SUMMARY PLAN DESCRIPTION
FOR THE

NEW BEDFORD EDUCATORS ASSOCIATION, INC. HEALTH AND WELFARE BENEFIT PLAN

ABOUT THIS SUMMARY PLAN DESCRIPTION

This document, together with any separate benefit plan certificates/booklets for your dental insurance coverage, constitute the Summary Plan Description ("SPD") for your dental benefits, and is intended to comply with the disclosure requirements set forth in regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974 (ERISA). You should use these materials to understand the dental benefits provided to you and your family.

This SPD does not serve as a guarantee of continued employment or benefits. The policies of the School Committee of the City of New Bedford (the "Employer") on hiring, discharge, layoff and discipline are in no way affected by the dental benefits described here.

If there is a discrepancy between this SPD and the official Plan document(s), the provisions of the Plan document(s) and/or any related dental insurance contracts are controlling and will govern. No vested rights of any nature are provided under the Plan. The New Bedford Educators Association, Inc. (the "Association"), as the Administrator of the Plan, may amend the Plan in its sole discretion, subject to any Collective Bargaining Agreements in effect between the Association and the School Committee.

Effective July 1, 2015

DENTAL BENEFITS
SUMMARY PLAN DESCRIPTION (SPD)

This document presents basic information about the dental benefits provided by the Plan as of the effective date on the front cover, and your rights to dental benefits as a Plan participant. This document, together with any separate dental benefit certificates/booklets (the "Booklet(s)"), constitute the Summary Plan Description ("SPD") for your dental benefits under the Plan. The Plan is maintained for the benefit of eligible employees, eligible retirees and their respective covered eligible dependents, and is intended to provide dental benefits to those individuals enrolled in the Plan. You and any of your dependents covered under the Plan should review this entire document and the applicable Booklet for the dental benefit features you have selected.

1. GENERAL PLAN INFORMATION

Name of Plan:	New Bedford Educators Association, Inc. Health and Welfare Benefit Plan (the "Plan")
Plan Sponsor:	New Bedford Educators Association, Inc. (the "Association") 160 William Street New Bedford, MA 02740 508-984-4441
Plan Administrator:	The Plan Sponsor is also the Plan Administrator. The Plan Administrator's address and telephone number is the same as that of the Plan Sponsor listed above.
Agent for Service of Legal Process:	The Plan Administrator, as listed above
Plan Sponsor's EIN:	04-6744659
Plan Number:	501
Type of Plan:	The Plan is a welfare benefit plan providing, for purposes of this SPD, dental insurance coverage described in the corresponding Booklets.
Sources of Plan Contributions:	Participants pay the entire cost of the dental insurance coverage they have enrolled in under the Plan. Neither the Plan Sponsor nor the School Committee of the City of New Bedford, Massachusetts (the "Employer") contribute to the cost of dental coverage. Participant contributions may vary depending on which dental benefits the Participant selects. In no event shall the Plan Sponsor or Employer pay or otherwise be liable for any deductible, coinsurance or

	copayment amounts related to the dental insurance coverage elected by Participants. Such amounts shall be the sole liability of the Participants.
Funding Medium:	This Plan is funded through the group dental insurance contract(s) listed in Appendix A, which are held in trust for the benefit of Participants by the Trustees of the New Bedford Educators Association, Inc. Health and Welfare Fund, a tax-exempt voluntary employees' beneficiary association ("VEBA") trust (the "Trust"), as defined under Section 501(c)(9) of the Internal Revenue Code of 1986, as amended (the "Code"). All contributions to the Plan shall be allocated to the applicable group contract for the purpose of funding dental benefits provided under the Plan. The group contract(s) shall be of such kind as the Plan Sponsor, in its sole discretion, deems appropriate for the Plan. With respect to any insured group contract, liability for providing benefits under such insured group contract shall be solely that of the insurance company issuing the applicable insured group contract and the Plan Sponsor and Employer shall have no liability for providing benefits under any insured contract.
Plan Year:	The plan year is the twelve month period from July 1 to June 30.
Collective Bargaining Agreements:	The Plan is maintained pursuant to Collective Bargaining Agreements between the Association and the Employer. You may obtain copies of the Collective Bargaining Agreements upon written request to the Plan Administrator, and copies of the Collective Bargaining Agreements are available for examination by Participants at the Plan Administrator's office during normal business hours.

2. Plan Eligibility and Enrollment

Eligibility for Dental Benefits

The documents listed in Appendix B generally detail the eligibility and enrollment requirements for the dental benefits offered under the Plan. The eligibility requirements for employees and retirees eligible to participate in dental benefits under the Plan ("Eligible Employees" and "Eligible Retirees", respectively) are summarized in Appendix A and incorporated by this reference.

Enrollment

If you are an Eligible Employee or Eligible Retiree, you may enroll in dental benefits once you meet the requirements for enrollment. The Plan Administrator may establish enrollment procedures for dental benefits in accordance with the applicable documents listed in Appendix B. The Plan Administrator may prescribe the form and/or manner of enrollment that must be completed by a prescribed deadline prior to commencement of dental benefit coverage under the Plan.

Eligible Employees and Eligible Retirees who are enrolled in dental benefits under the Plan ("Participants") may enroll their eligible spouse and dependents for the same coverage -- if and to the extent such coverage is available to spouses and dependents. Eligible spouses and dependents are those individuals who meet the requirements set forth in the applicable document listed in Appendix B. Upon request, you must provide proof of your spouse's or dependents' eligibility for coverage.

Under the Plan and this SPD, the term "spouse" means the opposite-sex or same-sex souse to whom the Participant is legally married under the laws of the jurisdiction in which the Participant's marriage took place. The spouse of a Participant includes a spouse of the same sex if the marriage was validly entered into in a state whose laws recognize the marriage of two individuals of the same sex even if such individuals are domiciled in a state that does not recognize the validity of same-sex marriages.

Timing of Enrollment and Enrollment Changes

Your opportunities to enroll for dental benefits under the Plan (which requires you to pay all of the costs of such benefits), as well as to change or cancel your enrollment, are generally limited to the following (discussed below or later in this SPD):

- You (and your eligible spouse/dependents) may enroll at the time you first meet the requirements for enrollment;

- You (and your eligible spouse/dependents) may enroll, or change or cancel your enrollment, during an annual open enrollment period (*see section 4 below*); or

- You (and your eligible spouse/dependents) may enroll, or change or cancel your enrollment outside of the annual open enrollment period if you experience a "change in status" that is consistent with your enrollment change request (*see section 5 below*).

3. Plan Benefits

Dental Benefits under the Plan

The dental benefits under the Plan are those described in the applicable Booklet(s), which have been provided to you under separate cover. Those Booklet(s) are incorporated by reference into this Summary Plan Description. For a complete description of these dental benefits, please refer to the Booklet(s) provided by the applicable insurance carrier/vendor.

Circumstances That May Cause Loss of the Plan's Dental Benefits

The Plan contains some restrictions on the type and amount of dental benefits payable as well as the circumstances under which dental benefits are paid. Circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture, rescission or suspension of any dental benefits are described in the separate Booklet(s). You should review the applicable Booklet(s) in order to acquaint yourself with these provisions. You may lose dental coverage under the Plan if the Plan is terminated or is amended to reduce or eliminate your dental coverage. Your dental coverage under the Plan generally terminates when you terminate employment with the Plan Sponsor or otherwise cease to be an Eligible Employee or when you cease to be an Eligible Retiree.

Provider Directories/Listings

Provider directories/listings for the applicable dental provider networks utilized by the Plan will be available through the dental plan provider via the internet. Paper copies will be made available, upon request, by the dental plan provider or the Plan Sponsor, free of charge.

4. Annual Open Enrollment Period

You have the opportunity to make changes to your dental benefit elections for the upcoming year during the annual open enrollment period. At that time you may choose to make changes to your dental benefits or keep your current dental benefit elections. Generally, the dental benefit elections you make will remain in effect for the entire year unless you experience a change in status or you qualify

for the special enrollment period (described in the following sections), which permits you to change your dental benefit elections.

Each year, you will be notified of the annual open enrollment period, enrollment procedures, dental coverage costs, and time frames available to enroll in or change your dental benefit elections for the upcoming year. It is important to review your annual open enrollment materials carefully when you receive them.

5. Changes in Status

Outside of the annual open enrollment period, federal law provides that you may change certain benefit elections only if you experience a change in status, and the change in your benefit election is consistent with your change in status, such as birth, death, marriage, divorce, or a change in your or your spouse's employment, subject to the terms of the Employer's Internal Revenue Code Section 125 cafeteria plan document.

As mentioned above, any requested change in dental benefit coverage outside the annual open enrollment period must be consistent with your change in status.

You must notify the Plan Sponsor within 31 days of your change in status. If you do not request a change to your dental benefit elections within 31 days of your change in status, you must wait until the next annual open enrollment period, or until you experience another change in status, to make a change.

The effective date of your change in dental benefit coverage generally will be the date that your change in status occurred. Any resulting change in the cost of your dental benefit coverage (for example, from individual coverage to family coverage) is effective on the first payroll period or direct payment period following the date of your requested change in coverage as a result of a change in status.

6. Cost of Coverage

The Plan Sponsor and the Employer, pursuant to the Collective Bargaining Agreements, will determine the level of Participant contribution for dental benefit coverage annually and will notify Eligible Employees and Participants in writing prior to each year as to what the Participant's cost will be for the upcoming year for coverage for Eligible Employees and Eligible Retirees and their respective eligible family members, and will notify Participants in writing prior to any mid-year change in cost.

If you are Eligible Employee Participant, you pay the entire cost of your dental benefit coverage through regular payroll deductions on a pre-tax basis. This means that the cost of your dental benefit coverage generally is deducted from your salary before federal, Social Security, and state income taxes are withheld. As a result, your taxable income is reduced, thereby saving you money.

However, it's important to note that paying for dental benefit coverage or making contributions on a pre-tax basis could reduce your future Social Security benefits. If you are an Eligible Retiree Participant, you pay the entire cost of your dental benefit coverage on an after-tax basis through direct billing or such other procedures as may be established by the Plan Administrator from time to time.

However, if you enroll someone (such as your domestic partner, ex-spouse or adult child older than age 26 -- if and to the extent permitted by the Plan) in dental benefit coverage and that person is not considered your spouse, child or other dependent for federal tax purposes, then the fair market value of the dental coverage provided to that individual must be included in your taxable gross income as imputed income if you are paying for that coverage on a pre-tax basis.. If you have any questions, please contact the Plan Sponsor. For additional information, please refer to IRS Notice 2004-79, IRS Notice 2010-38 and IRS Revenue Ruling 2013-17.

7. Plan Documents

The documents constituting the Plan may be reviewed in the offices of the Plan Administrator during normal business hours.

8. Health Continuation Coverage

Under the Federal Consolidated Omnibus Budget Reconciliation Act (“COBRA”), you may be eligible to continue coverage after group health coverage ends if you were enrolled in health coverage and you experience a qualifying event which would cause you to lose group health coverage.

For more information, please contact the Employer.

9. Plan Administration

Dental benefits furnished under the Plan are administered by the insurance carrier(s) from which such benefits are purchased. The name of each insurance carrier is set out in Appendix B. Unless otherwise indicated, all dental benefits furnished under the Plan are provided under the insurance policies, administrative contracts and/or plan documents identified in Appendix B, and the respective insurance carries and vendors identified therein provide all necessary administrative services.

10. Authority of Plan Administrator

The Plan Administrator has complete discretionary authority with regard to the operation, administration and interpretation of the Plan and any determination by the Plan Administrator relating to the Plan shall be final, binding and conclusive in the absence of clear and convincing evidence that the Plan Administrator acted arbitrarily and capriciously. The Plan Administrator may also delegate any of its responsibilities under the Plan to any other person or entity.

Any insurance carrier from which dental benefits are purchased has discretionary authority to construe any and all terms of the group insurance policy it has issued, and the power and discretion to determine questions of fact and law arising in connection with the administration, interpretation and application of the group insurance policy.

11. Plan Amendment or Termination

The Plan Administrator may amend the Plan at any time, subject to the Collective Bargaining Agreements. The Administrator has no obligation to maintain the Plan for any given length of time other than that required under the Collective Bargaining Agreements. The Plan will not automatically terminate if the Trust terminates. If the Trust terminates, the Plan Administrator shall have the ability to continue the Plan if it so chooses. Any claims or expenses incurred before the date of any Plan amendment or termination will be paid in accordance with the Plan terms in effect at the time the claim or expense was incurred; provided the claim is filed with the Plan in accordance with the applicable claims procedures and within the applicable time limits for filing such claims. No vested rights of any nature are provided under the Plan.

12. Qualified Medical Child Support Orders (QMCSOs)

As required by ERISA, the Plan recognizes qualified medical child support orders ("QMCSOs"). A QMCSO is a court order or an order issued by a state administrative agency in accordance with federal and state laws that require an alternate beneficiary (for example, a child or stepchild) to be covered by a plan participant's group health plan.

The Plan honors QMCSOs that meet the legal requirements for such orders. It is important to note that a QMCSO cannot require a plan to provide a type or form of benefit, or an option, that is not currently available from the plan to which the order is directed, unless receiving this benefit or option is necessary to meet the requirements of the Social Security Act, which relates to the enforcement of state child support laws and reimbursement of Medicaid.

A medical child support order must be provided to the Plan Sponsor to determine if it meets the legal requirements for a QMCSO. If it does, the alternate beneficiary is considered a beneficiary for the purposes of ERISA and is enrolled as a dependent of the Participant. If the Plan Sponsor receives a medical child support order that relates to you, you will be notified and then informed of the decision as to whether the order is a QMCSO.

A copy of the Plan's QMCSO procedures is available, free of charge, upon written request.

13. Benefit Claim Procedures

All claims for dental insurance benefits under the Plan and appeals of denied claims shall be submitted to the applicable insurance carrier, which shall be solely responsible for administering all such claims in accordance with ERISA (including the Department of Labor Regulations thereunder) and state law, as applicable. The final determination of the insurance carrier on review shall in all cases be final, and the Plan Sponsor and Employer shall not have any authority to overrule any determination of the insurance carrier of a fully insured dental benefit under the Plan.

14. 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 the Plan and Benefits

- Examine, free of charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual reports (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may charge a reasonable fee for copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant a copy of this summary annual report.

Continue Group Dental Plan Coverage

- Continue group dental 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 this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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 benefits plan. These persons are called fiduciaries. Plan fiduciaries must operate the

Plan prudently and in the interest of you and other Plan Participants and beneficiaries. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan. No one, including the Plan Sponsor, the Employer, the Association or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a dental benefit under the Plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time 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 medical child support order, you may file suit in a 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 a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about 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. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Publications Hotline at the Employee Benefits Security Administration.

In the event that the content of this SPD, or any oral or written representations made by any person regarding the Plan, conflicts or is inconsistent with the provisions of the Plan document(s), the provisions of the Plan and/or any related insurance contracts are controlling and will govern. No vested rights of any nature are provided under the Plan.

APPENDIX A

Eligibility Requirements

Effective as of the Date on the Cover Page of this SPD

A. Employees' Eligibility to Participate:

- Employees. Under the Plan, an Employee is an individual who:
  - Is employed in the service of the Employer; and
  - Is in a legal employee-employer relationship with the Employer for Federal withholding tax purposes.

  Employees do not include any individual who is self-employed in accordance with Code Section 401(c).

- Benefit Eligible Employees for Dental Coverage. Under the Plan, Benefit Eligible Employees eligible for the Plan's dental benefits are:
  - All Employees who are Unit A members of the Association (that is, all full-time and part-time professional Employees, including all nurses, performing teaching duties or duties of a related professional nature, including nursing duties) who are covered by the Unit A Collective Bargaining Agreement between the Association and the Employer;
  - All Employees who are Unit B members of the Association (that is, all administrators) who are covered by the Unit B Collective Bargaining Agreement between the Association and the Employer;
  - All Employees who (a) previously were Unit A or Unit B members of the Association, (b) had elected dental coverage under the Plan while they were Unit A or Unit B members, (c) cease to be Unit A or Unit B members because they have been hired by the Employer into positions that are not covered by the Unit A or Unit B Collective Bargaining Agreement between the Association and the Employer, and (d) elect to continue their dental coverage under the Plan after they cease to be Unit A or unit B members of the Association; and
  - All Employees who (a) are school principals, (b) are members of the Association, and (c) elect dental coverage under the Plan.

Under the Plan, Benefit Eligible Employees do not include independent contractors, freelancers and the like shall not be eligible even if they are subsequently determined to be common law employees for any purpose, including without limitation, for wage, labor or tax purposes by the Internal

Revenue Service, the Department of Labor or any other Federal or state agency, administrative body or court. Any such determination shall be prospective only.

B. Retirees' Eligibility to Participate:

- Retirees. Under the Plan, a Retiree is any former Benefit Eligible Employee who, on the date immediately preceding his or her retirement date from the Employer, was a Benefits Eligible Employee.

- Benefit Eligible Retirees. Under the Plan, Benefit Eligible Retirees are former Benefit Eligible Employees who, on the date immediately prior to their retirement date from the Employer, were Benefit Eligible Employees and were covered by group dental benefits under the Plan, and who, on their retirement date from the Employer, meet the eligibility requirements for retiree coverage set forth in the applicable group dental insurance contract(s).

Appendix B

Plan Administration

Effective as of the Date on the Cover Page of this SPD

Dental benefits are administered according to the terms of the applicable insurance policies, administrative contracts and plan documents. See the chart below for specific administration and funding information.

Vendor and Contact For Claims Administration	Funding Status	Group Contract Number
Blue Cross Blue Shield of Massachusetts www.bluecrossma.com 1-800-486-1136	Fully Insured*	For Benefit Eligible Employees: #002330422 For Benefit Eligible Retirees: #002330421
* The vendor listed above provides fully-insured benefits under one or more insurance policies or contracts issued to the Plan Sponsor. This vendor is solely responsible for insuring and providing the benefits under the insurance policies and contracts. The Plan Sponsor and the Employer have no liability for any benefits due or alleged to be due, under any such insurance policies or contracts.		

APPENDIX C

Claims Appeal Procedures

Effective as of the Date on the Cover Page of this SPD

In most cases, the time frames during which you may file a claim or an appeal, as well as the time frames within which the claims administrator must provide you with an answer, are governed by the Employee Retirement Income Security Act of 1974 (ERISA). Generally, the time frames applicable to your claim or appeal are based on the type of plan under which you are filing your claim or appeal. This Appendix will review the claims and appeals procedures and applicable time frames for group health benefit plans (such as group dental insurance plans) under applicable U.S. DOL regulations.

Group Health Benefit Features (such as Group Dental Insurance)

Types of Claims under Group Health Benefit Features (such as Group Dental Insurance)

For purposes of a group health benefit feature under the Plan (such as group dental insurance), an adverse benefit determination includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time). There are three different types of claims that may arise under a group health benefit feature, which are defined as follows:

Pre-Service Claim - A claim for health benefits that, by its terms, conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Urgent Care Claim - A pre-service claim for benefits where the otherwise applicable time frames for obtaining approval either: 1) could seriously jeopardize your life or health or your ability to regain maximum function, or 2) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be managed adequately without the care or treatment.

Post-Service Claim - A claim for benefits under a group health benefit feature that it not a pre-service claim or an urgent care claim.

Initial Claims for Benefits under Group Health Benefit Features
If you believe you are entitled to a benefit or to a greater amount of benefits under the applicable group health benefit feature(s) than the amount you have received or are receiving, either in whole or in part, you have the right to file a claim with the applicable Claims Administrator (see Appendix B for the address of the Claims Administrator(s)). In many cases, your initial claim for benefits is filed when you or your provider submits a request for benefit payment to the applicable Claims Administrator. In response to submission of this claim, you receive an "Explanation of Benefits" from the Claims Administrator, which indicates if your claim for benefits was approved or denied (either in full or in part).

General Rule. If you file a claim for benefits under a group health benefit feature, the applicable Claims Administrator must notify you of its benefit determination within the time frame(s) set forth below, based on the type of claim you filed:

Initial Urgent Care Claim - within 72 hours of receipt of the claim

Initial Pre-Service Claim - no later than 15 days after receipt of the claim

Initial Post-Service Claim - no later than 30 days after receipt of the claim

Missing Information. If you file an urgent care claim for benefits under a group health benefit feature and it is missing information, the applicable Claims Administrator must notify you no later than 24 hours after it receives your urgent care claim. In this case, the applicable Claims Administrator must give you 48 hours to provide the missing information.

If you file a pre-service or a post-service claim for benefits under a group health benefit feature and it is missing information, the applicable Claims Administrator may, but is not required to, notify you that information is missing.

However, if you are notified that information is missing, the applicable Claims Administrator must give you 45 days to provide the missing information.

Extension of Time. If the applicable Claims Administrator is unable to make a benefit determination within the time frames set forth above due to reasons beyond its control, the applicable Claims Administrator may extend the time frames for pre-service and post-service claims as follows:

Extension for Initial Pre-Service Claim - up to an additional 15 days

Extension for Initial Post-Service Claim - up to an additional 30 days

In the case of an extension, the applicable Claims Administrator must notify you in writing prior to the expiration of the initial review period. In addition, the extension notice must explain why the extension is necessary, the date by which the applicable Claims Administrator expects to make a determination, and, if applicable, the additional information that is needed to make the determination. Please note, no extension is available for urgent care claims.

Denial of Initial Claim for Benefits under Group Health Benefit Features

If your claim for benefits under a group health plan is denied, in whole or in part, the applicable Claims Administrator will notify you of the denial. The denial notice will:

- Explain the specific reason(s) why your claim was denied.
- Reference the applicable group health plan's provision(s) on which the denial is based.
- Describe any additional material or information that would be required to reconsider your claim and why that material or information is necessary.
- Explain the applicable group health plan's appeal procedures.
- Provide either a copy of any internal rule, guideline, or protocol relied upon in making the determination or a statement that such rule, guideline, or protocol was relied upon in making the determination and that it will be provided, upon request, free of charge.
- Explain any scientific or clinical judgment involved in the determination, or state that such an explanation will be provided, upon request, free of charge.

Upon receipt of a written denial of benefits from the applicable Claims Administrator, you will have the opportunity to submit written comments, documents, records, and other information related to your claim for benefits. In addition, you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal of Denied Claim for Benefits under Group Health Benefit Features

If you wish to appeal the denial of your claim for benefits under a group health benefit feature, in most cases you must file a written appeal no later than 180 days after you receive the initial claim denial notice. However, for denied urgent care claims only, you may submit your appeal orally or in writing. Appeals should be submitted to the applicable Claims Administrator as set forth in your denial notice (or refer to Appendix B for the address of the Claims Administrator(s)).

For some plans, there may be two levels of appeal permitted. The information provided by the Claims Administrator with your initial claim denial will indicate whether there is more than one level of appeal. If you are filing an appeal under a plan that has two levels of appeal and your first appeal is denied, you must file your second appeal no later than 60 days after your first appeal is denied. The applicable Claims Administrator will review your second (and final) appeal and provide written notice of a final decision.

Regardless of whether there is one level of appeal or two available under the applicable group health benefit feature, the appeal(s) will not be reviewed by the same person, or a subordinate of the person, who made the initial determination and deference will not be given to the initial review(s). In addition, if the appeal involves medical judgment, the applicable Claims Administrator will consult with an appropriately trained medical professional (e.g., a Physician or other professional licensed, accredited, or certified under state law to perform specified medical functions).

With respect to the assignment of any appeal of an adverse claims determination to a claims adjudicator or medical expert, neither the Employer, the Plan Administrator nor any Claims Administrator shall make any decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to a claims adjudicator or medical expert based upon the likelihood that the individual acting as the review processor will support a denial of benefits.

The Claims Administrator will provide you (free of charge) with new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale.

General Rule. If you file an appeal for benefits under a group health benefit feature, the applicable Claims Administrator must notify you of its benefit determination on appeal within the time frame(s) set forth below, based on the type of claim you are appealing:

Appeal of Urgent Care Claim - within 72 hours of receipt of appeal

Appeal of Pre-Service Claim - no later than 30 days after receipt of appeal (15 days after receipt of appeal if there are two levels of appeal)

Appeal of Post-Service Claim - no later than 60 days after receipt of appeal (30 days after receipt of appeal if there are two levels of appeal).

Extension of Time. The applicable Claims Administrator may extend the time frames for making its benefit determination on appeal.

Final Determination on Appeal for Benefits under Group Health Benefit Features

If your appeal is denied, the final determination on appeal will include the reason for the decision, along with specific references to the pertinent group health benefit feature provision(s) upon which the decision is based. It also will provide you with a copy of any internal rule, guideline, or protocol relied upon, or a statement that such rule, guideline, or protocol will be provided to you, upon request, free of charge. To the extent that any scientific or clinical judgment was used in making the determination, an explanation of such or a statement that such explanation will be provided, upon request, free of charge. In addition, the final determination on appeal will provide 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 it will include a statement regarding your right to bring an action under Section 502 of ERISA.

The Plan Sponsor, as Plan Administrator, retains at all times full discretionary authority with regard to the operation, administration and interpretation of the Plan and any determination by the Plan Administrator (including, but not limited to determinations of appeals) shall be final, binding and conclusive in the absence of clear and convincing evidence that the Plan Administrator acted arbitrarily and capriciously. The Plan Sponsor has also delegated discretionary authority to the applicable Claims Administrator with respect to carrying out its responsibilities under the Plan.

External Review for Group Health Benefit Features

If the health benefit feature identified in Appendix B provides for an external review procedure, to the extent required by applicable state or federal law, please refer to the Booklet for a description of the external review procedures.

The Plan's internal appeal process will not be deemed exhausted (thereby permitting you to seek immediate external or judicial review) based on a de minimis violation of the claims and appeal rules that was:

- De minimis;
- Non-prejudicial;
- Attributable to good cause or matters beyond the plan or insurer's control;
- In the context of an ongoing, good faith exchange of information between the claimant and the plan or insurer;

- and

- Not reflective of a pattern or practice of non-compliance by the plan or insurer.

The Plan Sponsor, as Plan Administrator, retains at all times full discretionary authority with regard to the operation, administration and interpretation of the Plan and any determination by the Plan Administrator (including, but not limited to determinations of appeals) shall be final, binding and conclusive in the absence of clear and convincing evidence that the Plan Administrator acted arbitrarily and capriciously. The Plan Sponsor has also delegated discretionary authority to the applicable Claims Administrator with respect to carrying out their responsibilities under the Plan.