HEALTH BENEFIT PLAN FOR KANSAS BANKERS ASSOCIATION
SUMMARY PLAN DESCRIPTION
(Non-Grandfathered)

The Summary Plan Description is an important document that tells you what the Plan provides and how it operates. It provides information on when you can begin to participate in the Plan, when and in what form benefits are paid, and how to file a claim for benefits.

This Document and the relevant Certificate(s) of Insurance (and any Schedule(s) of Benefits) together comprise the Summary Plan Description of the below-mentioned Plan. Copies of the Certificate(s) of Insurance (and any Schedule(s) of Benefits) are available at www.bcbsks.com. Paper versions of the Certificate(s) of Insurance (and any Schedule(s) of Benefits) are available upon request, without charge.

General Information

Plan Name: Health Benefit Plan for Kansas Bankers Association

Plan Sponsor: Kansas Bankers Association
610 SW Corporate View
Topeka, Kansas 66615

You may request information as to whether a particular employer contributes to the Plan, and, if so, that employer's address. The complete list of Participating Employers is also available to you, at no charge, upon written request to the Plan Administrator, and is available for examination at the office of the Plan Administrator.

Employer Identification Number (EIN): 48-0937602

Plan Number: 503

Plan Year: August 1 to July 31

Welfare Benefit Plan Type: Group Health and Dental

Plan Administration:

Type of Plan Administration:	Insurer Administration
Name of Plan Administrator:	Kansas Bankers Association
Address of Plan Administrator:	610 SW Corporate View Topeka, Kansas 66615
Phone Number of Plan Administrator:	785-232-3444

Name and Address of Person Designated as Agent for Service of Legal Process:

Edward L. Griffith
Vice President, Employee Benefits
Kansas Bankers Association
610 SW Corporate View
Topeka, Kansas 66615

Sources of Contributions to the Plan: A combination of employee and Participating Employer contributions.

Plan Funding Medium: The Kansas Bankers Association Welfare Benefit Fund (the "Trust Fund") is comprised of contributions made by employees, contributions made by Participating Employers, insurance contracts, investment income, and all other money or property received and held by the Trustee. The Trust Fund is maintained to pay premiums for group insurance, as well as other expenses connected with the administration of the Plan. Group health and dental benefits are underwritten and insured by Blue Cross Blue Shield of Kansas, 1133 Topeka Boulevard, Topeka, Kansas.

Name and Address of the Trustee:

Eric Stofer
Chief Financial Officer
Kansas Bankers Association
610 SW Corporate View
Topeka, Kansas 66615

Eligibility for Participation and Benefits: Each active employee working _____ or more hours per week for _____ (name of Employer). Coverage is effective on the first day of the month following _____.

Qualified Medical Child Support Orders: Participants and beneficiaries may obtain from Blue Cross Blue Shield of Kansas, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Orders (QMCSOs).

Group Medical and Dental Benefits: Please refer to your Certificate of Insurance for the following information:

- A description of the Plan's benefits;
- A description of any cost-sharing provisions (such as premiums, deductibles, coinsurance, and copayment amounts) for which the participant or beneficiary will be responsible;
- Any annual or lifetime caps or other limits on benefits under the Plan;
- The extent to which preventive services are covered under the Plan;
- Whether and under what circumstances existing and new drugs are covered under the Plan;
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures;
- Provisions governing the use of network providers;
- The composition of the provider network, and whether and under what circumstances coverage is provided for out-of-network services;
- Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care;
- Any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefits or service under the Plan; and
- A description of the Plan's provider network. *Provider lists are furnished automatically, without charge, as a separate document.*

Loss or Reduction of Plan Benefits: Please refer to your Certificate of Insurance for a description of the circumstances which may result in disqualification, ineligibility, or the denial, loss, forfeiture, suspension, offset, reduction, or subrogation of benefits.

The Plan Sponsor's Right to Terminate the Plans, or Amend or Eliminate Plan Benefits: The Plan Sponsor has the right, under the terms of the Plan, to modify or amend the Plan at any time. Any modification shall be effective as of the date of the amendment, or at such later date as the Plan Sponsor shall determine. The Plan Sponsor also has the right to terminate the Plan at any time. Termination of the Plan shall be binding on all participants and any Participating Employer. The Certificate of Insurance will disclose any Plan provisions governing the benefits, rights and obligations of participants and beneficiaries upon plan termination or the amendment or elimination of benefits under the Plan. To the extent applicable, the Certificate of Insurance will disclose any situations where the receipt of benefits is conditioned on the imposition of a fee or charge on a participant or beneficiary.

COBRA Continuation Coverage: Please refer to your Certificate of Insurance for a description of the Plan's provisions relating to COBRA continuation coverage.

Claims and Appeals Procedures: Please refer to your Certificate of Insurance for a description of the Plan's claims and appeals procedures.

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

ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- 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 make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- A reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificates of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or is you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries: In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, 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 you 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 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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 you telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, 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.