HIPAA Component Benefit Program to meet the requirements of 45 C.F.R. § 164.524. If an individual requests access to PHI in a Designated Record Set in an electronic format, the Sponsor agrees to permit such access and to direct a secure transmission of such PHI to the entity or person designated by the individual, provided that the direction from the individual is clear, conspicuous and specific.
- Make available PHI for amendment and incorporate any amendments to PHI in a Designated Record Set in accordance with 45 C.F.R. § 164.526. The Sponsor agrees to make said amendments within 10 calendar days of a written request by the HIPAA Component Benefit Program.
- Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528 and 42 U.S.C. § 17935(c). The Sponsor acknowledges that for purposes of 45 C.F.R. § 164.528, effective as of the applicable date set forth in 42

U.S.C. § 17935(c)(4), to the extent the Sponsor makes a disclosure of an electronic health record containing PHI from a Designated Record Set, the Sponsor will maintain such information as required by the Secretary in regulations promulgated pursuant to 42 U.S.C. § 17935(c)(2) notwithstanding the status of such disclosures as "treatment," "payment," or "health care operations" disclosures.

- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the HIPAA Component Benefit Program available to the Secretary of Health and Human Services for purposes of determining compliance by the HIPAA Component Benefit Program with HIPAA.
- If feasible, return or destroy all PHI received from the HIPAA Component Benefit Program that the Sponsor maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- Ensure that the adequate separation between HIPAA Component Benefit Program and Sponsor, required in 45 C.F.R. § 164.504(f)(2)(iii) and described in this Section, is established.
- Implement administrative, physical, and technical safeguards to the extent required by sections 164.308, 164.310, and 164.316 of title 45, Code of Federal Regulations and HITECH that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI or PHI the Sponsor creates, receives, maintains or transmits on behalf of the HIPAA Component Benefit Program (other than enrollment/disenrollment information) and it will ensure that any agents or subcontractors to whom it provides such electronic PHI agrees to implement reasonable and appropriate safeguards to protect the information.
- Comply with the other provisions of HIPAA, HITECH and any implementing regulations promulgated thereunder to the extent the same apply to the Sponsor.
- Limit its uses and disclosures of PHI to the "minimum necessary" amount of information to accomplish the intended purpose of the use, disclosure, or request for information. The Sponsor acknowledges that for purposes of this Section, it will be deemed to meet the "minimum necessary" requirement if it discloses only such information within the definition of a "limited data set" as described in 45 C.F.R. § 164.514(e)(2), or if it discloses only such information consistent with guidance required to be provided by the Secretary under 42 U.S.C. § 17935(b)(1)(B).
- To the extent the HIPAA Component Benefit Program is required to restrict the use or disclosure of PHI pursuant to 42 U.S.C. § 17935(a), or otherwise agrees to a restriction on the disclosure of PHI, the Sponsor agrees to abide by such requested restriction to the extent the Sponsor is made aware of the same via written notice from the HIPAA Component Benefit Program and to immediately implement the restriction as requested.

Adequate Separation Between HIPAA Component Benefit Program and Sponsor. In compliance with HIPAA, the Sponsor will designate persons entitled to access PHI. The Sponsor shall only allow those persons so identified to be given access to PHI. Those employees who have access to PHI from the HIPAA Component Benefit Program are listed in the Privacy Notice, either by name or individual position. The employees who have access to PHI listed in the Privacy Notice may only use and disclose PHI to the extent necessary to perform the Plan Administration Functions that the Sponsor performs for the HIPAA Component Benefit Program, including but not limited to: quality

assurance, claims processing, auditing, and monitoring. In the event that any of these specified persons do not comply with the provisions of this Article, that person, if an employee of the Sponsor, shall be subject to disciplinary action by the Sponsor for noncompliance pursuant to the Sponsor's employee discipline and termination procedures. If that person is a non-employee, the Sponsor shall take appropriate action with the entity involved, to ensure that appropriate discipline or sanctions are imposed and that non-compliance does not recur.

Permitted and Non-permitted Uses and Disclosure of PHI. Unless otherwise permitted by law, and subject to obtaining a written certification pursuant to subsection titled "Certification of Plan Sponsor", the HIPAA Component Benefit Program may disclose PHI to the Sponsor, provided the Sponsor uses or discloses such PHI only for the purpose of carrying out Plan Administration Functions that the Sponsor performs for the HIPAA Component Benefit Program, consistent with the provisions of subsection titled "Conditions of Disclosure." Notwithstanding the provisions of this Section to the contrary, in no event shall the Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 C.F.R. § 164.504(f). The HIPAA Component Benefit Program may not permit a health insurance issuer or HMO with respect to the HIPAA Component Benefit Program to disclose PHI to the Sponsor except as permitted by 45 C.F.R. § 164.504(f). The HIPAA Component Benefit Program may not disclose PHI to the Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Sponsor. The HIPAA Component Benefit Program shall not use or disclose PHI that is genetic information for underwriting purposes.

Information Regarding Participation. Notwithstanding the previous paragraph, the HIPAA Component Benefit Program, or a health insurance issuer or HMO with respect to the HIPAA Component Benefit Program, may disclose to the Sponsor information on whether an individual is participating in the HIPAA Component Benefit Program, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the HIPAA Component Benefit Program.

Privacy and Security Official. The HIPAA Component Benefit Program shall designate a Privacy and Security Official, who will be responsible for the HIPAA Component Benefit Program's compliance with HIPAA's Privacy and Security Rules. The Privacy Official and the Security Official may be the same individual. The Privacy and Security Official is responsible for ensuring the HIPAA Component Benefit Program's compliance with HIPAA's Privacy and Security Rules. The Privacy and Security Official may contract with, or otherwise utilize, the services of attorneys, accountants, brokers, consultants, or other third party experts as the Privacy and Security Official deems necessary or advisable.

19. Other Required Notices.

HIPAA Special Enrollment. If you are declining group health plan enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in one or more of the Component Benefit Programs if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If the other health coverage is provided under Medicaid or a state children's health insurance program, you must request enrollment within 60 days after your or your dependents' other coverage ends. In addition, if you have a new

dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under one or more Component Benefit Programs, you may be enroll yourself and your dependents in the Component Benefit Programs to which the subsidies apply. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for that premium assistance. If a Component Benefit Program or federal guidance expressly provides a longer period to request special enrollment, the longer period controls. To request special enrollment or obtain more information, contact the Plan Administrator.

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

Women's Health and Cancer Rights Act. For an individual who is receiving benefits under a Component Benefit Program that is a group health plan in connection with a mastectomy and who elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast; surgery/reconstruction of other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications, including lymphedemas. Please consult the summary plan description for the applicable Component Benefit Program for a description of cost-sharing for these benefits.

20. General Information.

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

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

Subrogation, Reimbursement. Your benefits under this Plan and the Component Benefit Programs may be subject to subrogation. This means that you may be required to reimburse the Plan for benefits you receive as a result of an injury or illness for which a third party is, or may be, held responsible. This prevents duplicate benefits. You may also be required to repay the Plan for any

overpaid or erroneously paid benefits. Please refer to the applicable summary plan description, insurance booklet, and/or other governing document for each Component Benefit Program for more information about subrogation and reimbursement.

Documents of Component Benefit Programs Control. The applicable summary plan descriptions, insurance booklets, and/or other governing documents of the Component Benefit Programs contain the terms of your right to receive benefits. If there is a conflict among the plans, the terms of the Component Benefit Programs will control the interpretation, unless otherwise required by law.

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

Governing Law. This Plan shall be construed according to applicable Federal law and, to the extent otherwise applicable, the laws of the State of Nebraska.

No Guarantee of Tax Consequences. The Sponsor and Participating Employer do not represent or guarantee that any particular federal or state income, payroll, personal property or other tax consequence will result from participation in this Plan or any one or more of the Component Benefit Programs. You should consult with your own tax advisors if you have questions.

Payments to Minors, Etc. If an individual entitled to receive benefits under the Plan is a minor or if a court has determined that the individual is not legally capable of giving valid receipt and discharge of benefits, or if the Plan Administrator deems the individual not to have such legal capabilities, the Plan Administrator will designate a person to receive payments on behalf of the individual. The Plan treats these payments as payments to the individual, and the payments fully discharge the Plan's liability.

Severability. If a court with jurisdiction holds any portion of this Plan invalid or unenforceable, the remaining provisions continue to be fully effective.

21. Statement of ERISA Rights. 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 PLAN BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all plan documents, including insurance contracts, and a copy of the latest annual report (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 (EBSA).
- Obtain, written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. 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 health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the applicable summary plan description and other documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. 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 welfare benefit of exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

In your claim for a welfare benefit is denied or ignored, in whole or in part, you have 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 schedules.

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 from the plan and do not receive them within 30 days, you may file suit in a federal court. 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 the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in

a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. 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 you may file suit in 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 your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you 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 of the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities by calling the publications hotline of the Employee Benefits Security Administration.

22. Conclusion. This Summary is intended to briefly highlight the provisions of the Component Benefit Programs. The Sponsor intends this Summary to be accurate. However, the terms of a Component Benefit Program will control any conflict with this Summary. You should consult with the Plan Administrator concerning the actual Component Benefit Program provisions if you have questions.

APPENDIX
COMPONENT BENEFIT PROGRAM INFORMATION

This Appendix summarizes key features of the Component Benefit Programs. The Sponsor may add or remove Component Benefit Programs from time to time. If anything in this Appendix differs from the actual terms of the Component Benefit Program, the Component Benefit Program controls.

In addition to the definitions set forth in the Plan above, the following definitions apply:

"Active Employee" means an individual employed by a Participating Employer or Qualifying Affiliate and who is scheduled to work at least 17.5 hours per week on a regular calendar year basis.

"Board" means the Board of Trustees of the Sponsor or a committee of the Board which is authorized by and acting by the Sponsor.

"Director" means an individual who is voting member of the board of directors of a Participating Employer or Qualifying Affiliate.

"Entry Date" means the date elected by the Participating Employer in the Participating Employer Agreement, upon which a new Active Employee or Director becomes covered under the Plans, provided that the Active Employee or Director enrolls within 31 days of the Entry Date.

"Financial Institution" means a bank, savings bank, or savings and loan association chartered by the State of Nebraska, or chartered by the federal government and authorized to do business in the State of Nebraska, or a trust company.

"Participating Employer" means an employer whose Participating Employer Agreement has been accepted by the Board.

"Participating Employer Agreement" means the Application and Participating Employer Agreement submitted by the Participating Employer to the Sponsor.

"Qualifying Affiliate" means:

(a) If the Participating Employer is a Financial Institution, an organization: (i) that is the holding company of the same Financial Institution; or (ii) that is a subsidiary of a holding company that owns the Participating Employer.

(b) If the Participating Employer is a holding company of a Financial Institution, an organization: (i) that is a Financial Institution owned by the Participating Employer; or (ii) that is a subsidiary of the Participating Employer.

(c) If a Participating Employer is a subsidiary of a Financial Institution holding company, an organization: (i) that is the Financial Institution holding company that owns the Participating Employer; (ii) that is a Financial Institution owned by the same Financial Institution holding company that owns the Participating Employer; or (iii) a subsidiary of the same Financial Institution holding company.

Component Benefit Program: Nebraska Bankers Association VEBA Group Insurance PPO Plans	
Type of Plan:	Welfare benefit plan providing hospital, medical, and surgical benefits.
Insured Status:	Self-Insured Benefit.
Contributions:	Participating Employer and employee contributions.
Type of Administration:	Third-party claims administrator.
Eligibility:	Active Employees and Directors of a Participating Employer or any Qualifying Affiliate identified in the Participating Employer Agreement.
Entry Date:	The Entry Date elected by the Participating Employer in the Participating Employer Agreement.

Component Benefit Program: Nebraska Bankers Association VEBA Dental Plan	
Type of Plan:	Welfare benefit plan providing dental care benefits.
Insured Status:	Fully Insured Benefit.
Contributions:	Participating Employer and employee contributions.
Type of Administration:	The insurer administers claims.
Eligibility:	Active Employees and Directors of a Participating Employer or any Qualifying Affiliate identified in the Participating Employer Agreement.
Entry Date:	The Entry Date elected by the Participating Employer in the Participating Employer Agreement.

Component Benefit Program: Nebraska Bankers Association VEBA Vision Plan	
Type of Plan:	Welfare benefit plan providing vision care benefits.
Insured Status:	Fully Insured Benefit.
Contributions:	Participating Employer and employee contributions.
Type of Administration:	The insurer administers claims.
Eligibility:	Active Employees and Directors of a Participating Employer or any Qualifying Affiliate identified in the Participating Employer Agreement.
Entry Date:	The Entry Date elected by the Participating Employer in the Participating Employer Agreement.

Component Benefit Program: Nebraska Bankers Association VEBA Life Insurance Plan	
Type of Plan:	Welfare benefit plan providing life insurance benefits.
Insured Status:	Fully Insured Benefit.
Contributions:	Participating Employer and employee contributions.
Type of Administration:	The insurer administers claims.
Eligibility:	Active Employees and Directors of a Participating Employer or any Qualifying Affiliate identified in the Participating Employer Agreement.
Entry Date:	The Entry Date elected by the Participating Employer in the Participating Employer Agreement.

Component Benefit Program: Nebraska Bankers Association VEBA Long-Term Disability Plan	
Type of Plan:	Welfare benefit plan providing long-term disability insurance benefits.
Insured Status:	Fully Insured Benefit.
Contributions:	Participating Employer and employee contributions.
Type of Administration:	The insurer administers claims.
Eligibility:	Active Employees and Directors of a Participating Employer or any Qualifying Affiliate identified in the Participating Employer Agreement.
Entry Date:	The Entry Date elected by the Participating Employer in the Participating Employer Agreement.

Component Benefit Program: Nebraska Bankers Association VEBA Short-Term Disability	
Type of Plan:	Welfare benefit plan providing short-term disability insurance benefits.
Insured Status:	Fully Insured Benefit.
Contributions:	Participating Employer and employee contributions.
Type of Administration:	The insurer administers claims.
Eligibility:	Active Employees and Directors of a Participating Employer or any Qualifying Affiliate identified in the Participating Employer Agreement.
Entry Date:	The Entry Date elected by the Participating Employer in the Participating Employer Agreement.

Component Benefit Program: Nebraska Bankers Association VEBA Employee Assistance Plan	
Type of Plan:	Welfare benefit plan providing employee assistance benefits.
Insured Status:	Fully Insured Benefit.
Contributions:	Participating Employer and employee contributions.
Type of Administration:	The insurer administers claims.
Eligibility:	Active Employees and Directors of a Participating Employer or any Qualifying Affiliate identified in the Participating Employer Agreement.
Entry Date:	The Entry Date elected by the Participating Employer in the Participating Employer Agreement.