

American Dairy Queen Corporation Short-Term Disability Plan

SUMMARY PLAN DESCRIPTION
POLICY #903928-001

Revised Effective 01/01/2026

TABLE OF CONTENTS

INTRODUCTION	1
PLAN OUTLINE.....	2
TERMS YOU SHOULD KNOW	4
BENEFIT PAYMENTS.....	5
TERMINATION OF COVERAGE.....	8
GENERAL EXCLUSIONS AND LIMITATIONS.....	9
GENERAL CLAIM INFORMATION.....	10
AMENDMENT AND TERMINATION OF THE PLAN	11
SUMMARY PLAN DESCRIPTION.....	12
YOUR RIGHTS UNDER ERISA	13

INTRODUCTION

About This Summary Plan Description

This Summary Plan Description (“SPD”) summarizes the Short-Term Disability (“STD”) benefit program for eligible employees of American Dairy Queen Corporation (“ADQ” or the “Company”) offered through the American Dairy Queen Group Health Plan (the “Plan”).

This SPD is effective October 1, 2018, and restated effective January 1, 2026. You should not rely on this information other than as a general summary of the features of the Plan’s benefit programs.

This SPD is based on various legal documents (such as the relevant American Dairy Queen Group Health Plan document) currently in effect. As such, your rights are governed by the terms of these legal documents. Also, any questions concerning the Plan shall be determined in accordance with the terms of the relevant legal document and not this SPD.

While every effort has been made to give you correct and complete information about your benefits, in the event of any conflict or inconsistency between the SPD and relevant legal documents, the terms of the legal documents will control.

In addition, no person has the authority to make any oral or written statement or representation of any kind which is legally binding upon the Company that alters the Plan or any legal document maintained in conjunction with the Plan.

The Company intends to continue the benefit programs as described in this SPD indefinitely but reserves the right, at its discretion, to change or even terminate all or any part of this Plan or the benefits offered hereunder at any time and in any manner to the extent permitted by law. As a result, this SPD is not a contract, nor is it a guarantee of your benefits.

If the Company does modify or terminate any of the benefit programs offered, a subsequent SPD or Summaries of Material Modifications will be provided to advise you of any such modifications or termination, as required by ERISA.

The Company retains unilateral discretion to interpret the Plan and to determine all questions arising under or in connection with the Plan, including all questions of eligibility to participate and obtain benefits under the Plan, its interpretation thereof in good faith to be final and conclusive on all interested persons.

How to use this SPD

Your SPD consists of this document. This document describes some general features of your benefit plan and includes a number of legal disclosures required under ERISA and other federal laws. The Attachments contain detailed summaries of the benefits themselves.

PLAN OUTLINE

Purpose

This Plan provides income continuation for Eligible Employees during qualified periods of disability resulting from non-work-related illnesses or accidents.

Description of Eligible Employees

The Plan applies to all U.S. employees of American Dairy Queen Corp (“ADQ”) and its subsidiaries and affiliated companies (within the meaning of Internal Revenue Code §414) who are scheduled to work at least 30 hours per week unless they are listed as ineligible employees below.

The following persons are not eligible to participate in the Plan: persons ADQ classifies in ADQ’s payroll system as temporary employees, seasonal employees, nonresident aliens, undocumented resident aliens, employees covered by a collective bargaining agreement (where plan benefits were the subject of good faith bargaining) which does not provide for participation in the Plan, or independent contractors, regardless of whether such persons are subsequently classified as common law employees during the period the Plan Sponsor treated such persons as independent contractors.

Eligibility for Coverage

You become eligible for coverage on the first day of the month following 30 days of employment. You must be Actively at Work as an Eligible Employee on the date coverage becomes effective, or coverage will not begin until you return to employment as an Eligible Employee.

Eligibility for coverage under the Plan will continue in the event an Eligible Employee takes an approved leave of absence for reasons covered under the Family and Medical Leave Act, state or local leave laws, or due to military service under the Company’s leave of absence policies. Eligibility for coverage under the Plan will be suspended for all other leaves of absence. If your eligibility for coverage under the Plan is suspended during a leave of absence, your eligibility for coverage will be restored when you return to eligible employment after the leave. The waiting period and other eligibility criteria will be deemed to be satisfied if they were satisfied prior to your leave of absence, not covered under the Plan.

Elimination Period

Benefit payments start after an Eligible Employee has been out of work for 7 calendar days due to a non-work-related accident, illness or medical condition.

You may use any available unused sick time, vacation time, and/or personal days (collectively “PTO” or Paid Time Off) during the Elimination Period.

Eligibility for Benefits

To be eligible for benefits under the Plan, you must incur a Short-Term Disability while eligible for coverage.

Benefit Payments

Eligible Employees with a Short-Term Disability will receive benefit payments in an amount equal to 67% of Base Pay after the seven (7) calendar day elimination (waiting) period. The elimination period is measured forward from the first day of work missed due to the disability. Benefit payments will coincide with regular payroll dates.

You may use any available unused PTO during any period when you are receiving Short-Term Disability benefit payments. At your direction, PTO will be applied at a rate up to 33% to “top up” the Short-Term Disability benefit payments, with the maximum of 100% of your regular base pay.

Definition of Base Pay

Base Pay means gross base earnings paid to an Eligible Employee. Base Pay does not include commissions, bonuses, overtime, or employee deferrals to the 401(k) Plan. Base Pay is determined as of the date the Short-Term Disability begins. For Full-time Employees who are paid an hourly rate instead of a salary, the Employee’s base salary shall be calculated as the Employee’s base hourly rate multiplied by 40 hours per week and not including any bonuses or overtime. In determining the amount of each payment due to a Part-time Employee, the Company will calculate the payment amount based on the average of the number of hours the Employee worked in the fifty-two (52) weeks prior to the disability.

Maximum Benefit Period

Short-Term Disability Benefits may continue for a maximum disability period of 26 weeks, which includes the one-week elimination (waiting) period, as long as you remain disabled under the terms of the Plan.

Source of Contributions to the Plan

The cost of this coverage is paid entirely by the general assets of the Company.

Liability for Benefits

All Short-Term Disability Benefits will be paid solely as provided for in this Plan.

TERMS YOU SHOULD KNOW

Many terms used in this booklet have special meanings. A list of these terms and their meanings follows:

- “Actively at Work” means you are actually performing your normal duties if it is a scheduled workday. If you are not at work due to a nonscheduled workday, holiday or vacation, “Actively at Work” means you are physically and mentally capable of performing your normal duties. This definition applies to your normal place of employment or some other location where your duties require you to be.
- “Base Pay” means the definition provided in the Plan Outline.
- “Employer” means American Dairy Queen Corporation and its U.S. subsidiaries and affiliated companies
- “Maximum Benefit Period” means the longest period during which Short-Term Disability Benefits may continue, such period being a maximum of 26 consecutive weeks, which includes the one-week elimination (waiting) period.
- “Plan” means this ADQ Short-Term Disability Plan as it may be amended from time to time.
- “Plan Sponsor” and “Plan Administrator” means American Dairy Queen Corporation.
- “Short-Term Disability” means any illness, disease, accidental injury, pregnancy or mental disorder in which the Plan Sponsor determines, based on such evidence as it may require in its discretion, prevents you from performing the substantial and material duties of your occupation in the usual or customary way on a full-time basis for a period longer than 7 calendar days due to the Short-Term Disability.
- “Short-Term Disability Benefits” means money that is paid as a benefit when your claim for disability benefits has been approved.
- “Unum” means Unum Insurance Company. Unum is the Company’s 3rd party disability claims adjudicator. Unum reviews all applications and medical evidence for short-term disability, Paid Family & Medical Leave claims for Minnesota and Colorado, as well as long-term disability claims. Unum makes all determinations (approvals and denials) for these claims.
- “Sparrow” means the Company’s 3rd party leave of absence management partner. Sparrow is the primary point of contact for employees on a leave of absence.

BENEFIT PAYMENTS

1. When do Short-Term Disability Benefits become payable?

Benefits become payable only after you and your attending physician complete a claim form, and your attending physician returns the completed claim form, including an attending physician's statement, to Unum.

2. What conditions must be met for benefit payments to continue?

Short-Term Disability benefits will be paid as long as you continue to have a Short-Term Disability, but not longer than the Maximum Benefit Period.

You may be required to see a physician selected by the Plan Administrator for an independent evaluation at the Plan Sponsor's expense. If you fail to comply with such a request, the result may be an interruption in your benefits.

3. How is the amount of benefit determined?

Your benefit will be equal to 67% of your Base Pay. Any benefit payable to you under the Plan will be subject to all required withholding and payroll taxes.

In addition, your Short-Term Disability Benefit may be offset or reduced by one or more of the following "Other Sources of Income":

- (A) Benefits received due to any state-paid family and medical leave law, regardless of whether the Company participates through the state's program or a private plan. Even if you don't apply, Short-Term Disability Benefits will be reduced based on your eligibility for state benefits. The total amount you will receive from both programs will not exceed your eligible Short-Term Disability Benefit.
- (B) Your benefits will be offset by any workers' compensation benefits you receive as a result of your disability;
- (C) Your benefits will be reduced by any income you receive from any employment other than employment under an approved rehabilitation program;
- (D) Your benefits will be offset by the amount of any insurance benefits you receive (including Long-Term disability) as a result of your disability;
- (E) Your benefits will be offset by the amount of any disability, retirement or unemployment benefits you receive under any government (whether or not you apply to receive the benefits), such as state-administered short-term disability benefits and Social Security disability or retirement benefits;
- (F) Any compensation, damages or any other payment you receive because of your disability, pursuant to the following provisions:

Where allowed by law, if you receive Short-Term Disability Benefits and have a lawful claim against another party or parties for compensation, damages or other payment because of the same disability and receive any such amounts from the other party or parties (including court costs and attorney fees), ADQ has the right

to be reimbursed for amounts paid to you under this Plan. ADQ will assume any legal right you have to collect any compensation, damages or any other payment related to your Short-Term Disability, including benefits from the responsible person's insurer, uninsured motorist coverage, underinsured motorist coverage, or other insurance coverage.

You must let ADQ know about any potential claim(s) or right(s) of recovery related to your Short-Term Disability; furnish any information and assistance that ADQ determines it will need to enforce your rights under this Section (E); not do anything to prejudice the rights or interests of ADQ; not compromise, settle, surrender or release any claim or right of recovery described above without getting the permission of ADQ; and reimburse ADQ to the extent of amounts paid under this Plan if you receive payment from the other party or parties.

Whether or not you execute a reimbursement agreement, in the event that the Plan provides benefits to you and then you recover a payment, either by settlement, judgment, no-fault automobile insurance statute, homeowners' insurance, or otherwise, from any Third Party or other source, then you will immediately reimburse the Plan for the full amount of any and all benefits paid in connection with such injury, illness, disability or death, up to the amount of the recovery. This right of reimbursement applies regardless of the label assigned to the recovery (including a grantors trust), and regardless of any purported allocation or itemization of such recovery to specific types of injuries. If the recovery is deemed by a court or settlement agreement to be for damages other than for lost wages, such as pain and suffering, you will still be required to reimburse the Plan first. The Plan will have a lien upon any such recovery in the amount of benefits or expenses paid by the Plan. The Plan's right of reimbursement will apply to the first dollar of any recovery obtained from the Third Party, even if the recovery obtained is less than the amount needed to make you whole.

4. Do I have to apply for benefits from all these "Other Sources of Income" since they may reduce or offset my Short-Term Disability Benefits under the Plan?

You must apply for benefits from all "Other Sources of Income" for which you are eligible and do whatever is necessary to obtain such benefits. As part of your proof of disability, you must furnish evidence that you have applied for benefits from all "Other Sources of Income" for which you are eligible or may become eligible. This includes making an application for such benefits **and** making all available appeals if your initial application for any such benefits is denied. You will be asked to provide written proof that all available appeals for benefits from these "Other Sources of Income" have been exhausted.

5. When do Short-Term Disability Benefits stop?

Short-Term Disability Benefits will stop on the **earliest** of:

- (A) The date you no longer have a Short-Term Disability;
- (B) The end of the Plan's Maximum Benefit Period;
- (C) The date your employment ends;
- (D) The date you cease to be an Eligible Employee;

- (E) The date you refuse to return to work on a part-time or full-time basis when it is determined that you are able to do so;
- (F) The date you commit any fraud or intentional misrepresentation of the Plan; or
- (G) The date you refuse to pay back benefits under any benefit program sponsored by ADQ.

6. If I am able to return to work on a part-time basis during my disability, how will my Short-Term Disability Benefits be affected by my return?

If you are released by your physician to return to work on a part-time basis during your disability, you will be expected to do so.

You will receive 100% of your Base Pay for the hours you are able to work. You will receive Short-Term Disability Benefits for the hours you do not work.

Your physician will define your medical limitations. The Plan Administrator reserves the right to request an independent medical exam to determine whether you are able to work part-time and under what limitations.

7. What happens if I return to work and become disabled again?

If you return to work and then become disabled again within fourteen (14) calendar days after returning to work due to the same cause or a related condition, the disability will be considered to be a Recurrent Disability. A Recurrent Disability is treated as part of your original Short-Term Disability. You will not be required to satisfy a new Waiting Period. However, your benefit payments will be subject to the Maximum Benefit Period of your original disability. That is, the days and weeks you were absent from work due to your previous disability will be counted toward your 26-week maximum.

If you return to work and then become disabled again more than fourteen (14) calendar days after returning to work due to the same cause or related condition, the disability will be considered a new disability and will not be treated as part of your original Short-Term Disability. You will be required to satisfy a new Waiting Period. Likewise, your benefit payments will not be subject to the Maximum Benefit Period of your original disability.

8. What happens if I am disabled while I am already receiving benefits for another disability?

If you become disabled while you are already receiving benefits under this Plan for another Short-Term Disability and the new disability is unrelated to your previous disability, the new disability will be considered to be a Concurrent Disability. A Concurrent Disability is treated as part of your original Short-Term Disability. You must satisfy a new Waiting Period and all other requirements of the Plan with respect to the new disability and your benefit payments will be subject to the Maximum Benefit Period of your original disability. That is, the days and weeks you were absent from work due to your previous disability will be counted toward your 26-week maximum.

TERMINATION OF COVERAGE

1. When does coverage terminate?

Your coverage will terminate on the earliest of the following dates:

- (A) The date you cease to be an Eligible Employee;
- (B) The date you terminate employment;
- (C) The date you die;
- (D) The date you commit a fraud or intentional misrepresentation of the Plan.

GENERAL EXCLUSIONS AND LIMITATIONS

1. What Short-Term Disabilities are not covered under this Plan?

- (A) A disability due to intentionally self-inflicted injuries or attempted suicide, whether or not due to mental illness;
- (B) A disability resulting from participation in or an attempt to participate in an assault, battery, felony, riot or civil commotion; or
- (C) A disability resulting from any injuries sustained while on a personal leave of absence, excluding jury duty and vacations; or
- (D) A disability resulting from a work-related illness or injury.

2. What other limitations apply to benefits under the Plan?

Short-Term Disability Benefits will not be paid for any of the following:

- (A) Any period for which you have a disability, but you are not under the continuing care of a physician;
- (B) With respect to a mental disorder, any period for which you are not under the continuing care of a specialist in psychiatric care;
- (C) With respect to alcoholism or drug addiction, any period for which you are not being actively supervised and receiving continuous treatment from a rehabilitation center or a designated institution approved for such treatment by an appropriate body in the governing jurisdiction or, if none exists, by the Plan Sponsor.
- (D) Any period during which you fail to submit to any medical examination requested by the Plan Sponsor. You will be required, at your own expense, to obtain a statement from your physician clearly showing that you are disabled. If the Plan Administrator wishes you to be examined by the Plan Sponsor's physician, the physician's fees for such examination will not be your responsibility.

GENERAL CLAIM INFORMATION

1. How do you make a claim for benefits?

The Eligible Employee must notify their manager and the Human Resources department of the request for leave as soon as possible. Notice should be at least 30 days before the proposed start of leave, or if the leave was not foreseeable, as soon as possible. The Benefits department will initiate the Eligible Employee with Sparrow, the Company's 3rd party leave management company. Sparrow will provide the Eligible Employee with any and all claim forms. For prompt payment of any Short-Term Disability Benefits, the claim form must be completed in full by you and your attending physician. Your attending physician must then send the form to Unum.

2. Who will review and decide the claim for benefits?

Unum will review each claim for benefits and will decide whether the claim satisfies the requirements for Short-Term Disability Benefits under the Plan.

3. When are claims for benefits paid?

Any Short-Term Disability Benefits payable under the Plan will be paid on regular payroll dates during the period you are entitled to benefits under the Plan. Short-Term Disability Benefits will be added to the next feasible payroll following benefit approval.

4. To whom are benefits paid?

All benefits are payable to Eligible Employees under the Plan.

AMENDMENT AND TERMINATION OF THE PLAN

The Plan Sponsor reserves the right to amend, modify, or terminate the Plan at any time, in its sole discretion. The Plan Sponsor will provide reasonable notification to Eligible Employees of any amendments or the termination of the Plan. No amendment or termination may be made that prematurely stops Short-Term Disability Benefits payments that would be made under this Plan after an Eligible Employee has met the waiting period and eligibility criteria.

GENERAL PROVISIONS

Correction of Errors.

In the event an incorrect amount is paid to or on behalf of an individual, any remaining payments may be adjusted to correct the error. The Plan Administrator may take such other action it deems necessary and equitable to correct such error.

No Additional Rights.

No person shall have any rights under the Plan, except as, and only to the extent, expressly provided for in the Plan. Neither the establishment or amendment of the Plan, or the payment of Short-Term Disability Benefits under the Plan, nor any action by the Plan Sponsor or Plan Administrator shall be held or construed to confer upon any person any right to continued employment, or, upon dismissal, any right or interest in Short-Term Disability Benefits other than as provided in the Plan.

Representations.

The Plan Sponsor does not represent or guarantee that any particular federal or state income, payroll, personal property, Social Security or other tax consequences will result from participation in the Plan. No oral representations can amend the Plan.

Severability.

If any provision of this Plan is held illegal or invalid for any reason, such determination shall not affect the remaining provisions of the Plan, which shall be construed as if the illegal or invalid provision had never been included.

Governing Law.

The Plan shall be construed in accordance with applicable federal law, and to the extent not preempted by applicable federal laws, the laws of the State of Minnesota, including its statute of limitations, but without regard to its laws respecting choice of law.

SUMMARY PLAN DESCRIPTION

Name of Plan: ADQ Short-Term Disability Plan

Name and Address of the Plan Sponsor: American Dairy Queen Corporation
8331 Norman Center Drive
8000 Tower, Suite 700
Bloomington, Minnesota 55437

Who Pays for the Plan: The cost of this Plan is paid entirely by the general assets of the Company.

Plan Sponsor's Tax Identification Number: 41-0853275

Plan Number: 550

Plan Year: January 1 – December 31

Plan Administrator and Named Fiduciary: American Dairy Queen Corporation
Human Resources Dept.
8331 Norman Center Drive
8000 Tower, Suite 700
Bloomington, Minnesota 55437

(952)830-0242

Type of Funding: Self-funded

Type of Plan: The Plan is an employee welfare benefit plan under Section 3(1) of ERISA.

Agent for Service of Legal Process: Plan Administrator as stated above.

Adopted Employers: Unified Supply Chain, Inc: 20-1292398
DQ Training Restaurants, LLC: 71-0924040

Plan Administrator's 3rd Party Claims Adjudicator: Unum Insurance Company

YOUR RIGHTS UNDER ERISA

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

1. Receive Information About Your Plan and Benefits

- You may examine, without charge, at the Plan Administrator's office and at other specified locations, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions
- You may obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for such copies.
- You may 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 report.

2. 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 Plan. The people who operate the Plan, who are called "fiduciaries", have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

3. Enforce Your Rights

If your claim for benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and you 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 a penalty (currently up to \$110 per day) until you receive the materials, unless the materials were not sent due to circumstances beyond the Plan Administrator's control.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or 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 suit, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

4. Assistance with Your Questions

If you have any additional questions about the Plan, you should contact the Plan Administrator. If you have any questions about your rights under ERISA, you should contact the Plan Administrator or the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

What if your claim is denied?

The Plan Administrator must advise you of their decision within 90 days of receipt of your claim for Short-Term Disability Benefits. In the event your claim is denied, you will receive a written notice from the Plan Administrator that must include

1. The specific reason or reasons for the denial, with reference to those Plan provisions on which the denial is based;
2. A description of any additional material or information necessary to complete the claim and an explanation of why that material or information is necessary; and
3. An explanation of the steps to be taken if you or your beneficiary wish to have either decision reviewed.

PLEASE NOTE that if the Plan Administrator does not respond to your claim within the time limits set forth above, you should automatically assume that your claim has been denied and you should begin the appeal process at that time.

What do you do to appeal?

You, the claimant, or your authorized representative may appeal a denied claim within 60 days after you receive the Plan Administrator's notice of denial. You have the right to:

1. Submit a written request for review to the Plan Administrator;
2. Review pertinent documents; and
3. Submit issues and comments, in writing, to the Plan Administrator.

The Plan Administrator will make a full and fair review of the claim and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made no later than 60 days following the Plan Administrator's receipt of your written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension, and a decision shall be made no later than 120 days following receipt of your request for review. The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Plan provisions upon which the final decision is based.

The procedures that apply to claims filed before that date are described in the section entitled “Your Rights Under ERISA.”.

To file a claim for Short-Term Disability Benefits, you must complete and submit a Short-Term Disability application form. These forms are available from the Human Resources Benefits Department and contain portions for both you and your medical provider to complete. You may appoint an authorized representative to act on your behalf in pursuing a claim for benefits.

Your claim will be decided within a reasonable time, not longer than 45 days after it is received. However, the 45-day period may be extended for up to 30 days for matters beyond the control of the Plan. You will receive written notice of any extension before the original 45-day period expires. The notice will include the reasons for the extension and the date by which the Plan expects to render a decision. The 30-day extension period may be extended a second time for up to an additional 30 days if a decision cannot be rendered within the first 30-day extension period due to matters beyond the control of the Plan. If there is a second extension, you will be notified in writing before the first 30-day extension period expires. The notice will include the reasons for the additional extension and the date by which the Plan expects to render a decision. If you are notified of an extension, the notice will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded at least 45 days to provide the specified information.

The Plan Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your claim.

If your claim is denied in whole or part, you will receive a written notice of the adverse benefit determination, setting forth:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
- if the decision was based on an internal rule, guideline, protocol or other similar criterion, a description of the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied on and that a copy of it will be provided to you free of charge upon request; and
- a description of any additional information or material necessary to perfect your claim and an explanation of why such material or information is necessary.

The notification will also advise you of the steps to be taken if you wish to appeal the decision, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse decision after appeal of your claim.

What if my claim for Short-Term Disability Benefits is denied?

The procedures that apply to claims filed before that date are described in the section entitled “Your Rights Under ERISA.”

If your claim has been denied in whole or part, you may appeal the decision to the Plan Administrator. You may appoint an authorized representative to act on your behalf in pursuing your appeal. Your appeal must be made in writing within 180 days of the initial notice of adverse benefit determination. If you do not appeal on time, you will lose the right to appeal the denial and your right to file suit

under ERISA, as you will have failed to exhaust the Plan's internal administrative appeal process, which is generally a prerequisite to bringing suit.

Your appeal should state the reasons you believe your claim should not have been denied, and should include any additional facts or documents you believe support your claim. You will have the opportunity to submit written comments, documents, records and other information. You may review (on request and at no charge) documents and other information relevant to your claim for benefits. You should make sure that your request for review includes all the information relevant to your claim. The Plan Administrator will review and consider all written comments and other information you submit with your appeal.

The Plan Administrator will review and decide your appeal within a reasonable time not longer than 45 days after it is submitted. The individual who conducts the review will not be the same individual who made the initial adverse benefit decision or that individual's subordinate and will not afford deference to the initial adverse benefit determination. The Plan Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with the initial adverse benefit decision and will not be any such expert's subordinate. The identity of any medical expert consulted in connection with your appeal will be provided.

The 45-day review period may be extended for up to 45 additional days if special circumstances require an extension of time for processing the claim. If the Plan Administrator determines that an extension of processing time is required, you will receive written notice of the extension before the original 45-day period expires. The notice will include the special circumstances requiring the extension of time and the date by which the Plan expects to render the decision on review.

If the initial denial of your claim is affirmed on review, you will be furnished with a written notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the adverse decision on review;
- the specific Plan provisions on which the decision is based;
- a statement of your right to review (on request and at no charge) relevant documents and other information;
- if the decision was based on an internal rule, guideline, protocol or other similar criterion, a description of the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied on and that a copy of it will be provided to you free of charge upon request; and
- a statement of your right to bring suit under § 502(a) of ERISA.

PLEASE NOTE that you must follow this claims procedure if you have a claim for benefits under the Plan. The failure to follow the claims procedure will prevent you from challenging an adverse decision in court. If you have complied with and exhausted the appropriate claims procedures and intend to exercise your right to bring civil action under ERISA Section 502(a), you must bring such action within 6 months following the date on which you submitted the last required appeal (or voluntary appeal, if offered and if filed) under such procedures. If you do not bring such action within such 6 month period, you will be barred from bringing an action under ERISA related to your claim.

The Plan will be construed in accordance with the laws of the state of Minnesota (determined without regard to any conflicts of law provisions), to the extent not preempted by federal law.