SUMMARY OF MATERIAL MODIFICATIONS
to the
INGREDION INCORPORATED
MASTER WELFARE AND CAFETERIA PLAN

TO: All Participants in and Beneficiaries of the Ingredion Incorporated Master Welfare and Cafeteria Plan (the "Plan")

FROM: The Plan Administrator

Date: April 1, 2018

The purpose of this Summary of Material Modifications ("SMM") is to notify you of changes which have been made to the Plan, effective as of the date provided below. This SMM modifies the information contained in your Summary Plan Description ("SPD").

The following Appendix C of the SPD is amended and replaced with the attachment hereto:

APPENDIX C
CLAIMS PROCEDURES

The procedures for filing claims under the plans are governed by the Employee Retirement Income Security Act of 1974 (ERISA). These procedures are described below.

FORMAL CLAIMS PROCEDURES

If you believe that you are entitled to benefits under a plan, then you must submit your claim in accordance with the Master Welfare Plan's claims procedures as described in this Appendix C. The insurance company or third party administrator for the applicable plan reviews all claims under a plan and is referred to as the "claims administrator" for your plan.

Claims procedures may also be described in the summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary provided by the insurance company or third party administrator for each benefit plan (which are described in Appendix D). When submitting a claim, you must follow the claims procedures described in such documents, in addition to the claims procedures described below. If there is any conflict between the claims procedures in this SPD and the claims procedures in the applicable summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary, the claims procedures in such benefit summary will govern unless the procedures are contrary to applicable law.

In all cases, you must follow the formal claims procedures when submitting a claim and before initiating a lawsuit or any other proceeding with regard to your claim under a plan.

INITIAL CLAIM

If you believe that you are entitled to benefits, then you must submit your claim in writing (or orally, if your claim is an ***urgent care claim*** under the Medical Plan, Dental Plan or Vision Plan) to the claims administrator at the address provided in Appendix A.

If your claim for benefits is denied, either in full or in part, then the claims administrator will send you a written or electronic notice within a reasonable period of time after receiving your claim, not to exceed the following time limits:

- 72 hours for ***urgent care claims*** under the Medical Plan, Dental Plan or Vision,
- 15 days for ***pre-service claims*** under the Medical Plan, Dental Plan or Vision Plan,
- 30 days for ***post-service claims*** under the Medical Plan, Dental Plan or Vision and claims under the Spending Accounts,
- 45 days for disability benefit claims, or
- 90 days for life and accident benefit claims.

If the claims administrator determines that it requires an extension of time to review your claim due to special circumstances (for life and accident benefit claims) or that an extension of time is necessary due to matters beyond the control of the plan (for medical, dental, vision and disability benefit claims), then you will be notified in writing of the required extension within the initial time limit, and the additional extension period will not exceed the following time periods:

- 15 days for medical, dental, vision or Spending Account claims (and no extension is allowed for ***urgent care claims***),
- two 30-day extensions for disability claims, or
- 90 days for life and accident benefit claims.

Any notice of extension will describe the circumstances requiring the extension and the expected date by which the claims administrator will make its determination.

Your denial notice will contain the specific reason(s) for the denial, references to the pertinent plan provisions on which the decision is based, and a description of any additional information or material needed to support your claim and why the additional information or material is necessary. The notice will also provide a description of the plan's appeal procedures and the time limits applicable to those procedures, including the expedited review process for an ***urgent care claim*** and a statement that you have a right to bring a civil action under section 502(a) of ERISA with respect to your claim (after you have completed the formal claim and appeal process described in this Appendix C).

Additionally, if the claims administrator makes an adverse benefit determination with respect to a benefit claim under the Medical Plan, Dental Plan, Vision Plan or Health Care Spending Account, then the notice of denial from the claims administrator will provide (1) a reference to any internal rule, guideline, protocol or similar criterion which it relied upon in making an adverse determination (or a statement that such criterion will be provided free of charge upon request) and (2) if the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances (or a statement that such explanation will be provided free of charge upon request). In addition to the above, if the claims administrator makes an adverse benefit determination with respect to a disability benefit claim, then the notice of denial from the claims administrator will also provide (1) a discussion of the decision, including an explanation of the basis for disagreeing with or not following (A) the views presented by you to the plan of health care professionals treating you and vocational professionals who evaluated you, (B) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the decision, and (C) a Social Security Administration determination presented by you to the plan; and (2) a statement that you are entitled to reasonable access to, and copies of, all documents, records and other information relevant to your claim. Such notice will be written in a manner calculated to be understood by you. Notification of the denial of a disability benefits claim will be provided to you in a culturally and linguistically appropriate manner (to the extent required by the regulations under section 503 of ERISA).

You may have an authorized representative pursue your benefit claim on your behalf. If you have an ***urgent care claim*** under the Medical Plan, Dental Plan or Vision Plan, a health care professional with knowledge of your medical condition will also be permitted to act on your behalf with respect to your claim.

Special Procedures Related to Claims Under the Medical Plan, Dental Plan, Vision Plan and Health Care Spending Account

For ***urgent care*** and ***pre-service claims***, you will be notified of the claims administrator's determination, regardless of whether the claim is approved or denied. For ***post-service claims***, you will be notified only if your claim is denied. You may be notified orally of the claims administrator's determination of your ***urgent care claim***. A written or electronic notification will be furnished to you within 3 days after the oral notification.

The term "**urgent care claim**" means any claim for medical care or medical treatment which, unless special time periods for making urgent care determinations were applied:

- Could seriously jeopardize your life or health or your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

An individual acting on behalf of the plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, can determine whether the claim is an ***urgent care claim***. However, if a physician with knowledge of your medical condition notifies the claims administrator that any claim is an ***urgent care claim***, then the claim will be treated as an ***urgent care claim***.

The term "**pre-service claim**" means a claim for a benefit with respect to which the plan conditions receipt of the benefit, in

whole or in part, on approval of the benefit before a person receives medical care.

The term "**post-service claim**" means any claim that is not a ***pre-service claim*** or ***urgent care claim***. ***Post-service claims*** generally involve only the payment or reimbursement of cost for medical care already provided.

If the claims administrator determines that your ***urgent care claim*** does not contain sufficient information to make a determination, then the claims administrator will notify you as soon as possible, but no later than 24 hours after receipt of your claim, of the specific information necessary to complete your claim. In such case, you will be provided a reasonable amount of time, not less than 48 hours, to provide the necessary information. The claims administrator will provide you with its determination of your ***urgent care claim*** as soon as possible, but no later than 48 hours after the earlier of (i) its receipt of the specified information and (ii) the end of the period given to you to provide the additional required information.

If the claims administrator determines that your ***pre-service claim*** has been improperly filed[1], then the claims administrator will notify you, and will provide you with information about the proper procedures for filing your claim, as soon as possible but no later than 5 days after receipt of your claim (or within 24 hours in the case of a failure to file a claim involving urgent care). This notification may be oral, unless you specifically request a written notification.

If an extension of time is required to review your ***pre-service claim***, ***post-service claim***, or Heath Care Spending Account claim due to the fact that you have not submitted required information, then the notice of extension will describe the additional information that is required and you will be given at least 45 days from receipt of the notice to provide the specified information.

If a plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination by the plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall be treated as a claim denial. The claims administrator shall notify you of such determination sufficiently in advance of the reduction or termination to allow you time to appeal the denial and obtain a determination on your appeal before the course of treatment is reduced or terminated.

If you submit a claim that is an ***urgent care claim*** requesting to extend an approved course of treatment beyond the initially prescribed period of time or number of treatments, then the claims administrator will respond to your claim within 24 hours of receipt, provided that the claim is submitted at least 24 hours before the expiration of the originally approved period.

Special Procedures Related to Disability Benefits Claims

If an extension is required to review a involving a disability determination (including any claim under the Long Term Disability Plan), the notice of extension will explain the standards on which entitlement to benefit is based, the unresolved issues that prevent a decision on your claim and the additional information needed to resolve the issues. In such case, you will be given at least 45 days to provide the specified information.

APPEAL WITH CLAIMS ADMINISTRATOR

If your claim is denied and you want to pursue your claim further, then you (or your authorized representative) must request a full and fair review of your denied claim by filing a written appeal (or oral appeal, if your claim is an ***urgent care claim*** under the Medical Plan, Dental Plan or Vision Plan) with the claims administrator within 60 days after you receive a denial notice (180 days in the case of a claim for medical, dental, vision, disability, or Spending Account benefits). Your appeal should be filed at the address

[1] This provision only applies to a failure that (1) is a communication by you or an authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters, and (2) is a communication that names you, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

provided for the appropriate claims administrator in Appendix A.

Your appeal may include any additional information to support your claim, including any written comments, documents, records or other information you wish to have considered (regardless of whether such information was submitted in your initial claim) with your written request for review. As part of your appeal, you, your representative or your beneficiary have the right to request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. The claims administrator has full responsibility and authority to review your claims.

You will receive written or electronic notification of the decision on your appeal within a reasonable period of time after the claims administrator receives your request for review of your claim denial, not to exceed the following time limits:

- 72 hours for appeals of ***urgent care claims*** under the Medical Plan, Dental Plan or Vision Plan,
- 30 days for appeals of ***pre-service claims*** under the Medical Plan, Dental Plan or Vision Plan (or 15 days if the claims administrator provides a second level of appeal),
- 60 days for appeals of ***post-service claims*** under the Medical Plan, Dental Plan or Vision Plan (or 30 days if the claims administrator provides a second level of appeal),
- 45 days for disability appeals,
- 60 days for appeals under the Spending Accounts, or
- 60 days for life or accident benefit appeals.

If the claims administrator determines that additional time is needed to review your appeal due to special circumstances, you will receive a written or electronic notice (within the initial time period) advising you that additional time is needed, not to exceed the following time periods:

- 45 days for disability claims or
- 60 days for life and accident benefit claims.

Extensions will not, however, be available to the claims administrator for appeals under the Medical Plan, Dental Plan, Vision Plan or Spending Accounts. Any notice of extension will describe the circumstances requiring the extension and the expected date by which the claims administrator will make its determination. If the reason for the extension of time is your failure to provide necessary information, then the time frame for making a benefit determination is stopped from the date the claims administrator sends you an extension notification until the date you respond to the request for additional information.

If your appeal is denied, either in full or in part, then the notice of denial will contain the specific reason(s) for denial with references to the pertinent plan provisions on which the denial is based and any additional information or material required to appeal the claim further (if an additional appeal is allowed). The notice will also state that (1) you have a right to bring a civil action for benefits under section 502(a) of ERISA (after you have completed the formal claim and appeal process described in this Appendix C) and (2) 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.

Additionally, if the claims administrator denies your appeal under the Medical Plan, Dental Plan, Vision Plan, Long Term Disability Plan or Health Care Spending Account, then the notice of denial from the claims administrator will provide (1) a reference to any internal rule, guideline, protocol or similar criterion which it relied upon in making an adverse determination (or a statement that such criterion will be provided free of charge upon request) and (2) if the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances (or a statement that such explanation will be provided free of charge upon request). In addition to the above, if the claims administrator denies your appeal with respect to a disability benefit claim, then the notice of denial from the claims administrator will also provide (1) a discussion of the decision, including an explanation of the basis for disagreeing with or not following (A) the views

presented by you to the plan of health care professionals treating you and vocational professionals who evaluated you, (B) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the decision, and (C) a Social Security Administration determination presented by you to the plan. Such notice will be written in a manner calculated to be understood by you. Notification of the denial of a disability benefits claim will be provided to you in a culturally and linguistically appropriate manner (to the extent required by the regulations under section 503 of ERISA).

Special Procedures Related to Appeals under the Medical Plan, Dental Plan, Vision Plan, and Health Care Spending Account, and Appeals of Disability Benefit Claims

The following procedures will apply to appeals under the Medical Plan, Dental Plan, Vision Plan, and Health Care Spending Account, and to any appeals of disability benefit claims (including under the Long Term Disability Plan):

- Your appeal will be reviewed by someone of the plan who is neither the individual who made the original adverse benefit determination with respect to your claim, nor a subordinate of such individual (the "Reviewer").
- The Reviewer will not give deference to the initial adverse decision on your claim.
- With respect to any benefit determination that is based, in whole or in part, on medical judgment, the Reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither an individual who was consulted in connection with the original adverse benefit determination with respect to your claim, nor a subordinate of such individual.
- Any expert whose advice was obtained in connection with the adverse determination of your benefit claim will be identified, regardless of whether the advice was relied upon in making the determination with respect to your claim.

If an appeal is made with respect to the denial of an ***urgent care claim***, then you may request, either orally or in writing, an expedited review of your appeal. All necessary information (including the benefit determination) will be transmitted to you by telephone, facsimile or other available similarly expeditious method.

ADDITIONAL STANDARDS RELATED TO APPEALS UNDER THE MEDICAL PROGRAM

The following standards apply only to appeals under the Medical Plan for health care benefits only.

As part of your appeal, in addition to the rights described above, (1) you, your representative or your beneficiary also have the right to review the claim file and to present evidence and testimony and (2) the right to receive, free of charge, (A) any new or additional evidence considered, relied upon or generated by the claims administrator in connection with the claim and (B) any new or additional rationale. Such new or additional evidence or rationale, as applicable, will be provided to you as soon as possible and sufficiently before the final internal claim denial is due.

If your appeal is denied, either in full or in part, then the notice of denial will contain the following additional information:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
- A description of the reason(s) for the denial, including the denial code and its corresponding meaning, as well as a description of the claim administrator's standard, if any, that was used in denying the claim. In the case of a final internal claim denial, this description will also include a discussion of the decision.
- A description of the available internal appeals and external review procedures, including information on how to initiate an appeal.

- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist you with the internal claims and appeals and external review process.

Deemed Exhaustion of Internal Claims and Appeals Process

In the event that the claims administrator does not comply with the internal claims and appeals procedures, as outlined above, you will be deemed to have exhausted the internal claims and appeals process and may immediately initiate an external review (as described below). You will also be entitled to pursue any available remedies under section 502(a) of ERISA or under state law. Notwithstanding the foregoing, the internal claims and appeals process will not be deemed to be exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the claims administrator demonstrates that the violation was for good cause or due to matters beyond the control of the claims administrator and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the claims administrator. This exception is not available if the violation is part of a pattern or practice of violations by the claims administrator. You may request a written explanation of the violation from the claims administrator, and such explanation will be provided to you within ten days and will include a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals procedures to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review on the basis that the program met the above-stated standards for the exception to apply, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten days), the claims administrator will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. The time period for re-filing the claim will begin to run upon your receipt of such notice.

STANDARD EXTERNAL REVIEW PROCESS

The following standards only apply to appeals (other than appeals involving eligibility) under the Medical Plan for health care benefits (1) that involve ***medical judgment***, as determined by an external reviewer, or (2) a ***rescission of coverage***.

> The term "**medical judgment**" includes, but is not limited to, determinations based on requirements for medical necessity, appropriateness of care, health care setting, level of care, effectiveness of a covered benefit or determinations as to whether a treatment is experimental or investigational.

> The term "**rescission of coverage**" means any retroactive termination of medical care coverage, except where an individual (or a person seeking coverage on behalf of the individual) either (i) performs an act, practice or omission that constitutes fraud, (ii) makes an intentional misrepresentation of material fact, or (iii) fails to timely pay required premiums or contributions towards the cost of coverage.

Request for External Review

You may file a request for an external review with the claims administrator provided that your request is filed within four months after the date you receive a denial notice. If there is not a corresponding date four months after the date the claims administrator receives your notice, then you must file the request by the first day of the fifth month following the claim administrator's receipt of the notice.

Preliminary Review

Within five business days following the receipt of the external review request, the claims administrator will complete a preliminary review of the request to determine whether (1) you or your beneficiary are (or were) covered under the Medical Plan at the time that the health care item or service was requested or, in the case of a retrospective review, was covered under such

program at the time the health care item or service was provided; (2) the claim denial does not relate to your or your ***family member's*** failure to meet the requirements for eligibility under the terms of the Medical Plan, (3) you have exhausted the program's internal appeal process (unless you are not required to do so due to the claims administrator's failure to comply with the internal claims and appeals procedures and such failure did not fall under one of the deemed exhaustion exceptions) and (4) you have provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, you or your representative will be issued a written notification. If your request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If your request is not complete, such notification will describe the information or materials needed to make the request complete and you will be allowed to perfect your request for external review within the four month filing period or within the 48 hour period the following the receipt of the notification, whichever is later.

Referral to an Independent Review Organization

Upon a determination that your request is eligible for external review following the preliminary review, the claims administrator will assign your claim to an accredited internal review organization ("IRO"). The assigned IRO will timely notify you in writing of your request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review.

Within five business days after the date of assignment to the IRO, the claims administrator will provide to the assigned IRO documents and any information considered in denying your claim. Failure by the claims administrator to timely provide the documents and information will not delay the conduct of the external review. If the claims administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse your claim denial. The IRO will notify you within one business day after making the decision.

Upon receipt of any information submitted by you, the assigned IRO will, within one business day, forward the information to the claims administrator. Upon receipt of any such information, the claims administrator may reconsider its denial of your claim that is the subject of the external review. Reconsideration by the claims administrator will not delay the external review. The external review may be terminated as a result of the reconsideration only if the claims administrator decides, upon completion of its reconsideration, to reverse its claim denial and provide you with coverage or payment. Within one business day after making such a decision, you will be provided written notice and the assigned IRO will terminate the external review.

The IRO will review all information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and will not be bound by any decisions or conclusions reached during the internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by you, the claims administrator, or your treating provider;
- The terms of the Medical Plan to ensure that the IRO's decision is not contrary to the terms of the program, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;

- Any applicable clinical review criteria developed and used by the claims administrator, unless the criteria are inconsistent with the terms of the Medical Plan or applicable law; and
- The opinion of the IRO's clinical reviewer or reviewers after considering the information described above to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned IRO will provide you with written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date(s) of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or Federal law to either you or the Medical Plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

COMPLIANCE WITH INDEPENDENT REVIEW ORGANIZATION DECISION

Upon the IRO's decision to reverse the claim administrator's claim denial, you will promptly receive coverage or payment for that claim.

EXPEDITED EXTERNAL REVIEW PROCESS

Request for Expedited External Review

You may request an expedited external review if you receive:

- A denial of a claim involving a medical condition for which the timeframe for completing an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed an expedited internal appeal request; or
- A final denial of a claim involving (1) a medical condition where the timeframe for completing a standard external review would seriously jeopardize your life or health or your ability to regain maximum function, (2) an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of request for expedited external review, the claims administrator will determine whether the request meets the reviewability requirements as set forth above for standard external review. You will receive a notice regarding the claim administrator's reviewability assessment. This notice will contain the same information that would be provided under a standard external review notice.

Referral to an IRO

Upon a determination that your request is eligible for external review following the preliminary review, the claims administrator will assign your claim to an IRO (using the process set out above for a standard external review). The claims administrator will provide or transmit all necessary documents and information considered in denying your claim to the assigned IRO electronically or by telephone

or facsimile or any other available expeditious method.

The IRO will consider the information or documents listed above under the procedures for standard review, to the extent the information or documents are available. In reaching its decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusion reached during the internal claims and appeals process.

The assigned IRO will provide you with notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide you with written confirmation of the decision. The notice will contain the same information that applies in the context of standard external review.

ADDITIONAL APPEAL WITH CLAIMS ADMINISTRATOR

Some claims administrators have a second level of appeal. Consult the summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary provided by the claims administrators for each benefit plan (described in Appendix D) to determine whether the claims administrator requires a second level of appeal. If a second level of appeal is required, it will follow the same general procedures as outlined above under the heading "Appeal with Claims Administrator."

EXHAUSTION OF CLAIMS PROCEDURES

You must follow and exhaust the claims and appeals procedures described in this Appendix C (including any claims procedures described in your summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary, which are incorporated by reference into this document) before you can file a lawsuit, seek arbitration or begin any other proceeding with regard to your claim for benefits under any plan described in this SPD.Arbitration or Mediation

Some of the plans may have procedures regarding the submission of your claim to arbitration or mediation after the claims procedures described in this Appendix C are exhausted. Please consult your summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary to determine whether arbitration is required or provided under a specific plan.

STATE LAW PREEMPTION

Nothing in this Appendix C shall be construed to supersede any provision of State insurance laws, except to the extent that such laws prevent the application of the provisions in this Appendix C.