**WELFARE BENEFIT PLAN SUMMARY OF MATERIAL MODIFICATIONS TO UPDATE CLAIMS PROCEDURES EFFECTIVE APRIL 1, 2018**

## I
## INTRODUCTION

This is a Summary of Material Modifications regarding the Welfare Benefit Plan. ("Plan"). This is merely a summary of the most important changes to the Plan and information contained in the Summary Plan Description ("SPD") previously provided to you. It supplements and amends that SPD so you should retain a copy of this document with your copy of the SPD. If you have any questions, you may contact the Plan Administrator.

## II
## SUMMARY OF CHANGES

**Claims Procedures:**

In General

Unless the applicable Included Benefit specifies claims procedures, the following procedures will apply. In all cases, the Plan Administrator or Claims Administrator will administer claims in accordance with Section 503 of ERISA and the associated regulations.

You must submit your claim for benefits in accordance with the Plan Administrator's guidelines. Claims may also be submitted to the Plan Administrator at the address specified at the beginning of this document.

Before you can file a lawsuit for benefits under the Plan, you must exhaust the Plan's internal remedies. A lawsuit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

A request for benefits is a "claim" subject to these procedures only if you or your authorized representative file the claim in accordance with these procedures. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under this section. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" for purposes of this section, unless the Plan Administrator determines that the inquiry is an attempt to file a claim. If the Plan Administrator or its delegate receives a claim, but there is not enough information to process the claim, you will be given an opportunity to provide the missing information.

You may designate an authorized representative by providing to the Plan Administrator with written notice of the designation. In the case of a claim for medical benefits involving urgent care, your health care professional with knowledge of your medical condition may act as your authorized representative.

Timing of Notice of Claim

The Plan Administrator will notify you of a claim denial within a reasonable period of time, but not later than the time frames below. The time frames will vary depending on the type of Included Benefit and may be extended for any period of time necessary for you to respond to a request for additional

information.

Group Health Plan Claims

The following procedures apply to the Included Benefits that are "group health plans." These include any medical, health FSA, wellness, and employee assistance plans.

**A. Urgent Care Claims**

An "urgent care" claim is any claim for medical care or treatment where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject the you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If you fail to follow the Plan's procedures for filing a urgent care claim, the Plan Administrator will notify you of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than 24 hours following the failure. Notification may be oral, unless you request written notification. This paragraph applies only to a communication from you that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific individual, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the claim by the Plan. If you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify you of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified information, or (2) the end of the period given to you to provide the specified additional information.

**B. Pre-Service Claims**

A "pre-service" claim is any claim where the Plan conditions receipt of the benefit on approval in advance of obtaining medical care. If you fail to follow the Plan's procedures for filing a pre-service claim, the Plan Administrator will notify you of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than 5 days following the failure. Notification may be oral, unless you request written notification. This paragraph applies only to a communication by you that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific individual, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Plan Administrator will notify you if its determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan

Administrator for up to an additional 15 days. The Plan Administrator may only extend the deadline if they determine both that such an extension is necessary due to matters beyond the control of the Plan and they notify you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

**C. Post-Service Claims**

A post-service claim is any claim for a benefit under the plan that is not a pre-service claim. In the case of a post-service claim, the Plan Administrator will notify you of the Plan's adverse benefit determination within a reasonable period of time, but no later than 30 days after receipt of the claim. This period may be extended one time by the Plan Administrator for up to an additional 15 days. The Plan Administrator may only extend the deadline if they determine both that such an extension is necessary due to matters beyond the control of the Plan and they notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

**D. Concurrent Care Claims**

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute claim denial. The Plan Administrator will notify you of the denial at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a review of that denial before the benefit is reduced or terminated.

Any request by you to extend the course of treatment beyond the period of time or number of treatments that is an urgent care claim will be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator will you of the denial, whether adverse or not, within 24 hours after the Plan receives the claim, provided that the claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

<u>Disability Benefit Claims</u>

The Plan Administrator will provide you with notice of an adverse benefits determination within 45 days after receipt of the claim. This period may be extended for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The period for making the determination may be extended for up to an additional 30 days if Plan Administrator notifies you prior to the expiration of the first 30-day extension period of the circumstances of the extension and the date by which the Plan expects to render a decision. Any notice extension under this section will explain the standards on which the entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and

you will be afforded at least 45 days within which to provide the specified information.

Non-Group Health Plan and Non-Disability Based Claims

For all other claims not described above, the Plan Administrator will provide you with a notice of claim denial within 90 days after receipt of the claim. This period may be extended one time by the Plan Administrator for up to an additional 90 days. The Plan Administrator may only extend the deadline if they determine both that such an extension is necessary due to matters beyond the control of the Plan and they notify you of the extension prior to the expiration of the initial 90-day period.

Content of Notice of Adverse Benefit Determination

If your claim is denied, the Plan Administrator will provide you with a written notice identifying:

1. the reason(s) for the denial;
2. the Plan provisions on which the denial is based;
3. any material or information needed to grant the claim and an explanation of why the additional information is necessary; and
4. an explanation of the steps that you must take if you wish to appeal the denial, including a statement that you may bring a civil action under ERISA.

In addition, if the denied claim is for a group health plan or disability benefit under the Plan, the following information will also be included in the written notice:

1. the specific rule, guideline, protocol, or other similar criterion, if any, that was relied upon in the denial; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or
2. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that the explanation will be provided free of charge to you upon request.

If the denied claim is for a disability benefit under the Plan, the following information will also be included in the written notice:

1. A discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination presented to the Plan made by the Social Security Administration.
2. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.
3. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

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

If the denied claim is for a group health plan benefit under the Plan, the following information will also be included in the written notice:

1. 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).
2. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
3. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist you with the internal claims and appeals and external review processes.
4. The Plan must also:
    a. Ensure that the reason or reasons for any adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim; and
    b. Provide to you, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination. The Plan must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

In the case of a denied urgent care claim where the Included Benefit is a group health plan, the notice will include a description of the expedited review process applicable to such claims.

This information may be provided orally provided that a written or electronic notification is furnished to you not later than 3 days after the oral notification.

<u>Appeal of Adverse Benefit Determination</u>

You may appeal the denial of a claim (including a rescission of coverage) by filing a written appeal with the Plan Administrator on or before the 60th day after you receive the Plan Administrator's written notice that the claim has been denied. If the denial involves a claim under an Included Benefit that is a group health plan or disability plan, you may file a written appeal on or before the 180th day after your receive written notice of the denial.

If the denial involves a claim for disability benefits, a denial includes a cancellation or discontinuance of coverage that has retroactive effect (unless it is due to your failure to pay required premiums).

Your written appeal must identify both the grounds and specific Plan provisions upon which the appeal is based. You will lose the right to appeal if your appeal is not timely made.

The Plan will provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefit. You may submit written comments, documents, records, and other information relating to the claim for benefits. The Plan will

take into account all comments, documents, records, and other information you submit relating to the claim, without regard to whether such information was submitted or considered in the initial claim. The Plan Administrator will consider the merits of your written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant.

If the claim is for group health plan or disability plan benefits the following will apply.

1. The review will not afford deference to the initial claim denial. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the denial that is the subject of the appeal, nor the subordinate of that individual.
2. In deciding an appeal of any denial that is based on a medical judgment, the appropriate named fiduciary 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 engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the claim denial that is the subject of the appeal, nor the subordinate of any such individual.
3. The Plan will identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether the advice was relied upon in the denial.
4. In the case of an urgent care claim, the Plan will expedite review of the claim and you may submit a request for an expedited appeal of a denial orally or in writing. All necessary information, including the Plan's benefit determination on review, will be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious method.
5. Before the Plan issues any adverse benefit determination, the Plan Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan) in connection with the claim, and any new or additional rationale must be provided to you as soon as possible and sufficiently in advance of the date on which the Plan must provide you with the notice of final adverse benefit determination so that you have a reasonable opportunity to respond prior to that date.
6. If the determination is based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is required to be provided to give you a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it in time for you to have a reasonable opportunity to respond, the Plan's deadline for providing a notice of final adverse benefit determination will be delayed until you have had reasonable opportunity to respond. After you respond, or had a reasonable opportunity to respond but failed to do so, the Plan Administrator will notify you of the Plan's benefit determination as soon as a Plan acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.

The Plan Administrator will ordinarily rule on an appeal of a claim denial within 60 days following receipt of the claim. The time frame will begin at the time your appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. However, if special circumstances require an extension and the Plan Administrator furnishes you with a written extension notice during the initial period, the

Plan Administrator may extend this period of time by 60 days if written notice of the extension is furnished to you prior to the termination of the initial 60-day period. In the event that the extension is due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review will start on the date that you respond to the request for additional information.

If the claim is for group health plan benefits, the Plan Administrator will notify you of the Plan's benefit determination on review as follows.

1. Urgent Care Claims The Plan Administrator will notify you of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination by the Plan.
2. Pre-Service Claims The plan administrator will notify you of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt by the Plan of your request for review of an adverse benefit determination.
3. Post-Service Claims The Plan Administrator will notify you of the Plan's benefit determination on review within a reasonable period of time, but no later than 60 days after receipt by the Plan of your request for review of an adverse benefit determination.

All claims and appeals involving group health plan benefits and disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will be made based upon the likelihood that the individual will support the denial of benefits.

The following applies to any claim for group health plan benefits (or appeal of a claim for group health plan benefits):

1. The Plan must ensure that any notice of adverse benefit determination includes 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);
2. The Plan must provide to you, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination. The Plan must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review;
3. The Plan must ensure that the reason or reasons for any adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of final adverse benefit determination, this description must include a discussion of the decision;
4. The Plan must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
5. The Plan must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist you with the internal claims and appeals and external review processes.

Denial of Appeal

If an appeal is wholly or partially denied, the Plan Administrator will provide you with a notice identifying:

1. the reason or reasons for such denial;
2. the Plan provisions on which the denial is based;
3. 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; and
4. a statement describing your right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator will be binding upon all parties.

If the denied claim is for a group health plan benefit under the Plan, the following information will also be included in the written notice:

1. 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);
2. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
3. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist you with the internal claims and appeals and external review processes; and
4. The Plan must also:
    a. Ensure that the reason or reasons for any adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim and a discussion of the decision if the notice is a final adverse benefit determination; and
    b. Provide to you, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination. The Plan must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review;

In the case of a group health plan or a plan providing disability benefits, the notice will also include:

1. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;
2. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
3. the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

In the case of a claim involving disability benefits, the notice will also include:

1. Any applicable contractual limitations period that applies to your right to bring an action under section 502(a) of ERISA, including the calendar date that the contractual limitations period expires for the claim.
2. A discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination presented to the Plan made by the Social Security Administration.
3. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.
4. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

External Claims Process

State ProcessTo the extent the Plan is required pursuant to DOL Reg. section 2590.715-2719(c)(1) to comply with a State external claims process that includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the Plan will comply with the state external claims process of DOL Reg. section 2590.715-2719(c).

Federal ProcessTo the extent the Plan is not required pursuant to DOL Reg. section 2590.715-2719(c)(1) to comply with the State external claims process, then the Plan will comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d)