

**BANNER HEALTH
&
LABORATORY SCIENCES
OF ARIZONA**

**LONG-TERM DISABILITY (LTD)
PLAN**

SUMMARY PLAN DESCRIPTION

Effective January 1, 2011

Banner Long-Term Disability Plan

Banner Health (Banner) sponsors the Banner Long-Term Disability Plan (the Plan) for its eligible employees. The Plan is self-funded, which means the LTD benefits are paid from the general assets of Banner Health.

The benefits referred to in this Summary Plan Description (SPD) are those in effect January 1, 2011. This SPD summarizes the benefits and important provisions of the Plan. If there is a conflict between a statement in this SPD and in the Banner Health Master Health and Welfare Benefits Plan, the terms of the Master Health and Welfare Benefit Plan shall control.

If, after referring to the information in this document, you still have a question concerning a Plan benefit, call the Plan Administrator at ABSENT8 Banner Plan Administration at 1-888-227-3688 or 480-684-7000 in the Phoenix-metropolitan area.

Asistencia para Miembros de Habla Hispana
Este folleto contiene un resumen en Ingles acerca de los derechos y beneficios de los empleados bajo el Plan de Beneficios de Salud Banner Health /Laboratory Sciences of Arizona. Si tiene dificultad entendiendo alguna parte de este folleto, por favor comuniquese con el Administrator del Plan durante las horas de trabajo.

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Introduction

The Plan may provide protection from an illness or injury that prevents you from working. This SPD describes the benefits you may be eligible for if you are unable to work due to an illness or injury (*Refer to “Disability or Disabled” in the Glossary/Definitions Section*).

Throughout this SPD, you will see references to the Plan Administrator, Claims Administrator and Appeals Administrator.

Plan Administrator

The Plan Administrator operates the Plan, other than deciding benefit claims and appeals. The Plan Administrator is Banner Plan Administration (BPA). You can contact BPA at 1-888-227-3688 or 480-684-7000 in the Phoenix-metropolitan area.

Claims Administrator

The Claims Administrator decides your initial claim for benefits under the Plan. BPA is also the Claims Administrator under the Plan and you can contact the Claims Administrator with respect to your initial claim for benefits at:

Banner Plan Administration
Attn: ABSENT8
P.O. Box 16846
Mesa, AZ 85211-6846
1-888-227-3688, or
480-684-7000 (in the Phoenix Metro area)

Appeals Administrator

If your initial claim for benefits under the Plan is denied, the Appeals Administrator decides the appeal for benefits under the Plan. The Appeals Administrator is the Appeals and Grievance Committee and you can contact the Appeals Administrator with respect to your appeal of a denied claim for benefits at:

Appeals and Grievance Committee
P.O. Box 16423 6th Floor
Mesa, AZ 85211-6423
480-684-7070

The Plan Administrator’s, Claims Administrator’s and Appeals Administrator’s authority is described in the *Plan Administration* Section

Eligibility

Eligible Employees

The LTD Plan is available to employees who are budgeted to work at least 32 hours per pay period and their employment status is either full-time or part-time, excluding Pay In Lieu, Per-Diem, Registry, Weekend Staffing, Travelers, Leased Employees and all other non-benefit eligible positions. This plan also excludes other employees covered under another Banner sponsored long-term disability plan (including, but not limited to the Banner Medical Group Long-Term Disability program).

LTD Eligibility Effective Date

You become eligible to participate in the LTD Plan on the 1st day following 365 days in an active and eligible employment status. If you are on a leave of absence, the days you are not actively at work do not count toward the 365 day waiting period except in the case of days for which you also receive pay under the Paid Time Off program.

Loss of Eligibility

You will cease to be eligible to participate in the LTD Plan on the earliest of the following:

- * The date you cease to be an employee;
- * The date on which you change to an ineligible employment status;
- * The date you begin an unexcused or unpaid leave of absence;
- * The date of your death
- * The effective date of a plan amendment that eliminates such coverage, or
- * The date the Plan is terminated.

Benefit Provisions

The LTD Plan benefit provides income protection that extends beyond STD. LTD payments may begin only if the Claims Administrator or Appeals Administrator, as applicable, determines that you suffer an injury or sickness of permanent or long continued duration that, directly and independently of all other causes, disables you so that you are completely prevented from engaging in **any** occupation or employment without regard to your skill, experience, training or education. (*Refer to the Disability or Disabled definition in the Glossary/Definitions*).

Example: Carol worked for Banner as a Registered Nurse prior to qualifying for STD benefits. In determining whether Carol is Disabled for purposes of LTD benefits under the Plan, the Plan Administrator does not take into account Carol's job position, or her skill, experience, training or education. If Carol is able to engage in any employment (*e.g.*, retail clerk, or dishwasher), she would not qualify for LTD benefits under the Plan.

For LTD eligibility, you must have qualified for short-term disability benefits or workers' compensation benefits for the first 182 consecutive days of your disability, and remained an employee of Banner for such 182 day period. The definition of "Disability or Disabled" for STD benefits and for workers' compensation benefits is not the same as the definition of "Disability or Disabled" for the LTD benefit under the Plan.

You must be under the care of a health care provider and follow the course of treatment and therapy prescribed by your health care provider in order to be considered for LTD benefits. You will be required to have your health care provider(s) send or fax copies of current Office/Progress Notes, Labs, and Consult Notes that will support your claim for LTD disability benefits. If there is a determination that you are disabled under the terms of the Plan, your file is subject to periodic review by BPA's medical professionals to determine your continued eligibility to receive LTD Plan benefits.

The Claims Administrator and Appeals Administrator, as applicable, have the sole discretion to determine

whether you are Disabled under the terms of the Plan. A determination of disability made by Social Security is not determinative of whether you are disabled under the terms of the Plan.

Filing a Claim for Benefits

You must submit the initial application for an LTD claim in writing to the Claims Administrator no later than 45 days after the LTD effective date. Send your claim to:

Claims Administrator

Banner Plan Administration

Attn: ABSENT8

P.O. Box 16846

Mesa, AZ 85211-6846

480-684-7000(in the Phoenix Metro area)

If a claim is not filed within the allowed timeframe, you will not be eligible for benefits under the LTD Plan. You must complete the claim and appeals procedures in order to exhaust your administrative remedies.

To be eligible for a LTD benefit, you must meet the Plan's definition of Disabled, and you or your health care provider must submit all necessary forms, along with proof that you have filed for Social Security Disability Insurance benefits (SSDI), and a copy of your SSDI estimated monthly benefit. Any fee charged by your health care provider for forms, medical records, etc. is your responsibility. Payment on an approved LTD claim is made on the first of each month for that month provided all additional requested medical or other information has been received by the Claims Administrator by the time payment is due.

See *How to Request LTD Benefits* below for details on the claims decision and your right to appeal a claim denial.

LTD Benefit Payments Calculation

LTD Effective Date - If a LTD claim is approved it will begin after 182 consecutive days of total disability, (Refer to the *Disability or Disabled* definition in the Glossary/Definitions). However, if you have available PTO hours at the end of your STD or Workers' Compensation claim, your LTD benefit payment date will begin after pay-out of all PTO hours. This will delay the beginning date of your LTD benefits by the number of PTO days paid.

LTD Benefit Amount – The monthly LTD Benefit Amount is a percentage of your pre-disability monthly base pay, reduced by other income benefits, as defined below. At no time will you be compensated at more than 70% of your pre-disability monthly base pay. Your LTD benefit will be paid monthly and reduced by the amount of your SSDI and/or State disability benefit or by the estimated amount of such SSDI and/or State disability benefit if you are in the process of applying for such benefits.

LTD pays an amount equal to the lesser of:

- I.** 60% of your pre-disability monthly base pay*; not less than \$100 or exceeding \$10,000 per month, reduced by the "other income benefits" as stated below; provided, however, that SSDI benefits payable to your spouse or dependent due to your disability under the Social Security Act are not taken into

account in making this calculation 1; **OR**

2. 70% of your pre-disability monthly base pay* not less than \$100 or exceeding \$10,000 per month, reduced by the “other income benefits” as stated below, and also reduced by family SSDI benefits payable to your spouse or dependent due to your disability under the Social Security Act taking into account any earnings adjustments made by the Social Security Administration to such disability benefits. This calculation 2 applies only in the event that one of your dependents receives family SSDI due to your disability.

*Your monthly base pay is the sum of your hourly base rate of pay multiplied by your budgeted hours during a bi-weekly pay cycle multiplied by 26 pay periods, divided by 12 months. Base pay does not include bonuses, incentive or performance pay, other special or unusual compensation, or amounts received under the Social Security Act and amounts received under any program of Workers’ Compensation.

Example: Tom works 40 hours per week at an hourly rate of pay of \$15.00. His monthly base rate of pay is \$2,600. The LTD calculation at the 60% and 70% rates are:

1. 60% of Monthly Salary = \$1,560

minus

“Other income benefits” (i.e. Tom’s SSDI) = \$750

LTD Plan Benefit = \$810

2. 70% of Monthly Salary = 1,820

minus

“Other income benefits” (i.e. Tom’s SSDI) = \$750

minus

Family SSDI benefits (i.e., SSDI benefits paid to Tom’s dependents due to Tom’s disability) = \$375

LTD Plan Benefit = \$695

Tom’s monthly LTD benefit is \$695.

Your LTD monthly benefit will be reduced by other income benefits.

Other income benefits are:

- Any Employer sponsored salary or wage continuance plan.
- Any amounts payable to you under any plan or program of Workers’ Compensation.
- Any SSDI payable to you due to your disability taking into account any earnings adjustments made by the Social Security Administration to such disability benefits. You must submit proof that you applied for SSDI. When a decision is reached, you must submit proof that you have been approved for or denied benefits. If you are denied benefits and the denial is not solely due to you not meeting the earnings requirement for benefits, then you must pursue your claims through the Social Security Administration hearing level. “Other income benefits” do not include the following:
 - any adjustments to your SSDI, other than an earnings adjustment (i.e., after your SSDI is initially determined, your SSDI amount may change due to an earnings adjustment made to take into account your earnings in the year you became disabled);
 - benefits payable to your spouse or dependent due to your disability; or

- benefits payable to your spouse or dependent for his or her own disability.
- Any Old Age benefit payable to you (excluding amounts payable to your spouse or dependents) under the Social Security Act taking into account any earnings adjustments made by Social Security Administration to such Old Age benefits, but disregarding any adjustment, other than earnings adjustments, which may be made to such Old Age benefit. If you are approved or denied for these benefits you must provide proof of this.
- Any amounts paid to you for any reason or under any circumstance by Banner or any affiliated employer other than wages or benefits provided by Banner.
- Any mandated State Disability Benefits. You must submit proof that you applied for these benefits. When a decision is reached, you must submit proof that you have been approved for or denied benefits.
- Benefits under any Federal program, Railroad Retirement Act, Canada Pension Plan, any provincial pension or disability plan or the Canada Old Age Security Act, for which you are eligible.
- No-fault auto laws and/or no fault insurance.
- Workers' Compensation or similar laws.
- Third party liability recovery, including amounts recovered from an insurer related to the disability for which you are receiving or have received LTD benefits.
- Unemployment insurance law or program, and other programs or plans such as:
 - A governmental compulsory disability benefit program,
 - Any other group disability income plan, fund or other arrangement contributed to by Banner, and
 - Any sick pay or other income or salary continuation paid to you by Banner, other than vacation or holiday pay.

Payment Adjustments

If you receive other income benefits in a lump sum and/or in monthly payments, you must provide BPA satisfactory proof of the breakdown of the amount attributable to lost income and the time period for which the lump sum is applicable. If you do not provide this information, your monthly benefit may be reduced by an amount equal to the monthly benefit otherwise payable. Banner will reduce the monthly benefit each month until the lump sum has been exhausted. However, if Banner is given proof of the time period and amount attributable to lost income, a retroactive adjustment will be made.

Your monthly benefit will not be:

- Less than \$100,
- Reduced due to the cost-of-living increases payable under other income benefits
- Reduced by pension benefits received from any Banner-sponsored pension plan,
- Reduced by any reasonable attorney fees included in any award of settlement, or
- Reduced by any sources of income other than "other income benefits" defined in this SPD.

While You Are Receiving LTD Benefits

- You must provide BPA with your authorization to obtain medical records pertaining to your condition. If requested, you must submit certification from your health care provider of your continuing disability on a form acceptable to BPA.

- At Banner’s expense, you may be requested to report for an initial examination, treatment or a re-examination by a health care provider selected by BPA. Your failure to do so will result in a denial of your claim or termination of further benefits. As a condition of continuing to receive benefits, you must remain under the regular care of a health care provider and follow the course of treatment and therapy prescribed by your health care provider. Reimbursements for travel are not covered for LTD claims.
- You are required to apply for SSDI and to submit proof to BPA that you have done this along with written proof of the estimated monthly benefit. If your application is denied, then you must pursue your claims through the Social Security Administration hearing level. You must cooperate with BPA in connection with your claim for SSDI. Failure to cooperate will result in a denial of your LTD claim or suspension of further benefits if your claim has already been approved.
- If you and your eligible dependents are enrolled in Banner’s company-sponsored medical, pharmacy, dental, or vision plan at the time you are approved for LTD benefits, you may continue certain benefits under the provisions of COBRA for up to 29 months.
- If LTD benefits are denied you must contact your Human Resources Department.

LTD Benefit Maximum

If you remain disabled, disability benefits cease at the times specified below, depending upon when disability begins. An exception to this rule occurs if your disability is due to a mental disorder (Refer to the *Mental Disorder* definition in the Glossary/Definitions). In that case, benefits are payable for no more than 24 months. The limitation on benefits for a mental disorder applies even if the mental disorder has a physical cause or physical symptoms, and even if the disability is caused by a combination of mental and physical factors. This is also the maximum LTD benefit for mental disorders during your lifetime under the LTD Plan. If your disability is determined by the Claims Administrator or Appeals Administrator, as applicable, to have been due to a mental disorder, a subsequent event or condition that extends or continues your disability will not be payable beyond the 24 months.

Age Disability Begins	Date Monthly Disability Cease
61 or younger	At age 65
62	42 months following the date disability occurs
63	36 months following the date disability occurs
64	30 months following the date disability occurs
65	24 months following the date disability occurs
66	21 months following the date disability occurs
67	18 months following the date disability occurs
68	15 months following the date disability occurs
69 or older	12 months following the date disability occurs

General Exclusions of LTD Plan

The following disabilities are excluded from LTD Plan benefits:

- Disability incurred before the effective date of this Plan;
- Disability incurred before the date you become eligible under the Plan;
- Disability due to an act of war, whether declared or undeclared;
- Disability due to reversal of voluntary sterilization;
- Disability due to a sex change operation or procedure;
- Disability due to your participation in a riot or other civil disorder;
- Disability arising from your commission of any act which is a misdemeanor or felony under any state or federal law;
- Disability due to any injury suffered while you are engaged in any business or employment for remuneration or profit other than employment with Banner;
- Disability resulting from your illegal acts or caused by your illegal use of any prescribed or controlled narcotic or substance. This exclusion will not apply to any disability that is diagnosed immediately after a participant voluntarily discloses to the company illegal use of any prescribed or controlled narcotic or substance before the participant has been requested by the company to submit to or take any “for cause” test for drugs or any other substance. A “for cause” test is any drug or substance test required by the company in accordance with company personnel policies;
- Disability certified by a close relative; and
- Disability incurred during military service.

Termination of LTD Plan Benefits

Your benefits under the LTD Plan will stop on the earliest of the following dates:

- * You no longer meet the definition of Disability or Disabled under the terms of the Plan;
- * The day you commit or attempt to commit fraudulent activity against the Plan, Banner, or a related entity;
- * The day you reach LTD Maximum Benefits according to the Plan;
- * The day you fail to comply with the Plan’s requirements related to your disability or fail to provide information requested by the Plan Administrator; or
- * The date the Plan is terminated;

How to Request LTD Benefits

Claims Decision Procedure

See Filing a Claim for Benefits above for details on how to file a claim for LTD benefits. The Claims Administrator will notify you of its decision within 45 days of its receipt of your completed claim. The Claims Administrator can increase its time for rendering a decision on your claim for an additional 30 days if it notifies you of the extension, the reason for the need for the extension, and the expected date of decision on the claim.

If your claim is denied in whole or in part, including if the claim is denied because of incomplete information submitted by you, the Claims Administrator will notify you in writing or by electronic notification of the adverse benefit determination. The notification you receive will include:

- the specific reason or reasons for the adverse benefit determination;
- reference to the specific Plan provisions on which the determination is based;
- a description of any additional material or information that you must provide to complete your claim and an explanation of why the material or information is necessary;
- a description of the Plan’s appeal procedures and time limits; and
- if an internal rule, guideline, protocol, or other criteria was used in making the adverse determination, the Claims Administrator will inform you of the specific rule, guideline, protocol, or other criteria and provide a copy of the rule, guideline, protocol, or other criteria free of charge to you upon request.

You have the right to access certain information and documents from the Claims Administrator used in making the initial determination. If your claim is denied, you may file an appeal. You must timely complete the claim and appeals procedures in order to exhaust your administrative remedies.

Appeals Procedure

If your claim is denied, you may send a written request for review by the Appeals Administrator, along with all information or documentation to support your claim for the benefit. Your request for review is called an “appeal.” Your appeal, and all supporting medical information and documentation, must be sent to the Appeals Administrator within one hundred eighty (180) days of your receipt of the notification that the original claim was denied. Receipt of the notification that the original claim was denied is presumed to occur three days after the date of the determination, unless the third day is a Sunday or federal holiday, in which case it is the first business day after. Your appeal is considered “complete” as of the earlier of (i) the date on which you inform us that you have submitted all supporting medical information and documentation for your appeal, or (ii) the last day of the 180 day period for submitting your appeal. For example:

- LTD claim was denied on Monday, October 3, 2011
- Receipt of the denial is presumed to occur Thursday, October 6, 2011
- You send a written appeal on January 3, 2012
- You cannot submit any information or documentation in support of your appeal after April 3, 2012

Send your appeal to:

Appeals Administrator

Appeals and Grievance Committee

P.O. Box 16423 6th Floor

Mesa, AZ 85211-6423

480-684-7070

If you do not file your appeal within the allowed time frame, you will not be allowed to file an appeal. You must timely complete the claim and appeals procedures in order to exhaust your administrative remedies.

The Appeals Administrator will decide all appeals. The Appeals Administrator does not include any individual(s) at the Claims Administrator who decided your original claim or anyone who is organizationally subordinate to such individual(s). If the adverse benefit determination is based in whole or in part on a medical judgment, the Appeals Administrator will consult with a physician or physicians who are not connected with your original claim and who are not subordinate to any physician consulted in connection with the claim decision.

Timelines Applicable to the Formal Appeal Process

The Appeals Administrator will decide the appeal and send a notice of its decision to you within forty-five (45) days of the date on which your appeal is complete. If, because of special circumstances, the Appeals Administrator cannot make a decision within the initial review period, the review period may be extended up to an additional 45 days. If an extension is necessary, you will be notified before the end of the initial 45-day period.

The written notice of decision will include:

- The specific reason or reasons for the adverse determination and reference to the specific Plan provisions on which the determination is based;
- 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 claimant's claim for benefits;
- 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 the claimant upon request;
- 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 claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and 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."

Exhaustion of Administrative Remedies

You must timely comply with and exhaust the Claims and Appeal Procedures described above for every issue deemed relevant by you or your covered dependent, prior to bringing an action for benefits under the Plan under Section 502(a) of ERISA. Exhaustion of the Appeal Procedure includes the requirement that you and your covered dependents timely raise all reasons for challenging a denial of benefits.

Limitations Period on Legal Actions and Limitation on Venue

No legal action may be brought for benefits under the Plan after one (1) year from the date of the Appeals and Grievance Committee's final decision on appeal. Any legal action brought in connection with the Plan must be filed in the United States District Court, District of Arizona - Phoenix.

General Provisions

Plan Administration

The **Plan Administrator** has the sole and complete discretionary authority to control and manage the operation and administration of the Plan, and to construe the terms of the Plan, including the making of factual determinations. The Plan Administrator is Banner Plan Administration (BPA). You can contact BPA at 1-888-227-3688 or 480-684-7000 in the Phoenix-metropolitan area.

The **Claims Administrator** has the sole and complete discretionary authority to determine initial claims for Plan benefits and, in carrying out this function, to construe the terms of the Plan, including the making of factual determinations. The Claims Administrator is:

Banner Plan Administration
Attn: ABSENT8
P.O. Box 16846
Mesa, AZ 85211-6846
480-684-7000(in the Phoenix Metro area)

The **Appeals Administrator** has the sole and complete discretionary authority to determine participant appeals of denied claims for Plan benefits and, in carrying out this function, to construe the terms of the Plan, including the making of factual determinations. The Appeals Administrator is:

Appeals and Grievance Committee
P.O. Box 16423 6th Floor
Mesa, AZ 85211-6423
480-684-7070 (in the Phoenix Metro area)

The Claims Administrator (with respect to initial claims for benefits) and the Appeals Administrator (with respect to appeals of denied claims for benefits) shall have the discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan will be paid only if the Claims Administrator, or Appeals Administrator, as applicable, decides in its sole and complete discretion that the applicant is entitled to them. The decisions of the Plan Administrator, Claims Administrator, and Appeals Administrator, as applicable, shall be final and conclusive with respect to all questions relating to the Plan.

The Plan Administrator may delegate to other persons responsibilities for performing certain duties of the Plan Administrator under the terms of the Plan. The Plan Administrator, Claims Administrator, and Appeals Administrator, as applicable, may seek such expert advice as reasonably necessary with respect to the Plan. The Plan Administrator, Claims Administrator, and Appeals Administrator, as applicable, shall be entitled to rely upon the information and advice furnished by such delegates and experts, unless actually knowing such information and advice to be inaccurate or unlawful. The Plan Administrator may adopt uniform rules for the administration of the Plan from time to time, as it deems necessary or appropriate.

No Participant Vested Rights to Benefits

Banner reserves the right to change, modify, amend, suspend, or terminate any or all of the benefits provided here in whole or in part, at any time for any reason it determines to be appropriate, by a written instrument approved by the Health and Welfare Plan Committee, and executed by the Chief Executive Officer, Vice President Total Rewards, or Vice President Managed Care and Benefits Administration. No participant has a vested right to the continuation of any particular benefit provided by the Plan. Termination or amendment of the Plan will not affect any benefit levels related to a disability claim approved while the Plan was in force.

Subrogation and Reimbursement

Recovery of Benefits Paid or Payable

The Plan may not be obligated to pay benefits due to a disability for which a third party is liable or legally responsible. The following rules apply to the payment of benefits under the Plan and are designed to avoid overpaying benefits, paying duplicate benefits, and paying benefits when sickness or injury benefits also are paid from another source. By accepting benefits under the Plan, you agree to the following recovery terms and you agree to assist the Plan Administrator in the Plan's recovery. All references in this "Recovery of Benefits Paid or Payable" section to "you" or "your" include your guardian, estate or other legal representative.

Subrogation

If the Plan pays benefits for a disability that was caused by an act or omission of a third party, the Plan will be "subrogated" to all of your rights of recovery. "Subrogated" or "Subrogation" means the Plan may take your place (or "stand in your shoes") in pursuing your legal rights or a legal claim against the third party or your right to any recovery pursued on your behalf by the Plan or anyone else. If you receive benefits under the Plan for a disability that was caused by an act or omission of a third party, you must immediately notify the Plan Administrator of the name of any third party against whom you might have a claim as a result of your disability.

The following entities or forms of insurance are examples of third parties that may be responsible for making payment:

- Any no-fault insurance.
- Medical benefit coverage under any automobile liability plan. This includes your or any third party's policy under which you are entitled to benefits.
- Under-insured and insured motorist coverage.
- Any automobile medical payments and personal injury protection benefits.
- Any third party liability insurance.
- Any workers' compensation insurance.

By accepting benefits under the Plan, you agree to this subrogation provision (as well as the other provisions of the Plan), including that you:

- Automatically assign to the Plan (you "subrogate") any right to recover payments and any actual recovery from any third party.
- Agree to notify the Plan Administrator when a third party may be liable for a disability covered under the Plan. You further agree to notify the Plan Administrator within 30 days of making any claim relating to that third party's liability. Failure to notify the Plan Administrator will suspend benefit payments for the applicable sickness or injury. Such suspension will be lifted when you sign the agreement discussed below.
- Recognize the Plan's right to recover its payment for Plan expenses from the third party who caused and/or is liable for the disability related to the Plan's benefit payments.
- Agree to cooperate with the Plan to provide information about your disability and otherwise do whatever is necessary to secure the Plan's subrogation right, including signing any necessary documents for the Plan to fully subrogate your claim.
- Agree to cooperate fully with the Plan in collecting from the person who caused the disability. (If a claim is settled without protecting the Plan's interests, your rights to full compensation may be lost.)
- Agree that no settlement proceeds will be distributed unless and until the Plan's interest has been paid to the satisfaction of the Plan's fiduciaries.
- Agree to refrain from any action or inaction that may prejudice the Plan's ability to obtain recovery

from you or the third party.

After you notify the Plan Administrator that a third party may be liable for expenses, or if the Plan Administrator believes a third party may be completely or partially liable for your disability, the Plan will require you to sign a statement evidencing your agreement with these provisions and to cooperate with the Plan Administrator in pursuing its subrogation rights

To exercise its subrogation rights, the Plan may: (1) place a lien against a third party to the extent benefits have been paid; (2) bring an action on its own behalf, or on your behalf, against the third party (even if you do not pursue a claim against a third party); and (3) join any action filed by or on your behalf in order to recover its benefit payments. The Plan may make a demand on you directly.

The Plan has a right of subrogation against recoveries from a third party, including a right to any property to which the original recovery is converted. The Plan is granted this right of subrogation against all recoveries from a third party (whether by litigation, arbitration, settlement of a claim, or otherwise), however the recovery is designated (e.g., as payment for expenses). This right of recovery is primary, even if you are not made whole (i.e., compensated in full). The Plan's subrogation rights apply to any benefits paid or payable by the Plan on your behalf as a result of any disability that was caused by an act or omission of a third party and to the Plan's expenses to enforce its rights under this section. This right of subrogation shall remain in effect until the Plan is repaid in full or until the claim is settled by the Plan fiduciary.

If you do not fully cooperate with the Plan in its efforts to enforce its subrogation rights, the Plan may reduce the amount payable to you or on your behalf for current or future benefits until the Plan has made a full recovery. In the event the Plan makes total payments that exceed the maximum amount to which you are entitled, the Plan shall have the right to recover the excess amount from persons where such excess payments were made, including, but not limited to, withholding payments otherwise available under the Plan. The Plan also reserves the right to bring legal action against you.

The Plan has a right to payment or reimbursement for any legal fees it expends in exercising its right to subrogation. Also, the recovery rights of the Plan outlined in this provision will be reduced by an amount representing the Plan's agreed-upon share of any costs or attorney's fees you incurred in obtaining compensation.

Reimbursement

If the Plan pays benefits for a disability that was caused by an act or omission of a third party, the Plan has the right to be repaid (reimbursed) for such benefits from any settlement, judgment, or insurance proceeds you receive from (or on behalf of) that third party. This right of reimbursement is independent of the Plan's subrogation rights described in the previous section. The Plan Administrator can exercise the Plan's right of reimbursement without exercising the Plan's subrogation rights. You must repay the Plan on a first-dollar basis (meaning that the Plan has a right to be repaid first from any monies you receive). The Plan has a right to reimbursement whether or not the third party admitted liability for the payment and whether or not a portion of the settlement, judgment, or insurance proceeds was identified as a reimbursement of expenses or anything else. If you receive benefits under the Plan for a disability that was caused by an act or omission of a third party, you must immediately notify the Plan Administrator of the name of any third party against whom you might have a claim as a result of your disability.

A third party includes any person or organization (including an insurance company). For example, if you are injured in an automobile accident and the person who hit you was at fault, the person who hit you (and his or

her insurance company) is the third party whose act or omission caused your sickness or injury. If appropriate under the circumstances, you or your insurer may be considered a third party if you are or may be responsible for your disability and/or you have insurance coverage for injury, illness, or disability. The following entities or forms of insurance are examples of third parties that may be responsible for making payment:

- Any no-fault insurance.
- Medical benefit coverage under any automobile liability plan. This includes your or any third party's policy under which you are entitled to benefits.
- Under-insured and insured motorist coverage.
- Any automobile medical payments and personal injury protection benefits.
- Any homeowner's insurance either yours or someone else's.
- Any general liability insurance.
- Any workers' compensation insurance.

By accepting benefits under the Plan, you agree to this reimbursement provisions (as well as the other provisions of the Plan), including that you:

- Automatically assign to the Plan any right to recover payments and any actual recovery from any third party, including any payments the third party makes to you.
- Agree to notify the Plan Administrator when a third party may be liable for any disability covered under the Plan. You further agree to notify the Plan Administrator within 30 days of making any claim relating to that third party's claim. Failure to notify the Plan Administrator will suspend benefit payments for the applicable sickness or injury. Such suspension will be lifted when you sign the agreement discussed below.
- Agree to repay to the Plan the benefits and/or expenses paid on your behalf out of any recovery made from the third party.
- Agree to hold any money received from a third party in trust for the benefit of the Plan and to distribute the proceeds to the Plan upon demand by the Plan.
- Recognize the Plan's right to recover its payment for expenses from the third party who caused and/or is liable for the disability related to the benefit payments.
- Agree to execute and deliver such instruments as may be required by the Plan and to do whatever is necessary to secure the Plan's right of reimbursement.
- Agree to cooperate fully with the Plan in collecting from the person who caused the disability. (If a claim is settled without protecting the Plan's interests, your rights to full compensation may be lost.)
- Agree that no settlement proceeds will be distributed unless and until the Plan's interest has been paid to the satisfaction of the Plan's fiduciaries.
- Agree to refrain from any action or inaction that may prejudice the Plan's ability to obtain recovery.

After you notify the Plan Administrator that a third party may be liable for expenses, or if the Plan Administrator believes a third party may be completely or partially liable for your disability, the Plan will require you to sign statement evidencing your agreement with these provisions and to cooperate with the Plan Administrator in pursuing its reimbursement rights

The Plan has a first-priority lien on any amount you recover from a third party, including a right to any property to which the original recovery is converted. The Plan is granted this right of first reimbursement from all recoveries from a third party (whether by litigation, arbitration, settlement of a claim, or otherwise), however the recovery is designated (e.g., as payment for expenses). This right of recovery is primary, even if you are not made whole (i.e., compensated in full). The Plan's reimbursement rights apply to any benefits paid or payable by the Plan on your behalf as a result of any sickness or injury that was caused by an act or omission of a third

party and to the Plan's expenses to enforce its rights under this section. This first-priority lien and right of reimbursement shall remain in effect until the Plan is repaid in full or until the claim is settled by the Plan fiduciary.

If you do not reimburse the Plan from any settlement, judgment, or insurance proceeds, or otherwise do not fully cooperate with the Plan's attempts to make a recovery, the Plan may reduce the amount payable to or on your behalf for current or future benefits until the Plan has been fully reimbursed. If you recover amounts from the third party that exceed the benefit payments already made by the Plan, the Plan may reduce its payment of future expenses for the applicable sickness or injury by the excess. In the event the Plan makes total payments that exceed the maximum amount to which you are entitled, the Plan shall have the right to recover the excess amount from persons to, or for, or with respect to whom, such excess payments were made, including, but not limited to, withholding payments otherwise available under the Plan. The Plan also reserves the right to bring legal action to obtain such reimbursement.

The Plan has a right to reimbursement for any legal fees it expends in exercising its right to reimbursement. Also, the recovery rights of the Plan outlined in this provision will be reduced by an amount representing the Plan's agreed-upon share of any costs or attorney's fees you incurred in obtaining compensation.

No Waiver of Rights

If the Plan Administrator fails to exercise any of its rights under the Plan, the failure to exercise any right, or the failure to require you to perform any obligations described in the Plan, will not be deemed a waiver of the right. The failure of the Plan Administrator to exercise its right will not prevent the Plan Administrator from exercising the right or requiring you to perform at any later time, and will not result in a waiver of its rights with respect to a subsequent event.

Your Rights Under ERISA

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the United States Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan documents and other Plan information on written request to the Plan Administrator. You may be charged for the cost of duplicating 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.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes certain duties on the people responsible for

the operation of the Plan. The people who operate the Plan, called fiduciaries, 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 or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For example:

1. If you request 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.
2. If your claim for benefits is denied or ignored in whole or in part after a final review, you may file suit in a state or federal court.
3. If the fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the United States Department of Labor or file suit in federal court.
4. If you file a suit against the Plan, the court will decide who should pay court costs and legal fees. If you win your suit, the court may order the person you have sued to pay the court costs and legal fees. If you lose your suit, the court may order you to pay the costs and a fee if, for example, the court decides your suit was 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, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

General Plan Information

The name of the Plan:

Banner Long-Term Disability Plan under the Banner Health Master Health and Welfare Benefits Plan

Plan Sponsor

Banner
c/o BPA Operations Compliance
525 W. Brown Road
Mesa, AZ 85201
800-827-2464
480-684-7070 (in the Phoenix-metropolitan area)

Employer Identification Number

45-0233470

Plan Identification Number:

500

The fiscal year-end:

December 31

(For purposes of maintaining the Plan's financial records.)

Plan Funding

Self-funded, with benefits paid from the general assets of Banner

Plan Administrator

Banner Plan Administration
c/o BPA Operations Compliance
525 W Brown Road
Mesa, AZ 85201
800-827-2464
480-684-7070 (in the Phoenix Metro area)

(Legal process may be served upon the Plan Administrator at the above address.)

Claims Administrator

Banner Plan Administration
Attn: ABSENT8
P.O. Box 16846
Mesa, AZ 85211-6846
1-888-227-3688, or
480-684-7000 (in the Phoenix Metro area)

Appeals Administrator

Appeals and Grievance Committee

P.O. Box 16423 6th Floor

Mesa, AZ 85211-6423

480-684-7070 **INSERT toll-free number if available]**

Glossary/Definitions

The following terms define specific wording used throughout this booklet.

“Active Work or Actively at Work” means any day on which an employee is required to perform and is performing scheduled work duties or an active employee on paid time off (PTO), in accordance with the Employer’s applicable personnel policies.

“Base Pay or Base Rate of Pay” means your fixed hourly rate of pay but does not include additional pay such as overtime, incentive pay, bonuses etc

“Close Relative” means you, your parents, grandparents, siblings, child or grandchild, your spouse; and the spouse of a close relative irrespective of his or her profession or employment.

“Disability” or “Disabled” means an injury or sickness of permanent or long continued duration which, directly, and independently of other injury or sickness, completely prevents you from engaging in **any** occupation **without** regard to your skill, experience, training or education. For LTD eligibility, you must have qualified for short-term disability benefits or workers’ compensation benefit for the first 182 consecutive days of your disability.

“ERISA” means the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

“Full-Time Employee” A full-time (FA) budgeted position of 64 or more hours during pay cycle (two week period of time). All other employment classifications other than Part-Time Employee are excluded, which includes Pay In Lieu, Per-Diem, Registry, Weekend Staffing, Travelers, Leased Employees and all other non-benefit eligible positions.

”Health Care Provider” means a Medical Doctor (M.D.), Doctor of Osteopathy (DO), Doctor of Podiatry (D.P.M.) or Dentist (D.D.S. or D.M.D) licensed to practice in the locality where services are rendered and practicing within the scope of his/her license. The term “health care provider” includes a licensed Clinical Psychologist, Physician’s Assistant (P.A.) and a Nurse Practitioner (N.P.). The term health care provider shall not include any person who is a close relative of yours.

“Illness” is bodily sickness or disease.

“Injury” A bodily injury resulting directly from an accident and independently of all other causes. An injury must occur and disability must begin while you are a participant under the Plan.

“Inpatient” means treatment in CMS approved facility during that period when charges are made for room and board.

“Mental Disorder” means a mental, nervous, behavioral, alcohol or drug-related condition as referenced according to the Official Disability Guide, published by the Work Loss Data Institute.

“Part-Time Employee” means a Part-Time (PA) budgeted position regularly scheduled to work 32 hours but not more than 63 hours during a pay cycle (two week period of time). All other employment classifications

other than Full-Time Employee are excluded, which includes Pay In Lieu, Per-Diem, Registry, Weekend Staffing, Travelers, Leased Employees and all other non-benefit eligible positions.

“**Plan**” means all of the benefits and provisions described in this document.

“**Plan Sponsor**” means Banner.

“**Sickness**” means any physical or mental disorder including periods of pregnancy during which a participant is disabled.

“**Subrogation**” means the Plan may take your place (or “stand in your shoes”) in pursuing your legal rights or a legal claim against the third party or your right to any recovery pursued on your behalf by the Plan or anyone else.

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