MANATTS, INC. EMPLOYEE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

This Summary Plan Description (SPD) is a brief description of the Plan as established effective December 31, 2018. The Plan offers coverage for eligible employees. This SPD is not meant to interpret, extend, or change the provisions of the Plan in any way. A copy of the Plan is on file at your Employer's office and may be read by you at any reasonable time. If you have any questions regarding the Plan, you should contact the Employer.

Non- English Assistance

This booklet contains a summary in English of Your Plan rights and benefits under this Plan. If You have difficulty understanding any part of this booklet, You should contact the Human Resources Department of Manatts, Inc. during office hours.

Spanish Translation

Este folleto tiene un resumen en ingles de sus derechos y beneficios bajo este Plan. Si usted tiene dificultad entendiendo cualquier parte de este folleto, póngase en contacto con el Departmento de Recursos Humanos de Manatts, Inc.durante horas de oficina.

GENERAL ADMINISTRATIVE PROVISIONS

This Summary Plan Description (SPD) is provided to you in compliance with the Employee Retirement Income Security Act of 1974 (ERISA). The SPD is the document which sets forth the terms and conditions of the benefits the Sponsoring Employer chooses to provide in its employee benefit plan. The SPD may be amended at any time by the Sponsoring Employer. The general administrative provisions of the Plan are as follows:

Name of the Plan:	Manatts, Inc. Employee Benefit Plan
Sponsoring Employer:	Manatts, Inc. 1775 Old 6 Road Brooklyn, IA 52211 (641) 522-9206
Employer ID Number:	42-1377409
Participating Employers:	Manatts, Inc. Beneficial Technologies, LLC Determann Asphalt Paving, LLC IIIowa Investments Inc. L.L. Pelling Company, Inc. Valley Environmental Services, LLC Wendling Quarries Inc. Cunningham-Reis, LLC Participants and beneficiaries may receive, upon written request, information as to whether a participating employer is a sponsor of the Plan and, if the employer is a plan sponsor, the employer's address.
Type of Plan:	An employee welfare plan.This Plan consists of the following Underlying Plans: voluntary dental, life, voluntary life, short term disability, voluntary long term disability, employee assistance program, voluntary vision, group accident and critical illness, health care flexible spending account, and such other employee benefit plans which may be adopted. The benefits, limitations, and exclusions for each such benefit plan and/or insurance program are more particularly described in the separate Summary Plan Description (SPD) for that plan or program. Summary Plan Descriptions for the above-referenced Underlying Plans are attached hereto.
Plan Number:	506
Effective Date:	The effective date of Plan is December 31, 2018.

Plan Year:	January 1 to December 31. The first Plan Year shall be a short Plan Year beginning and ending on December 31, 2018.
Plan Administrator:	Manatts, Inc. 1775 Old 6 Road Brooklyn, IA 52211 (641) 522-9206
Type of Administration:	Claims administration of each Underlying Plan is detailed in the Summary Plan Description for that plan. The Summary Plan Description for any group health plan shall state whether a health insurance issuer is responsible, in whole or in part, for the financing or administration of the group health plan, to what extent benefits of such plan are guaranteed under a contract or policy of insurance, the nature of any administrative services by the insurance issuer, and the name and address of the insurance issuer. If the Underlying Plan does not provide for detailed claims administration or if such claims administration procedures are legally deficient, the Plan's claims procedures shall be used. The Plan Administrator has the exclusive right, power, and authority, in its sole and absolute discretion, to administer and interpret the Plan as set forth in the Plan document. Determinations made by the Plan Administrator on any disputes arising under the Plan, including (but not limited to) questions of fact, construction, interpretation, and administration shall be final, conclusive, and binding on all persons having an interest in or under the Plan.
Agent for Service of Legal Process:	Manatts, Inc. 1775 Old 6 Road Brooklyn, IA 52211
Cost of Benefits:	The costs for this Plan are paid for through your contributions and your Employer's contributions, as applicable for each Underlying Plan.
Eligibility:	The eligibility requirements for each benefit plan are set forth in the Underlying Plan. A Participant is eligible for employee assistance program benefits on the first date of employment with the Employer. An otherwise eligible employee of a newly acquired affiliate or subsidiary will be deemed to have completed his/her waiting period on the later of the acquisition date or benefit effective date according to the terms of the acquisition to the extent that such employee has completed the waiting period with the prior owner. If however, the employee is covered under the prior owner's plan on the date of the acquisition and is otherwise eligible, the waiting period will be waived in its entirety.
Effective Date:	The dates on which eligibility begins for each benefit plan or program are set forth in the Underlying Plan.
Qualified Medical Child Support Orders:	To the extent an Underlying Plan constitutes a group health plan within the meaning of Section 733 of ERISA, participants and beneficiaries may obtain from the Plan Administrator, without charge, a copy of such Underlying Plan's procedures governing qualified medical child support order determinations.
Provider Network:	To the extent an Underlying Plan is a group health plan which has a provider network, the separate Summary Plan Description for such Underlying Plan shall include a general description of such provider network. For information on how to access the listing of providers, contact the Plan Administrator.
Amendment and Termination:	Unless an Underlying Plan document provides otherwise, the Sponsoring Employer, acting by a majority vote of its Board of Directors, has the right to amend, in whole or in part, or terminate, in whole or in part, the Plan or any Underlying Plan at any time and for

any reason. However, any such amendment or termination will not deprive a participant or beneficiary of the right to receive any benefits due and owing as of the effective date of the amendment or termination. To the extent a retired employee ("retiree") is eligible to receive benefits pursuant to an Underlying Plan, the amendment and termination authority hereunder shall include the right to amend or terminate the Plan or such Underlying Plan with respect to any retiree, or classes of retirees who are eligible for such benefits.

Termination of Participation: You shall cease to be a Participant of an Underlying Plan on the date determined pursuant to the applicable Plan Document(s) or Certificate(s) of the Underlying Plan; provided, however, in the absence of a date of termination provided for in the applicable Underlying Plan, you shall cease to be a participant of an Underlying Plan on the date you terminate employment with the Employer. Termination of participation in one or more Underlying Plan does not necessarily terminate participation in another Underlying Plan. For purposes of an Underlying Plan which does not specify a termination of coverage date, you are considered to be in continuous employment for purposes of continuing coverage under the Plan (1) during a leave of absence up to twelve (12) weeks (26 weeks in the case where you need to care for a Covered Servicemember who is recovering from a serious injury or illness sustained in the line of duty on active duty and that manifested itself before or after the member became a veteran) that is granted by the Employer as leave under the Family and Medical Leave Act of 1993 and (2) during any period of qualifying military leave to the extent the Uniformed Services Employment and Reemployment Rights Act of 1994 requires benefits to be continued during such leave.

Special Enrollment Rights: If you declined enrollment in the Plan for you or your eligible dependent(s) (including your spouse) because of coverage under Medicaid or the Children's Health Insurance Program, there may be a right to enroll in this Plan or an Underlying Plan if there is a loss of eligibility for the government provided coverage. However, a request for special enrollment must be made within sixty (60) days after the government provided coverage ends.

In addition, if you have declined enrollment in the Plan for yourself of your eligible dependent(s) (including your spouse), and later become eligible for state assistance through a Medicaid or Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan or an Underlying Plan. However, a request for enrollment must be made within sixty (60) days after the determination of eligibility for state assistance.

For information on these special enrollment rights, contact the Plan Administrator.

ALTERNATIVE EMPLOYER PROVIDED COVERAGE FOR EMPLOYEE ASSISTANCE PROGRAM BENEFITS

With respect to your coverage under an Underlying Plan that is an employee assistance program sponsored by the Employer, the Employer will automatically provide to you, your spouse, your dependent children, and any other qualified beneficiaries (defined below) identical, alternative coverage to what you currently receive in the event a "qualifying event" (defined below) occurs. This alternative coverage is identical to the COBRA continuation coverage provided below and will satisfy all of the COBRA continuation coverage requirements discussed below. In the event the Employer chooses not to provide identical, alternative coverage to you with respect to and Underlying Plan that is an employee assistance program upon experiencing a "qualifying event", you will be eligible for COBRA continuation coverage as provided for below.

Continuation coverage for Underlying Plans other than the employee assistance program will be provided in accordance with the "COBRA Continuation Coverage" provisions below, as applicable.

COBRA CONTINUATION COVERAGE

This section contains information about your right to COBRA continuation coverage, which is a temporary extension of coverage of group health plan benefits that may be offered under the Plan. This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. For purposes of this "COBRA Continuation Coverage" section of the SPD, the term "Plan" will mean, unless the context indicates otherwise, each

Underlying Plan which constitutes a group health plan within the meaning of Section 733 of ERISA. This "COBRA continuation coverage" section will apply to an Underlying Plan which is a group health plan. This "COBRA continuation coverage" section will not apply to an Underlying Plan which is not a group health plan.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage.

This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is Manatts, Inc., 1775 Old 6 Road, P.O. Box 535, Brooklyn, IA 52211, (641) 522-9206. The Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a qualified beneficiary. A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries.

Under the Plan, qualified beneficiaries who elect must pay for COBRA continuation coverage. The continuation coverage premium may be up to 102 percent of the cost to the Plan for such period of coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the Employer or employee). The applicable COBRA premium will be computed and fixed before the beginning of a 12-month premium cycle selected by the Plan. The Plan may increase a qualified beneficiary's premium amount during this 12-month premium cycle only if the Plan has previously charged less than 102 percent (150 percent during a disability extension) of the cost to the Plan for similarly situated beneficiaries or the qualified beneficiary changes the coverage being received.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Manatts, Inc. and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the Plan will offer COBRA continuation coverage to qualified beneficiaries within 44 days of the loss of coverage.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator in writing within 60 days after the qualifying event occurs. You must send this notice to Manatts, Inc., 1775 Old 6 Road, P.O. Box 535, Brooklyn, IA 52211. The notice must include sufficient information to enable the Plan Administrator to determine from the notice the Plan, the covered employee and qualified beneficiary(ies), the qualifying event, and the date on which the qualifying event occurred. A notice that does not contain all of the required information will not be considered notice of a qualifying event. Failure to supplement the notice with the additional information necessary to meet the foregoing content requirements will result in the loss of the right to elect continuation coverage. Within 14 days of receipt of written notice of such qualifying event (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), the Plan Administrator will offer COBRA continuation coverage to the qualified beneficiar(ies).

In the event that the Plan Administrator receives a notice from a qualified beneficiary relating to a qualifying event, determination of disability by the Social Security Administration, or second qualifying event regarding a covered employee, qualified beneficiary, or other individual and determines that the individual is not entitled to continuation coverage under Part 6 of Title I of the Act, the Plan Administrator will provide to such individual an explanation as to why the individual is not entitled to continuation coverage. Otherwise, after the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date health coverage is lost.

The Trade Act of 2014 reinstated a special COBRA election period for individuals who are deemed eligible for trade adjustment assistance benefits because of a job loss due to trade-related reasons (for example, jobs that are lost to overseas business or that are adversely affected by foreign imports). Individuals are deemed eligible for benefits by the U.S. Department of Labor (DOL) or state labor agencies through a certification process. The special election period applies to deemed eligible individuals who have not previously elected COBRA coverage, but only if the eligibility determination occurs within six months of the loss of health coverage. The special election period begins on the first day of the month that the individual becomes eligible for benefits. If COBRA coverage is elected under this special election period, it begins on the first day of the special period -- there is no "reach back" to provide COBRA coverage from the date that coverage was lost to the beginning of the new election period. The election period ends in 60 days or six months following the initial loss of coverage, whichever is earlier.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period
of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified in writing of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the original 18-month COBRA continuation coverage. If you receive a disability determination from the Social Security Administration prior to the occurrence of the qualifying event, you must provide written notice to the Plan Administrator of the disability determination within sixty days of the date on which the qualified beneficiary loses coverage under the Plan as a result of the qualifying event. This notice should be sent to the Plan Administrator, Manatts, Inc., 1775 Old 6 Road, P.O. Box 535, Brooklyn, IA 52211. The notice must include sufficient information to enable the Plan Administrator to determine from the notice the Plan, the covered employee and qualified beneficiary(ies), the disability, and the date of the disability and the date on which the disability was determined.

If, during continued coverage, the Social Security Administration determines that the employee or family member is no longer disabled, the individual must inform the Plan Administrator of this determination within 30 days of the date it is made.

Different premium rules apply if coverage is extended to 29 months due to an individual being deemed disabled. In such cases, for months 19 through 29 of COBRA coverage (or months 19 through 36 for qualified beneficiaries who incur a second qualifying event during the disability extension period), the COBRA premium for coverage covering the disabled individual may be as much as 150 percent of the cost to the Plan for such period of coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first event not occurred. The extension is also available to a dependent child would have lost eligibility for coverage under the Plan had the first event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified in writing of the second qualifying event within 60 days of the second qualifying event. This notice should be sent to the Plan Administrator, Manatts, Inc., 1775 Old 6 Road, P.O. Box 535, Brooklyn, IA 52211.

Paying for Coverage

The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary. This payment must cover the period of coverage from the date of the COBRA election retroactive to the date of the loss of coverage due to the qualifying event. Premiums for successive periods of coverage are due on the date stated in the Plan with a minimum 30-day grace period for payments. Regardless of the due date stated in the Plan, at the election of the payor, premium payments may be made in monthly installments. At its discretion, the Plan Administrator may also permit a qualified beneficiary to make payments at other intervals.

Payment is considered to be made on the date it is sent to the plan. If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage. If the amount of the payment made to the Plan is made in error but is not significantly less than the amount due, the plan will notify you of the deficiency and grant a reasonable period, but in no event less than 30 days, to pay the difference. The Plan is not obligated to send monthly premium notices. COBRA beneficiaries remain subject to the rules of the Plan and therefore must satisfy all costs.

The Trade Act of 2014 reinstated a federal tax credit that qualified beneficiaries can use to offset the cost of COBRA coverage. The COBRA tax credit, equal to a percent of the cost of COBRA coverage, only applies to workers who lose their jobs due to trade-related reasons. If the special tax credit is available, an eligible individual can have the credit forwarded to the Plan, and then pay the remaining percent of the COBRA premium. The Plan will be responsible for seeking the premium balance from the government. If you have any questions regarding the TAA, please contact the Health Care Tax Credit (HCTC) Customer Service department at (866) 628-4282. TDD/TYY callers, please call (866) 626-4282. Or visit the HCTC on the Web at http://www.irs.gov (IRS keyword: HCTC).

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administer or you may contact the nearest Regional or District office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members, or change in marital status. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

Under the federal privacy regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 and the privacy regulations issued thereunder ("HIPAA"), health plans are required to protect the confidentiality of your Protected Health

Information ("PHI"), which includes identifiable health information related to your condition, services provided to you or payments made for your care. To the extent an Underlying Plan is a health plan which is subject to HIPAA, the following provisions apply:

The Plan will not use or disclose PHI except as necessary for treatment, payment, health care operations and plan administration functions, or as otherwise permitted or required by law, without your written authorization. According to the law, the Plan has required all of its Business Associates with respect to any Underlying Plan which is a health plan to comply with HIPAA's privacy rules.

Before the Plan will disclose, or permit one of its agents or contractors to disclose, PHI to the Plan Sponsor or any Employer, the Plan will require the Plan Sponsor or Employer to (i) certify that the information is necessary in connection with plan administration functions or other permitted functions performed or to be performed by the Plan Sponsor or Employer; (ii) amend the Plan documents and provide certification of amendment to give assurances that the Plan Sponsor or Employer will use and disclose the information solely in connection with such plan administration or other permitted functions; and (iii) not use or further disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor or any Employer without the participant's authorization.

Under HIPAA, you have certain rights with respect to your PHI, including the right to see and copy the information, to receive an accounting of certain disclosures of the information and, under certain circumstances, to amend the information and request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a Notice of Privacy Practices with respect to any Underlying Plan that is a health plan, which provides a complete description of your rights under HIPAA's privacy rules. You may request a copy of this Notice of Privacy Practices at any time by contacting the Privacy Officer, Manatts, Inc., 1775 Old 6 Road, P.O. Box 535, Brooklyn, IA 52211. If you have questions about the privacy of your health information, please contact the Privacy Officer at the preceding address.

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

Title II of HIPAA requires group health plans to secure participants' private health information that it creates, receives, maintains, or transmits electronically. The Plan will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information, and will require its agents and contractors to do the same. Reporting of known security incidents to the Plan is part of those safeguards.
The Plan has established safeguards that are supported by reasonable and appropriate security measures to ensure that the Plan does not disclose, or permit one of its agents or contractors to disclose, PHI to the entity adopting the Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

To the extent an Underlying Plan constitutes a group health plan within the meaning of Section 733 of ERISA, the Underlying Plan shall provide benefits in accordance with the applicable requirements of any qualified medical child support order as described in and which satisfies the requirements of Section 609 of the Employee Retirement Income Security Act of 1974. For this purpose, a National Medical Support Notice issued pursuant to Section 401(b) of the Child Support Performance and Incentive Act of 1998, shall be deemed a qualified medical support order. Any such order which attempts to provide any type or form of benefit, coverage or option, not otherwise provided under the Underlying Plan, shall not be recognized and will not bind the Underlying Plan, the Underlying Plan Administrator, or any Employer.

The Underlying Plan Administrator shall establish procedures in accordance with Section 609 of the Employee Retirement Income Security Act of 1974 for determining the qualified status of a medical child support order served upon the Underlying Plan and how to administer the provision of benefits under such qualified orders. The Underlying Plan Administrator shall follow all applicable procedures set forth in said Section 609 which apply when a medical child support order is received, including notification of all required persons of such procedures. You and your beneficiaries may obtain from the Underlying Plan Administrator, free of charge, a copy of the Underlying Plan's procedures governing qualified medical child support order determinations.

You will be responsible for paying the required contributions for any coverage that may be necessary to comply with the qualified medical child support order, such as when a change to family coverage is required under the Underlying Plan to provide the coverage for the child that is the subject of such order.

CLAIMS PROCEDURES

No action at law or in equity shall be instituted to recover under the Plan prior to the expiration of ninety (90) days after a claim for benefits has been filed in accordance with the requirements of the Plan; nor shall any such action be instituted at any time unless instituted within the time period specified in the Underlying Plan or, if no period is specified, within one (1) year after the date the expenses due to injury or illness which are the subject of or are otherwise involved in such action are incurred or are alleged to have been incurred; provided, however, that any limitation on actions regarding benefits shall be as provided in the Plan.

Any claim for benefits provided by an Underlying Plan shall be submitted and addressed in accordance with the claims procedure prescribed under the terms of such Underlying Plan. In the event the Underlying Plan does not prescribe a claims procedure that satisfies the requirements of Section 503 of ERISA, the applicable claims procedure prescribed below shall apply with respect to such Underlying Plan:

(a) General. The claims procedure in this paragraph (a) shall apply with respect to any claim filed for benefits (other than disability benefits) provided by an Underlying Plan other than an Underlying Plan that constitutes a group health plan within the meaning of Section 733(a).

(1) A claim shall be filed in writing with the Plan Administrator and decided within a reasonable period of time, but not later than ninety (90) days by the Plan Administrator This 90-day period may be extended for up to ninety (90) days in the case of special circumstances. If a decision is unable to be made within the initial ninety (90) day period due to special circumstances, the Plan Administrator will notify the claimant within such 90-day period of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If the claim is wholly or partially denied, such written notice shall:

(i) set forth an explanation of the specific findings and conclusions on which such denial is based, making reference to the pertinent provisions of the Plan or Underlying Plan documents;

(ii) describe any additional information or material needed to support the claim and explain why such information or material if any, is necessary; and

(iii) describe the review procedures and the time limits that apply to the review procedures, and state that the claimant has a right to civil action under Section 502(a) of ERISA following any adverse benefit determination on review.

(2) A claimant or his duly authorized representative may review all pertinent documents and may request a review by the Plan Administrator of such decision denying the claim. Any such request must be filed in writing with the Plan Administrator within sixty (60) days after receipt by the claimant of written notice of the decision. Such written request for review shall contain all additional information which the claimant wishes the Plan Administrator to consider.

(3) The Plan Administrator will review the claim and any additional information furnished by the claimant. The Plan Administrator will decide the appeal and notify the claimant of its decision within a reasonable period of time, but not later than sixty (60) days after the appeal is received by the Plan Administrator. This 60-day period may be extended for up to sixty (60) days if special circumstances require an extension of time for processing the claim. If a decision on review is unable to be made within the initial sixty (60) day period, the Plan Administrator will notify the claimant within such 60-day period of the special circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. After the claimant's appeal is denied, the Plan Administrator will tell the claimant how it was decided and what provisions of the Plan or Underlying Plan it relied upon. If the claim for benefits is denied on appeal, the claimant will be provided the following:

(i) the specific reason or reasons for the denial;

(ii) an explanation of the specific findings, reasons and conclusions on which such denial is based, making reference to the pertinent provisions of the Plan or Underlying Plan documents; and

(iii) a statement explaining the claimant is entitled to receive, upon written request and free of charge, reasonable access to all information relevant to the claim for benefits.

(b) Group Health Plan. The claims procedure in this paragraph (b) shall apply with respect to any claim filed for benefits provided by an Underlying Plan that constitutes a group health plan within the meaning of Section 733(a) of ERISA.

(1) In the case of an urgent care claim, a claim shall be filed with the Plan Administrator and decided as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the Plan Administrator receives the claim unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Underlying Plan. In the case of such a failure, the Plan Administrator will notify the claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim, of the specific information needed to complete the claim. The claimant will then have a reasonable amount of time, taking into account the circumstances, of at least forty-eight (48) hours, to provide the specified information to the Plan Administrator. The Plan Administrator will notify the claimant of its decision as soon as possible, but in no event later than forty-eight (48) hours after the earlier of the Plan

Administrator's receipt of the specified information, or the end of the period afforded the claimant to provide the specified additional information.

(2) If the Underlying Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, the following rules shall apply:

(i) Any reduction or termination by the Underlying Plan (other than by an amendment to, or the termination of, the Underlying Plan) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Plan Administrator shall notify the claimant, in accordance with subparagraph (b)(5), of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(ii) Any request by the claimant to extend the course of treatment beyond the period of time or number of treatments that is an urgent care claim shall be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator shall notify the claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Underlying Plan, provided that any such claim is made to the Underlying Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with subparagraph (b)(5), and any appeal shall be governed by subparagraphs (b)(6), (b)(7), and (b)(8).

(3) In the case of a pre-service claim, a claim shall be filed in writing with the Plan Administrator and decided within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim by the Plan Administrator (unless special circumstances require an extension of up to fifteen (15) additional days). If a decision is unable to be made within the initial fifteen (15) day period due to matters beyond the control of the Underlying Plan, the Plan Administrator will notify the claimant within such 15-day period of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If an extension is required because the claimant failed to submit information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will then have forty-five (45) days from receipt of the notice of extension to provide the specified information. Notification of any adverse benefit determination pursuant to this subparagraph (b)(3) shall be made in accordance with subparagraph (b)(5).

(4) In the case of a post-service claim, a claim shall be filed in writing with the Plan Administrator and decided within thirty (30) days by the Plan Administrator (unless special circumstances require an extension of up to fifteen (15) additional days). If a decision is unable to be made within the initial thirty (30) day period due to matters beyond the control of the Underlying Plan, the Plan Administrator will notify the claimant within such 30-day period of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If an extension beyond the initial 30-day period is required because the claimant failed to submit information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will then have forty-five (45) days from receipt of the notice of extension to provide the specified information.

(5) If a claim is wholly or partially denied, a written notice will be provided to the claimant, and such written notice shall:

(i) set forth an explanation of the specific findings, reasons and conclusions on which such denial is based, making reference to the pertinent provisions of the Plan or Underlying Plan documents;

(ii) describe any additional information or material needed to support the claim and explain why such information or material if any, is necessary;

(iii) provide a description of the review procedures and the time limits that apply to the review procedures, and a statement that the claimant has a right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;

(iv) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, or other similar criterion will be provided free of charge to the claimant upon request;

(v) if the decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Underlying Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(vi) in the case of an adverse determination concerning an urgent care claim, describe the expedited review process that applies to such claims;

(vii) for an Underlying group health plan which is not an Excepted Benefit or Grandfathered Health Plan, the Plan Administrator's decision will include sufficient information to identify the claim (including the date or dates of service, the health care provider and the claim amount (if applicable)) as well as a statement that the diagnosis and treatment codes and their respective corresponding meanings are available for review upon request;

(viii) for an Underlying group health plan which is not an Excepted Benefit or Grandfathered Health Plan, an explanation of the principal reason or reasons for the Plan's decision, including the denial code and its corresponding meaning, as well as the Plan's standard, if any, that was relied on in making the decision;

(ix) for an Underlying group health plan which is not an Excepted Benefit or Grandfathered Health Plan, a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and

(x) for an Underlying group health plan which is not an Excepted Benefit or Grandfathered Health Plan, the availability of, and current contact information for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

Notwithstanding the foregoing provisions of this subparagraph (b)(5), in the case of an urgent care claim, the Plan Administrator may provide the information described in subparagraphs (b)(5)(i) through (b)(5)(vi) to the claimant orally, provided that a written or electronic notice that satisfies subparagraphs (b)(5)(i) through (b)(5)(vi) is provided to the claimant within three (3) days after the oral notification.

(6) A claimant or his duly authorized representative may review all pertinent documents and may request in writing a review by the Plan Administrator of such decision denying the claim. Any such request must be filed in writing with the Plan Administrator within 180 days after receipt by the claimant of written notice of the decision. Such written request for review shall contain all additional information which the claimant wishes the Plan Administrator to consider, and the claimant may submit comments in writing, documents, records, or any other information relevant to the claim for benefits. Furthermore, the Plan Administrator must provide the claimant, free of charge, with any additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim as well as any new or additional rationale used in the determination. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

(7) The decision on appeal will be made subject to the following rules:

(i) The decision on appeal will take into consideration all information submitted by the claimant regardless of whether the claimant submitted such information in the initial claim for benefits.

(ii) The decision on appeal will not afford deference to the initial adverse determination.

(iii) The decision on appeal will be conducted by the Appeals Committee and no members of the Appeals Committee shall be the same person that made the initial determination, nor the subordinate of such person.

(iv) If the adverse decision is based in whole or in part on a medical judgment, including a determination with regard to whether a particular treatment, drug, or other item is experimental,

investigational, or not medically necessary or appropriate, then the Appeals Committee will consult with a health care professional trained and experienced in the field of medicine involved in the medical judgment. The health care professional will not be the same person who was consulted in connection with the adverse determination that is being appealed, nor the subordinate of such individual.

(v) The Appeals Committee will identify any medical or vocational experts whose advice was obtained on behalf of the Underlying Plan in connection with the initial adverse determination, regardless of whether the advice was relied upon in making the adverse determination.

(vi) In the case of an urgent care claim, an expedited review process shall apply in accordance with the following:

(A) A request for an expedited appeal may be submitted orally or in writing by the claimant.

(B) All necessary information, including the Appeal Committee's benefit determination on review, shall be transmitted between the Appeals Committee and the claimant by telephone, facsimile, or other available similarly expeditious method.

(8) The Appeals Committee will review the claim and any additional information furnished by the claimant. In the case of an urgent care claim, the Appeals Committee will decide the appeal and notify the claimant of its decision as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the appeal is received by the Appeals Committee. In the case of a pre-service claim, the Appeals Committee will decide the appeal and notify the claimant of its decision within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after the appeal is received by the Appeals Committee. In the case of a post-service claim, the Appeals Committee will decide the appeal and notify the claimant within a reasonable period of time, but not later than sixty (60) days after the appeal is received by the Appeals Committee.

After the claimant's appeal is decided, the Appeals Committee will tell the claimant how it was decided and what provisions of the Plan or Underlying Plan it relied upon. If the claim for benefits is denied on appeal, the claimant will be provided the following:

(i) the specific reason or reasons for denial;

(ii) an explanation of the specific findings, reasons and conclusions on which such denial is based, making reference to the pertinent provisions of the Plan or Underlying Plan documents;

(iii) a statement explaining the claimant is entitled to receive, upon written request and free of charge, reasonable access to all information relevant to the claim for benefits;

(iv) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making an adverse decision on appeal, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(v) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Underlying Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(vi) for an Underlying group health plan which is not an Excepted Benefit or Grandfathered Health Plan, the Plan Administrator's decision will include sufficient information to identify the claim (including the date or dates of service, the health care provider and the claim amount (if applicable)) as well as a statement that the diagnosis and treatment codes and their respective corresponding meanings are available for review upon request;

(vii) for an Underlying group health plan which is not an Excepted Benefit or Grandfathered Health Plan, an explanation of the principal reason or reasons for the Plan's decision, including the denial code and its corresponding meaning, as well as the Plan's standard, if any, that was relied on in making the decision and a discussion of the decision;

(viii) for an Underlying group health plan which is not an Excepted Benefit or Grandfathered Health Plan, a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(ix) for an Underlying group health plan which is not an Excepted Benefit or Grandfathered Health Plan, the availability of, and current contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes; and

(x) a statement that reads as follows: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

The Employer may appoint an Appeals Committee of not less than one individual who shall serve at the pleasure of the Employer. No member of the Appeals Committee will be directly or indirectly involved with the initial determination of a claim for benefits. Vacancies on the Appeals Committee arising by resignation, death, removal or otherwise shall be filed by the Employer in the same manner as the original appointment. The purpose of the Appeals Committee is to review an initial adverse benefits determination upon appeal by the claimant. The Appeals Committee shall act by a majority of its members then in office, and shall possess all of the Plan Administrator's discretionary power and authority as provided elsewhere in the Plan or Underlying Plan to the extent such discretionary power and authority relates to the appeal and determination of a claim for benefits. In the case where the Employer does not form an Appeals Committee, the decision on appeal will be conducted by a person who is not the same person that made the initial determination nor the subordinate of such person, and the provisions of subparagraphs (b)(6), (b)(7) and (b)(8) shall apply to such person.

(9) For an Underlying group health plan which is not an Excepted Benefit or Grandfathered Health Plan, for purposes of this subparagraph (b), the Plan Administrator must also ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and the impartiality of the persons involved in making the decision.

(10) External Review Program. For an Underlying group health plan which is not an Excepted Benefit or Grandfathered Health Plan, the following External Review Program is available to claimants. If after exhausting the Plan's internal claims appeals, a claimant is not satisfied with the final determination, the claimant may choose to participate in the External Review Program. This program only applies if the adverse benefit determination is based on:

(i) For Fully-Insured Group Health Plans – medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit

(ii) For Self-Insured Group Health Plans – all determinations (initial or on appeal) involving medical judgment (including, but not limited to those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or determinations that a treatment is experimental or investigational, as determined by the external reviewer, and all rescissions of coverage.

This External Review Program offers an independent review process to review an adverse benefit determination. The process is available at no charge to a claimant after the claimant exhausts the internal appeals process of this subparagraph (b) above and the claimant receives a decision that is unfavorable.

If the Plan Administrator fails to respond to the claimant's internal appeal (except for de minimis violations) within the time frames stated in this subparagraph (b) above or if the Plan Administrator fails to satisfy any other requirements promulgated within this subparagraph (b), a claimant will be deemed to have exhausted the internal claims and appeals processes and may initiate an External Review. If the Plan Administrator asserts that the violation was de minimis, the claimant may request a written explanation of the violation from the Plan, and Plan Administrator must provide such explanation within ten (10) days, including a specific description of its basis, if any for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or court rejects the claimant's request for immediate review on the basis that the Plan met the de minimis standard, the claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within ten (10) days, the Plan Administrator

shall provide the claimant with notice of the opportunity to resubmit and pursue the internal appeal. Timeframes for re-filing the claim shall begin to run upon the claimant's receipt of such notice.

Upon receipt of a notice of a final External Review decision reversing the adverse benefit determination or final internal adverse benefit determination, the plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

All requests for an External Review must be made within four (4) months of the date the claimant receives the adverse benefit determination or final internal adverse benefit determination. The claimant, the claimant's treating physician, or an authorized designated representative may request an External Review by contacting the Plan Administrator, Manatts, Inc., 1775 Old 6 Road, P.O. Box 535, Brooklyn, IA 52211, (641) 522-9206. Neither the claimant, the Plan Administrator or the Employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

(i) Fully-Insured Group Health Plans. A fully-insured group health plan that is subject to state insurance laws is required to follow the applicable state external review process that is binding on a health insurance issuer offering group health insurance coverage that includes the consumer protections in the National Association of Insurance Commissions Uniform Health Carrier External Review Model Act. A fully-insured group health plan will be subject to the Federal External Review process if the state in which the Plan is governed does not have a State External Review process or the State External Review process does not meet, at a minimum, the National Association of Insurance Commissions Uniform Health Carrier External Review Model Act.

(ii) Self-Insured Group Health Plans. A self-insured group health plan that is not subject to state insurance laws (by reason of ERISA preemption) is required to offer an External Review process in accordance with Federal guidelines, which have not yet been issued. In the interim, a self-insured group health plan may opt to comply with a state-provided external review process if such state chooses to expand access to their external review process to self-insured plans. Alternatively, a self-insured group health plan may offer an External Review Process in accordance with the following guidelines:

Standard External Review. Within five (5) business days following the date of receipt of the External Review request, the Plan Administrator must complete a preliminary review of the request. Within one (1) business day after the completion of the preliminary review, the Plan Administrator will notify the claimant in writing as to the eligibility of the claim for External Review. If the request is complete but not eligible for External Review, such notification must include the reasons for the request's ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification must describe the information or materials needed to make the request complete and the plan must allow a claimant to perfect the request for External Review within the four (4) month filing period or within the forty-eight (48) hour period following the receipt of the notification, whichever is later.

Upon completion of the preliminary review, the Plan Administrator must assign an Independent Review Organization ("IRO") to conduct the External Review. In conducting the External Review, the Plan Administrator shall contract with at least three (3) IROs for assignment under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. The IRO must provide the following:

- The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.
- The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for External Review. This notice will include a statement that the claimant may

submit in writing to the assigned IRO within ten (10) business days following the date of receipt of the notice additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.

- Within five (5) business days after the date of assignment of the IRO, the Plan Administrator must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan Administrator to timely provide the documents and information must not delay the conduct of the External Review. If the Plan Administrator fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision reversing the adverse benefit determination or final adverse benefit determination. Within one (1) business day after making the decision, the IRO must notify the claimant and the Plan Administrator.
- Upon receipt of any information submitted by the claimant, the assigned IRO must within one (1) business day forward the information to the Plan Administrator. Upon receipt of any such information, the Plan Administrator may reconsider its adverse benefit determination or final internal adverse benefit determination that is subject to the External Review. Reconsideration by the Plan Administrator may not delay the External Review. The External Review may be terminated as a result of the reconsideration only if the Plan Administrator decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one (1) business day after making such a decision, the Plan Administrator must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the External Review upon receipt of the notice from the Plan Administrator.

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

    - The claimant's medical records;
    - The attending health care professional's recommendation;
    - Reports from appropriate health care professionals and other documents submitted by the Plan Administrator, claimant, or the claimant's treating provider;
    - The terms of the claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with the 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 review criteria developed and used by the Plan Administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
    - The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- The assigned IRO must provide written notice of the final External Review decision within forty-five (45) days after the IRO receives the request for the External Review. The IRO must deliver the notice of final External Review decision to the claimant and Plan Administrator.
- The assigned IRO's decision will contain:
    - A general description of the reason for the request for External Review and the reasons for the previous denial. The IRO's decision will include the sufficient information to

identify the claim (including the date or dates of service, the health care provider and the claim amount (if applicable)) as well as a statement that the diagnosis and treatment codes and their respective corresponding meanings are available for review;
    - 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;
    - An explanation 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 the 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 the group health plan or to the claimant;
    - A statement that judicial review may be available to the claimant; and
    - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.
- The IRO shall maintain records of all claims and notices associated with the External Review process for six (6) years. An IRO must make such records available for examination by the claimant, Plan Administrator, or State or Federal oversight agency upon request, except where such disclosure would violate the State or Federal privacy laws.

Expedited External Review. A group health plan must allow a claimant to make a request for an expedited External Review with the Plan Administrator at the time the claimant receives:

- An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
- A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Preliminary Review. Immediately upon receipt of the request for expedited External Review, the Plan Administrator must determine whether the request meets the reviewability requirements set forth above for the standard External Review.

Referral to an Independent Review Organization. Upon a determination that a request is eligible for External Review following the preliminary review, the Plan Administrator will assign an IRO pursuant to the requirements set forth above for standard review. The Plan Administrator must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Notice of Final External Review Determination. The Plan's contract with the assigned IRO must require the IRO to provide notice of the final External Review decision, in accordance with the requirements set forth above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited External Review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan Administrator.

You may contact the Plan Administrator, Manatts, Inc., 1775 Old 6 Road, P.O. Box 535, Brooklyn, IA 52211, (641) 522-9206, for more information regarding your External Review rights and the External Review process.

The following terms in this subparagraph (b) shall have the respective meanings set forth below:

(i) An "urgent care claim" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations:

(A) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(B) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

An urgent care claim is to be determined by an individual acting on behalf of the Underlying Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; provided, however, any claim that a physician with knowledge of the claimant's medical condition determines is an urgent care claim shall be treated as an urgent care claim for purposes of this subparagraph (b).

(ii) A "pre-service claim" means any claim for a benefit with respect to which the terms of the Underlying Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(iii) A "post-service claim" means any claim for a benefit that is not a pre-service claim.

(iv) A "Grandfathered Health Plan" is a group health plan that existed on March 23, 2010, within the meaning of and exempt from certain mandated coverages under the Patient Protection and Affordable Care Act, Health Care and Education Reconciliation Act of 2010, and the rules and regulations issued thereunder.

(v) An "Independent Review Organization" is an organization that a group health plan that is not an Excepted Benefit or Grandfathered Health Plan must engage to provide External Review Services for purposes of Claims Appeals Processing as required under the Patient Protection and Affordable Care Act, the Health Care and Education Reconciliation Act of 2010, and the rules and regulations issued thereunder.

(vi) An "Excepted Benefit" is a group health plan that is excepted from certain requirements under the Health Insurance Portability and Accountability Act of 1996, the Patient Protection and Affordable Care Act, the Health Care and Education Reconciliation Act of 2010, and the rules and regulations issued thereunder.

(vii) For an Underlying group health plan which is not an Excepted Benefit or Grandfathered Health Plan, an "adverse determination" shall include a rescission of coverage by an Underlying Plan, which includes a rescission, cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(c) Disability Benefits. The claims procedure prescribed in this paragraph (c) shall apply with respect to any disability claim for benefits provided by the Plan or an Underlying Plan.

(1) A claim shall be filed in writing with the Plan Administrator and decided within a reasonable period of time, but not later than forty-five (45) days by the Plan Administrator. This 45-day period may be extended for up to thirty (30) days in a case where there are special circumstances that are beyond the control of the Plan or Underlying Plan. If a decision is unable to be made within the initial forty-five (45) day period due to matters beyond the control of the Underlying Plan, the Plan Administrator will notify

the claimant within such 45-day period of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision.

If the Plan Administrator determines, before the end of the initial 30-day extension period, that a decision cannot be made within the initial 30-day extension period due to circumstances beyond the control of the Plan or Underlying Plan, the initial 30-day extension period may be extended for an additional thirty (30) days. If special circumstances require an additional extension period of time for processing the claim, written notice of the additional extension period shall be furnished by the Plan Administrator to the claimant prior to the expiration of the initial 30-day extension period. The notice of additional extension period shall indicate the special circumstances necessitating the additional extension and the date by which the notice of decision with respect to the claim shall be furnished.

Any notice of extension shall also indicate, if applicable, the standards on which entitlement to a benefit is based, any unresolved issues that are preventing a decision to be made with respect to the claim, and if additional information is needed to resolve those issues, the notice of extension shall indicate that the claimant has forty-five (45) days from receipt of said notice of extension to provide the specified information. Commencement of Benefit payments shall constitute notice of approval of a claim to the extent of the amount of the approved Benefit.

If the claim results in an adverse benefit determination, a written notice will be provided to the claimant, and such written notice shall, in a manner calculated to be understood by the claimant:

(i) set forth an explanation of the specific findings, reasons, and conclusions on which such denial is based, making reference to the pertinent provisions of the Plan or Underlying Plan documents and including an explanation of the basis for disagreeing with the following: (1) the views presented by the claimant to the Plan or Underlying Plan of health care professionals treating the claimant and of vocational professionals who evaluated the claimant, (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan or Underlying Plan in connection with a claimant's adverse benefit determination (without regard to whether the advice was relied upon in making the benefit determination), and (3) a disability determination regarding the claimant presented by the claimant to the Plan or Underlying Plan made by the Social Security Administration;

(ii) describe any additional information or material needed to support the claim and explain why such information or material if any, is necessary;

(iii) provide a description of the Plan's or Underlying Plan's review procedures and the time limits that apply to the review procedures, and a statement that the claimant has a right to bring a civil action under Section 502(a) of ERISA following an adverse benefit of determination on review;

(iv) either include the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan or Underlying Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan or Underlying Plan do not exist;

(v) if the adverse determination was based on a medical necessity or experimental treatment or similar exclusion or limit, contain either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Underlying Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(vi) contain a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

(2) A claimant or his duly authorized representative may review all pertinent documents and may request in writing a review by the Plan Administrator of such adverse benefit determination. Any such request must be filed in writing with the Plan Administrator within 180 days after receipt by the claimant of written notice of the decision. Such written request for review shall contain all additional information which the claimant wishes the Plan Administrator to consider, and the claimant may submit comments in writing, documents, records, or any other information relevant to the claim for benefits.

(3) The decision on appeal will be made subject to the following rules:

(i) The decision on appeal will take into consideration all information submitted by the claimant regardless of whether the claimant submitted such information in the initial claim for benefits.

(ii) The decision on appeal will not afford deference to the initial adverse determination.

(iii) The decision on appeal will be conducted by the Appeals Committee and no members of the Appeals Committee shall be the same person that made the initial determination, nor the subordinate of such person.

(iv) If the adverse decision is based in whole or in part on a medical judgment, including a determination with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, then the Appeals Committee will consult with a health care professional trained and experienced in the field of medicine involved in the medical judgment. The health care professional will not be the same person who was consulted in connection with the adverse determination that is being appealed, nor the subordinate of such individual.

(v) The Appeals Committee will identify any medical or vocational experts whose advice was obtained on behalf of the Plan or Underlying Plan in connection with the initial adverse determination, regardless of whether the advice was relied upon in making the adverse determination.

(vi) As soon as possible and sufficiently in advance of the date on which notice of an adverse benefit decision is made on appeal is required to be provided to the claimant, the Plan Administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or Underlying Plan, insurer, or other person making the benefit determination (or at the direction of the Plan or Underlying Plan, insurer, or such other person) in connection with the claim, so as to provide the claimant a reasonable opportunity to respond prior to such date.

(vii) As soon as possible and sufficiently in advance of the date on which notice of an adverse benefit decision is made on appeal is required to be provided to the claimant, the Plan Administrator shall provide the claimant, free of charge, with an explanation of any different, new or additional rationale considered, relied upon, or generated by the Plan or Underlying Plan, insurer, or other person making the benefit determination (or at the direction of the Plan or Underlying Plan, insurer, or other such person) in connection with the claim, so as to provide the claimant a reasonable opportunity to respond prior to such date.

(4) The Appeals Committee will review the claim and any additional information furnished by the claimant. The Appeals Committee will decide the appeal and notify the claimant of its decision within a reasonable period of time, but not later than forty-five (45) days after the appeal is received by the Appeals Committee (unless special circumstances require an extension of up to forty-five (45) additional days). If a decision on review is unable to be made within the initial forty-five (45) day period, the Appeals Committee will notify the claimant within such 45-day period of the special circumstances requiring the extension of time and the date by which the Appeals Committee expects to render a decision. After the claimant's appeal is decided, the Appeals Committee will tell the claimant how it was decided and what provisions of the Plan or Underlying Plan it relied upon. If the claim for benefits is denied on appeal, the claimant will be provided the following:

(i) an explanation of the specific findings, reasons, and conclusions on which such denial is based, making reference to the pertinent provisions of the Plan or Underlying Plan documents and including an explanation of the basis for disagreeing with the following: (1) the views presented by the claimant to the Plan or Underlying Plan of health care professionals treating the claimant and of vocational professionals who evaluated the claimant, (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan or Underlying Plan in connection with a claimant's adverse benefit determination (without regard to whether the advice was relied upon in making the benefit determination), and (3) a disability determination regarding the claimant presented by the claimant to the Plan or Underlying Plan made by the Social Security Administration;

(ii) a statement explaining the claimant is entitled to receive, upon written request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(iii) either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan or Underlying Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar of the Plan or Underlying Plan do not exist;

(iv) if the adverse determination was based on a medical necessity or experimental treatment or similar exclusion or limit, contain either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Underlying Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(v) a statement that reads as follows: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency"; and

(vi) a statement that the claimant has a right to bring a civil action under Section 502(a) of ERISA following the adverse benefit of determination on review.

The Employer may appoint an Appeals Committee of not less than one individual who shall serve at the pleasure of the Employer. No member of the Appeals Committee will be directly or indirectly involved with the initial determination of a claim for benefits. Vacancies on the Appeals Committee arising by resignation, death, removal or otherwise shall be filled by the Employer in the same manner as the original appointment. The purpose of the Appeals Committee is to review an initial adverse benefits determination upon appeal by the claimant. The Appeals Committee shall act by a majority of its members then in office, and shall possess all of the Plan Administrator's discretionary power and authority as provided elsewhere in this Plan or Underlying Plan to the extent such discretionary power and authority relates to the appeal and determination of a claim for benefits. In the case where the Employer does not form an Appeals Committee, the decision on appeal will be conducted by a person who is not the same person that made the initial determination nor the subordinate of such person, and the provisions of subparagraphs (c)(2), (c)(3) and (c)(4) shall apply to such person.

(5) If any of the material procedures set forth in this subparagraph (c) are not adhered to, the claimant is deemed to have exhausted the administrative remedies available under the Plan or Underlying Plan, the claim or appeal is deemed denied, and the claimant may immediately pursue his or her claim in court under Section 502(a) of ERISA.

(6) The procedures set forth in this subparagraph (c) shall ensure independence and impartiality of all persons involved, including insulating claims adjudicators, medical experts, and vocational experts from conflicts of interest.

(7) All notices set forth in this subparagraph (c) shall be provided in a culturally and linguistically appropriate manner, and upon written request, claimants shall have access to language-assistance services.

(8) The following terms in this subparagraph (c) shall have the respective meanings set forth below:

(i) A "disability claim" or "claim" is any claim for benefits that involve a determination regarding an individual's ability to engage in gainful activity due to a physical or mental impairment.

(ii) A "claimant" is any Plan Participant or Beneficiary making a claim for benefits under this Section (c). A claimant is not precluded from procuring an authorized representative to act on his or her behalf or pursuing or appealing a benefit claim on the claimant's behalf, but the Plan Administrator may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, for purposes of protecting the claimant's privacy.

(iii) An "adverse benefit determination" is a denial, reduction, rescission, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, rescission, termination, or failure to provide or make payment that is based on a determination of a Participant's or Beneficiary's eligibility to Participate in the Plan or Underlying Plan.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under an Underlying Plan that is a group health plan (within the meaning of Section 733(a) of ERISA) as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.

The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file the suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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