CBE COMPANIES, INC.

Short-Term Disability Summary Plan Description
7670-03-411755

BENEFITS ADMINISTERED BY

UMR℠

A UnitedHealthcare Company

Table of Contents

CBE COMPANIES, INC.

GROUP SHORT-TERM DISABILITY BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You with summary information on Your short-term disability benefits, along with information on Your rights and obligations under this Plan. As a valued Employee of CBE COMPANIES, INC., we are pleased to provide You with benefits that can help meet Your need for temporary income support during Your period of disability.

CBE COMPANIES, INC. provides short-term disability benefits for eligible Employees who become Disabled, as defined in this document, due to an Illness or Injury.

CBE COMPANIES, INC. is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of an independent Third Party Administrator, UMR Inc., hereinafter "UMR", to process claims and handle other duties for this self-funded Plan. UMR as Third Party Administrator, does not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of its general assets. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA) and its amendments.

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan and most will be listed in the Glossary of Terms. Other capitalized terms are defined within the provision the term is used. When reading this document, please refer to the Glossary of Terms. Becoming familiar with the terms defined in the Glossary will help You better understand the provisions of this group short-term disability Plan.

The requirements for being covered under this Plan, the provisions concerning eligibility for and termination of coverage, maximum Disability benefits, the procedures to be followed in submitting claims for benefits and remedies available for appeal of claims denied are outlined in the following pages of this document. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions.

This document becomes effective on May 1, 2014.

PLAN INFORMATION

Plan Name	CBE COMPANIES, INC. GROUP SHORT-TERM DISABILITY BENEFIT PLAN
Name And Address Of Employer	CBE COMPANIES, INC. 1309 TECHNOLOGY PKWY CEDAR FALLS IA 50613
Name, Address And Phone Number Of Plan Administrator	CBE COMPANIES, INC. 1309 TECHNOLOGY PKWY CEDAR FALLS IA 50613 319-833-1015
Named Fiduciary	CBE COMPANIES, INC.
Employer Identification Number Assigned By The IRS	46-2116941
Plan Number Assigned By The Plan Sponsor	502
Type Of Benefit Plan Provided	Self-Funded Plan providing Short-Term Disability Benefits
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments.
Name And Address Of Agent For Service Of Legal Process	CBE COMPANIES, INC. AND ITS SUBSIDIARIES 1309 TECHNOLOGY PKWY CEDAR FALLS IA 50613
Funding Of The Plan	Employer Contributions Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer.
Benefit Plan Year	Begins on January 1 and ends on the following December 31.
ERISA And Other Federal Compliance	It is intended that this Plan meet applicable legal requirements. In the event of a conflict between this Plan and applicable laws, provisions of law shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrator for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrator shall be subject to review only if it is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrator shall be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement to the limited standard and scope of review described by this section. Accepting any benefits or making any claim for benefits under this Plan means that You consent to the limited standard and scope of review afforded under law.

BENEFIT CLASS DESCRIPTION

The Covered Person's benefit class is determined by the designations shown below:

Class	Class Description	Benefit Plan
A01	ALL EMPLOYEES	001

LOCATION DESCRIPTION

Location	Description	Billing Division	Reporting Sub
010	CBE COMPANIES, INC. - WATERLOO 1309 TECHNOLOGY PKWY CEDAR FALLS IA 50613	010	0010
014	CBE COMPANIES, INC. - OVERLAND PARK 1309 TECHNOLOGY PKWY CEDAR FALLS IA 50613	014	0014
015	CBE COMPANIES, INC. 1309 TECHNOLOGY PKWY CEDAR FALLS IA 50613	015	0015
100	CBE COMPANIES, INC. - OFFSITE 1309 TECHNOLOGY PKWY CEDAR FALLS IA 50613	100	0100

SCHEDULE OF BENEFITS

Benefit Plan 001

Short-Term Disability Benefits (Employee Only)

WEEKLY DISABILITY BENEFIT

Total Disability	60 Percent of Weekly Earnings, up to $1,200.00 maximum per week.
Maximum Benefit Period Per Disability	13 weeks

Disability benefits are calculated on a 7-day workweek basis. When benefits are payable for less than a full week, benefits shall be calculated on 1/7th of the Disability benefit for each day of Illness or Injury.

BENEFIT WAITING PERIOD

Benefit Waiting Period is included in the maximum benefit period.

Benefits for eligible Employees begin on:

- The 15th day of the Disability due to Injury. This Plan has a calendar day Benefit Waiting Period for an Injury.
- The 15th day of the Disability due to Illness. This Plan has a calendar day Benefit Waiting Period for an Illness.

If the Employee works less than four hours in a day, the Plan will apply that day toward satisfaction of the Benefit Waiting Period if the time off is related to the Disability and the Employee is deemed Totally Disabled on that day. If the Employee works four or more hours in a day, the Plan will not consider that day toward satisfaction of the Benefit Waiting Period.

BENEFIT DEDUCTIONS OR OFFSETS

An order imposed by a court of law which requires that the Plan pay benefits to a third party, including court orders providing for support of a child, spouse or former spouse. Your benefit will also be offset by actions taken by government agencies, including the IRS, to collect amounts due or any other garnishment or similar collection action brought against the Plan.

Your Disability benefit will be offset by:

- Any amount the Employee receives from state temporary Disability benefits in California.

You may be required to submit written documentation.

BENEFIT INCREASE/DECREASE

If Your weekly benefits change (increase or decrease) as a result of a Plan change during Your Disability, the change will be effective the date You return to work.

HOLIDAYS AND VACATIONS

The Plan continues to pay Disability benefits to You through a paid holiday scheduled by Your employer.

If You choose to take paid vacation time while You are receiving Disability benefits, You may do so and also receive Your Disability benefit.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan document. The Plan may request documentation from You in order to make these determinations. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

ELIGIBILITY WAITING PERIOD

If You are eligible, You must complete an eligibility Waiting Period before coverage becomes effective. The eligibility Waiting Period is a period of time that must pass before You become eligible for coverage under the terms of this Plan.

You are eligible for short-term disability coverage on the date listed below under the Effective Date section, upon completion of one year of continuous, full-time active employment immediately prior to Your eligibility date.

The start of Your eligibility Waiting Period is the date of hire for the job that made You eligible for coverage under this Plan.

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee Actively at Work and regularly works full time 30 or more hours per week, but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Temporary or leased employees.
- An Independent Contractor who signs an agreement with the employer as an Independent Contractor or other Independent Contractors as defined in this document.
- A consultant who is paid on other than a regular wage or salary by the employer.
- A member of the employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used to determine a person's initial eligibility for coverage under this Plan. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, shall change a person's eligibility for benefits.

ENROLLMENT PROCEDURES

You must enroll within 30 days after You become eligible for Disability coverage under this Plan. It is Your responsibility to make Your enrollment elections on time. Your enrollment elections must be made in the form and manner provided by Your employer.

EFFECTIVE DATE OF COVERAGE

Your coverage will become effective on the day immediately following completion of the eligibility Waiting Period, if any, for eligible Employees.

Example: If the plan has a 60 day eligibility Waiting Period, and the member meets the Waiting Period on December 12th. The member would not be eligible for payment until the 1st of the following month. If the member is disabled between December 12th and December 31st, he must meet the definition of Actively at Work under the plan, if it applies, in order to be eligible for payment on the 1st of the following month. If the member does not meet the definition of Actively at Work, he would not be eligible for payment of STD benefits on the Disability that occurred prior to the coverage effective date, even though he did meet the Waiting Period under eligibility.

QUALIFYING FOR BENEFIT DETAILS

This Plan provides You the Disability benefit shown in the Schedule of Benefits beginning after You have been Disabled for the number of days as shown on the Schedule of Benefits (Benefit Waiting Period) and shall continue while You are Disabled, subject to all Plan terms. The Plan does not provide a Disability benefit if You do not satisfy all Plan requirements.

PROOF OF DISABILITY

You must prove that You are Disabled by submitting sufficient documentation to the Plan. The Plan may require You to be examined by a Physician(s) or other medical practitioner(s), at the Plan's expense.

INITIAL DISABILITY DOCUMENTATION

The Plan requires the following documentation when a Disability claim is submitted:

- An attending Physician statement.
- An employer statement.
- An Employee statement and authorization.

DISABILITY REVIEW PROCESS

The Plan can require an examination as often as is reasonable to evaluate Your Disability status. During the period You are receiving Disability benefits, the Plan requires one or any combination of the following to verify Your Disability status:

- Your regular Physician may be asked to submit written verification on a periodic basis.
- Your claim for Disability benefits may be reviewed by a Disability nurse, who may contact You regarding Your claim.
- Your claim for Disability benefits may be referred to an Independent Reviewer. Independent Reviewers are board certified Physicians providing a retrospective review of Your Disability, which includes a review of Your Physician's medical treatment plan. The individual who completes the Independent Review prepares a comprehensive report including a determination of a Disability or non-Disability.
- Your claim for Disability benefits may be referred for an Independent Medical Exam (IME). An Independent Medical Exam is an onsite medical exam performed by an independent Physician to determine an individual's current Disability status.
- Your claim for Disability benefits may be referred to a licensed therapist for a Functional Capacity Exam (FCE). A Functional Capacity Exam includes extensive tests done by a licensed therapist to assess factors that affect a person's ability to perform specific Essential Duties of an occupation and activities of daily living. The FCE is a way to help ensure a safe and successful return to work for the Employee.
- The Plan may conduct various Disability investigations including activity checks, limited continuance of Disability, initial Disability evaluation, pre-existing investigation, home visits, surveillance and/or other activities to verify the status of Your Disability.

DETERMINATION OF DISABILITY BENEFITS

You must meet the Plan's definition of Disability to qualify for Disability benefits. The Plan Administrator or its designee has discretion to determine whether or not You meet the definition of Disability under the Plan. Your Physician does not determine whether You meet the definition of Disability under the Plan.

Total Disability or Totally Disabled means that due to an Illness or Injury, an Employee is:

Wholly and continuously prevented from performing any Duty and all Essential Duties of the Employee's Regular Occupation at this company.

In addition to meeting the Plan's definition of Disability, to be deemed Disabled under this Plan, the Plan also requires that:

- You must be receiving Regular Care from a Physician due to the Illness or Injury; and
- The Physician has deemed You to be Disabled under their clinical standards; and
- The Disability begins while You are covered under this Plan.

FIRST DAY OF DISABILITY

The first day of Your Disability shall be the later of the day after Your last day worked and the first day the Physician deemed You disabled.

ACTIVELY AT WORK

You must be Actively at Work the day before You are deemed Disabled by the Plan.

PERIODS OF DISABILITY

You are eligible to receive only one maximum Disability benefit per Disability whether or not You are Disabled due to more than one Illness or Injury at one time.

DISABILITY DUE TO THE SAME OR RELATED CAUSE

If You have not returned to work, for at least 2 consecutive weeks of full-time work the Plan pays benefits for a Disability as a continuation of a prior Disability that resulted in benefits under the plan. A new Benefit Waiting Period need not be satisfied. The same maximum benefit and benefit period as the prior Disability applies, as shown in the Schedule of Benefits.

If You have returned to work for at least 2 consecutive weeks, You are eligible for a new maximum period of Disability, subject to the maximum Disability benefit as shown in the Schedule of Benefits. A new Benefit Waiting Period must be satisfied.

DISABILITY DUE TO A DIFFERENT OR UNRELATED CAUSE

The Plan pays benefits for a Disability due to a Different or Unrelated Cause as a continuation of a prior Disability if You have not returned to work. The same maximum benefit and benefit period as the prior Disability applies to the continuation, as shown in the Schedule of Benefits. A new Benefit Waiting Period need not be satisfied.

The Plan pays benefits for a Disability that is due to a Different or Unrelated Cause as a new period of Disability if You have returned to work for at least one full day. A new Benefit Waiting Period must be satisfied.

You are eligible for a new maximum period of Disability, subject to the maximum Disability benefit as shown in the Schedule of Benefits.

TERMINATION AND REINSTATEMENT OF DISABILITY BENEFITS

DATE DISABILITY BENEFIT PAYMENTS END

The Plan will stop Disability payments to You on the earliest of the following dates:

- The date You are no longer Disabled as defined in this document.
- If Your employment terminates while You are receiving Disability benefits under this Plan, those benefits will end on the date Your coverage terminates under this Plan.
- The date You die.
- The date You fail to respond to the Plan's Disability review process.
- The date You commit a fraudulent act as set forth in this document.
- At the point in time that You refuse to receive medical treatment that is generally acknowledged by Physicians to cure or improve Your condition so as to reduce its disabling effects.

DATE COVERAGE TERMINATES

Your coverage under this Plan will end on the earliest of:

- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The day of the month in which You are no longer a member of a covered class, as determined by Your employer; or
- The day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan; or
- The date You do not return to work or Your scheduled return date after leave under Family and Medical Leave Act.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Disability coverage will continue according to Your employer's guidelines during an approved leave of absence. The Disability benefit period may be counted as Family and Medical Leave, for those qualifying for Family and Medical Leave as provided by law. Upon return from FMLA leave to active employment, You are entitled to Disability benefits on the same basis as before Your FMLA leave.

REINSTATEMENT OF DISABILITY BENEFITS

An Employee will retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer.

If Your coverage ends due to termination of employment, approved leave of absence or lay-off and You later return to active work, You must meet all requirements of a new Employee. Refer to the information on Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act of 1994 for possible exceptions, or contact Your Human Resources or Personnel office.

Benefits shall be reinstated for individuals who serve in the military services upon reemployment in accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA). Reinstated benefits shall not take into account the military absence and cannot be subject to eligibility Waiting Periods.

EXCLUSIONS AND LIMITATIONS

The Plan will not pay Disability benefits if the Disability is due to:

- Any occupational or work-related Illness or Injury when workers' compensation or similar benefits have paid on account of the period of Disability.
- A military related Illness or Injury that is caused by any act or incident of declared or undeclared war, riots, insurrection or acts of terrorism while the Employee is on military duty in the Uniformed Services. Uniformed Services include the Army, Navy, Marine Corps, Air Force, Coast Guard, the Army National Guard, the Air National Guard, the Commissioned Corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.
- Acts of War: Illness or Injury caused or contributed to by international armed conflict, hostile acts of foreign enemies, terrorism, invasion, or war or acts of war, whether declared or undeclared.
- Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony. The Plan shall enforce this exclusion based upon reasonable information showing that this criminal activity took place.
- Illness or Injury for which You are not treated by a Physician.
- Elective cosmetic surgery, which includes medical or surgical procedures which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons.
- Illness or Injury related to an excluded medical service under Your medical Plan when the Disability would not have arose but for the election of the excluded medical service or supply.
- Intentionally self-inflicted injuries.

In addition, the Plan will not pay Disability benefits if:

- You are not Actively at Work as defined by the Plan.
- You are not under the Regular Care of a Physician.
- You are not Totally Disabled as defined by the Plan.
- You did not submit sufficient documentation to prove Your Disability as required by the Plan.
- You are not responsive to the Plan's Disability review process.
- You are incarcerated in a penal or correctional facility.
- Disability as the result of radial keratotomy, keratomileusis surgery, lasik surgery, or other keratorefractive eye surgery to improve nearsightedness or far sightedness and/or astigmatism.
- Disability as the result of reversal of sterilization, sexual dysfunction, sex counseling, or sex transformations; care, services or treatment for noncongenitial transsexualism, gender dysphoria, or sexual reassignment or change.
- Disability as the result of abortion, unless performed out of medically necessity to save the life of the mother.
- Disability as a result of fertility and sterility studies, procedures to enhance fertility, actual or attempted impregnation or fertilization, which involves either a Covered Person or a surrogate as a donor or a recipient; or diagnosis or treatment of infertility, including but not limited to artificial insemination, in vitro fertilization, gamete intra fallopian transplants, fertility drugs or embryo transplants of any kind and related tests and procedures, or any other artificial or experimental fertilization procedures.
- Disability resulting from the treatment, activities or drugs prescribed in connection with obesity, weight control or medical weight reduction programs including but not limited to: wiring of the teeth or jaws, mason shunt, banding, gastroplasty and all forms of intestinal by-pass surgery or complications thereof, or any service or supply related to the medical management of obesity.
- Disability as a result of surgical insertion of penile prosthesis, including complications thereof, regardless of diagnosis.
- Disability which is the result of drugs, treatments, service or supplies which are considered investigational because they do not meet generally accepted standards for medical practice in the United States or which are not deemed medically necessary. This includes any related confinement, treatment, service or supplies.

- Disability for Injury or Illness caused or contributed to by illegal use of alcohol unless the source of Injury is due to a medical or mental health condition or an act of domestic violence.
- Disability as a result of services, supplies, care or treatment to a Covered Person for Injury or Illness resulting from the Covered Person's voluntary taking of or being under the influence of any gas, fumes or alcohol or any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician unless the source of Injury is due to a medical or mental health condition or an act of domestic violence.
- Disability as the result of appliances or medical or surgical treatment, physical therapy or restoration of temporomandibular joint disorder (TMJ), myofacial dysfunction or Craniomandibular Pain Syndrome (CPS).
- Disability as a result of genetic testing or pre-conception testing.
- Disability due to preventive removal of tissue or organ by surgery solely because of the probability of developing a malignancy.
- Disability resulting from participating in hazardous activity, including but not limited to, motorized vehicle racing, bungee jumping, sky diving, rock climbing and scuba diving.
- Disability as a result of non-human or mechanical organ or tissue transplant.
- Disability as a result of a cochlear implant.
- Disability as a result of being a surrogate mother.
- Disability as a result of complications of a non-covered procedure.
- Disability as a result of surgery or treatment for malocclusion of the jaw.
- Disability as a result of radioactive contamination or the hazardous properties of nuclear material.
- Disability as a result of Vertebral Axial Decompression (VAX-D).
- Disability as a result of services/treatment that is court ordered.
- Disability as a result of gynecomastia (enlargement of breast tissue in males).
- Disability as a result of hyperhidrosis (excessive sweating).

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

Covered Persons are being provided benefits pursuant to this group short-term disability Plan. This Plan is designed to provide you with short-term income support during a period of disability. This Plan is not intended to serve as a supplement to, or replacement for, any benefits You may recover from any Other Party as the result of an Illness or Injury caused by an act or omission of the Other Party. Benefits under this Plan are excluded subject to the terms and conditions of this Subrogation, Reimbursement and Offset Provision anytime there is an Other Party who is liable or responsible (legally or voluntarily) to make payments in relation to the Illness or Injury.

For purposes of this section, **Other Party** is defined to include, but is not limited to, the following:

- The party or parties that caused the Illness or Injury;
- The insurer or other indemnifier of the party or parties who caused the Illness or Injury;
- The Covered Person's own insurer including, but not limited to, uninsured motorist, underinsured motorist, no-fault insurers, or home owners insurance;
- A worker's compensation or school insurer;
- Any other person, entity, policy or plan that is liable or legally responsible to make payments in relation to the Illness or Injury

For purposes of this section, **Recovery** is defined to include, but is not limited to, any amount paid or payable by an Other Party through a settlement, judgment, mediation, arbitration, or other means in connection with an Injury or Illness.

This section is applicable when a Covered Person has received benefits under this Plan related to an Illness or Injury that arose as the result of an act or omission of any Other Party. If the Covered Person has the legal right to seek a Recovery from such Other Party, benefits will only be payable if You agree to the following:

- That the Plan is subrogated to all rights the Covered Person may have, and You acknowledge that the Plan will have a first priority lien and right of recovery, on any Recovery received from any Other Party. Any Covered Person accepting benefits from the Plan assigns from any such Recovery an amount equal to the benefits paid by the Plan. A Covered Person further agrees that notice of this assignment presented to the Covered Person's attorney and/or insurance company or other party responsible for payment of the damages is binding on the party receiving such notice.

- That the Covered Person, or their legal representative, shall notify the Plan of any claim or potential claim the Covered Person has against any Other Party within 30 days of the act which gives rise to such claim. That, if requested, the Covered Person or legal representative shall supply the Plan with any information that is reasonably necessary to protect the Plan's subrogation interests.

- If an act or omission of an Other Party causing an Illness or Injury results in payments being made under the Plan, that the Covered Person do anything that would prejudice the Plan's rights to recover payments.

- That, if requested, the Covered Person shall execute documents (including a lien agreement) and deliver instruments and papers and do whatever else in necessary to protect the Plan's rights. Such documents may require the Covered Person to direct their attorney (and other representatives) in writing to retain separately from any Recovery that the attorney or representative receive on the Covered Person's behalf an amount of money sufficient to reimburse the Plan as required by such agreement and to pay such money to the Plan. In the event the Covered Person does not sign or refuses to sign such an agreement, the Plan has no obligation to make any payment for any treatment required as a result of the act or omission of any Other Party, such agreement is expressly incorporated in this Plan and will be provided to the Covered Person at anytime upon request.

- The Plan is also granted a right of reimbursement from the proceeds of any Recovery obtained or that may be obtained by the Covered Person. This right of reimbursement runs concurrent with and is not necessarily exclusive of the Plan's subrogation and lien rights described above. A Covered Person shall promptly convey to the Plan any amounts received from any Recovery for the reasonable value of the medical benefits advanced by the Plan or provided by the Plan to the Covered Person.

- In the event that the Covered Person fails to cooperate with the Plan or fails to comply with the terms of this provision, the Plan may offset or otherwise reduce present or future benefits otherwise payable to the Covered Person under the Plan. Moreover, in the event that a Covered Person fails to cooperate with the Plan, the Covered Person shall be responsible for any and all costs incurred by the Plan in enforcing its rights, including but not limited to attorney's fees.

- That the Plan has a right to recover, either through subrogation, reimbursement, offset or through other means any amount, from the first dollar, that the Covered Person or any other person or organization on behalf of the Covered Person has received or is entitled to receive as a result of the Illness or Injury to the full extent of benefits paid or provided by the Plan.

- That the Plan's rights under this section shall be in first priority, to the full extent of any and all benefits paid or payable under the Plan, and will not be reduced due to the Covered Person's own negligence or due to the Covered Person not being made whole.

- That the Covered Person shall be solely responsible for all expenses of recovery from any Other Party, including but not limited to all attorney's fees and costs, which amounts will not reduce the amount of reimbursement payable to the Plan under the operation of any common fund doctrines.

- The Plan will not pay any fees or costs associated with any claim or lawsuit without the Plan's express written consent in advance.

- That the Covered Person or their legal representative or legal guardian, shall be considered a constructive trustee with respect to any Recovery received or that may be received from any Other Party in consideration of an Illness or Injury for which they have received benefits. Any such funds will be held in trust until the Plan's lien is satisfied.

- That the Plan reserves the right to independently pursue and recover paid benefits.

- The Plan's Subrogation, Reimbursement and Offset provisions apply to a Recovery obtained by the Covered Person in connection with an Injury or Illness without regard to the description, name or label applied to the Recovery.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures include administrative safeguards and processes that are designed to ensure and verify that benefit claims determinations are made in accordance with the Plan document. The Plan provisions will be applied consistently with respect to similarly situated individuals.

CLAIM PAYMENTS BY OTHER ORGANIZATIONS

Any functions performed by the Plan for claim payments may be performed by an agency or organization specifically designated by the Plan for this purpose. Any functions performed by such agency or organization shall be considered functions performed by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person who can contact the Plan on Your behalf to help with claims, appeals or other benefit issues.

If an Employee chooses to use a Personal Representative, the Employee must submit a written letter to the Plan stating the following: The name of the Personal Representative, the date and duration of the appointment and any other pertinent information. This letter must be signed by the covered person to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS AND PROOF OF LOSS PERIOD

A claim is a written request for payment of a benefit under this Plan. If You become Disabled, please contact Your Human Resources or Personnel office for information on how to submit a claim for Disability payments. Claims must be submitted as soon as possible after a person is unable to work due to a non-occupational Illness or Injury, but no later than 12 months from the date the Disability occurred.

HOW DISABILITY BENEFITS ARE CALCULATED

Your maximum weekly Disability benefit amount is stated on the Schedule of Benefits. The Plan determines Your weekly benefit amount by multiplying Your Weekly Earnings by the percent listed on the Schedule of Benefits.

NOTIFICATION OF BENEFIT DETERMINATION

Each time a request for Disability benefits is processed, You will either receive a payment for the amount of Your Disability benefits, or You will receive a letter denying the benefit request.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

Disability claims will be processed within 45 days, however the Plan can have two 30-day extensions if notice is provided to the person submitting the claim.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Employee is no longer eligible to participate in a Plan.

If a claim is being denied in whole or in part, You will receive a letter within the timelines listed above, unless the Plan is waiting for additional information from You or Your Physician. The letter will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Employee to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Employee can take to submit the claim for review (appeal).
- If an internal rule or guideline was relied upon, or if the denial was based on medical necessity or similar exclusion, the Plan will notify You of that fact. You have the right to request a copy of the rule/guideline or scientific/clinical criteria that was relied upon, and such information will be provided to You free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If You disagree with the denial of a claim, You or Your duly Personal Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below:

First Level of Appeal: This is a **mandatory** appeal level. The Employee must exhaust the following internal procedures before any outside action is taken.

- You must file Your appeal within 180 days of the date You received the claim denial notice form from the Plan showing that Your claim was denied. The Plan will assume that You received the written notice five (5) days after the Plan mailed it to You.
- You or Your Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- You may submit written comments, documents, records and other information relating to the claim to explain why You believe the denial should be overturned. This information should be submitted at the time You submit the written request for a review.
- You have the right to submit evidence that Your claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If Your benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with Your claim, they will be identified upon Your request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After Your claim has been reviewed, You will receive written notification letting You know if the claim is being approved or denied. The notification will provide You with the information outlined under the Adverse Benefit Determination section above. It will also notify You of Your right to file suit under ERISA after You have completed all mandatory appeal levels described in this document.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after You have followed the mandatory appeal level as required above. This Plan also agrees that it will not charge You a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if You elect to pursue a claim in court before following this voluntary appeal process. Your decision about whether to submit a benefit dispute through this voluntary appeal level will have no affect on Your rights to any other benefits under the Plan. If You have any questions regarding the voluntary level of appeal including applicable rules, Your right to representation (Personal Representative) or other details, please contact the Plan. Refer to the ERISA Statement of Rights section of this document for details on Your additional rights to challenge the benefit decision under section 502(a) of ERISA.

Appeals should be sent within the prescribed time period as stated above to:

Send first level Disability appeals to:
UMR DISABILITY
CLAIMS APPEAL UNIT
PO BOX 8015
WAUSAU WI 54402-8015

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a Disability claim that has been appealed, the Plan will notify You of its decision within a reasonable period of time but no later than 45 calendar days after the Plan receives Your request for review. A 45-day extension can be utilized by the Plan if necessary due to matters beyond its control if the Plan gives You a written notice during the original 45-day period. You may however voluntarily extend these timelines.

Determination Period on Hold (Appeals): When the Plan needs additional information from You regarding the appeal, the time for the appeal determination is put on hold from the date a notice is sent to You until the date You respond to the request for additional information. If You do not provide needed information to the Plan within 60 calendar days of the date on the notice, the Plan will make a decision on the appeal based on the information that it has at that time.

LEGAL ACTIONS FOLLOWING APPEALS

After completing all mandatory appeal levels through this Plan, You have the right to further appeal Adverse Benefit Determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the ERISA Statement of Rights section for more details. No such action may be filed against the Plan after three years from the date the Plan gives You a final determination on Your appeal.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that You have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date benefits should have ended; or
- Made to You or any party on Your behalf where the employer determines the payment to You or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against You if the Plan has paid You or any other party on Your behalf.

FRAUD

Fraud is a crime that can be prosecuted. Any covered person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime if You file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. Fraud also includes stating that You are unable to perform certain activities at work, but then engaging in similar activities during Your Disability leave. For example, if a person is on Disability leave due to a back Injury or inability to bend or lift, that person should not be playing sports during the Disability leave or lifting heavy items. These actions, as well as submission of false information, will result in denial of Your claim, and are subject to prosecution and punishment to the full extent allowed under state and/or federal law. The Plan will pursue all appropriate legal remedies in the event of fraud.

As a covered person, You must:

- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of Your knowledge. If someone else —such as Your spouse or another family member – files claims on Your behalf, You should review the form before You sign it.

- Review the statement and check when You receive it to make certain that benefits have been paid correctly based on Your knowledge of the benefits under this Plan. Notify the Plan immediately if You notice a problem.

- Refrain from doing any unnecessary activity that would potentially increase the severity of Your Disability or increase the length of time You are off work for the Disability.