Minneapolis College of Art and Design- #277
Supplemental Short-Term Disability Income Benefit Plan

Amendment #1

Effective April 1, 2018, the Minneapolis College of Art and Design Supplemental Short-Term Disability Income Benefit Plan is hereby amended as follows:

1. All references to Sheffield, Olson & McQueen, Inc. has been deleted and replaced with the following

   EBSO, Inc.

2. Under General Plan Information, in the section titled Contract Administrator has been deleted and replaced with the following:

   Contract Administrator: EBSO, Inc.
   2145 Ford Parkway, Suite 300
   St. Paul, Minnesota 55116-1914
   (651) 695-2500/1-800-486-7664

3. **Claim Procedures**, and **Claim Denials and Review Procedures**, has been deleted and replaced with the following:

Claim/Appeal Procedures

The procedures outlined below must be followed by Employees ("claimants") to obtain payment of disability income benefits under this Plan.

All claims and questions regarding Disability Income Claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Master Plan Document and summary plan description may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion. The Plan Administrator has retained the services of an independent third party administrator, EBSO, Inc. ("Claims Administrator") to provide technical services, including the processing of claims.

Each Employee claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator, in its sole discretion may require, written proof of the existence of the disability and that the disability is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the claimant is not disabled or that the disability is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Definitions

Words which are capitalized in this document are either defined below or in the Master Plan Document (see Definitions of General Terms, General Information and General Provisions) and summary plan description.

Disability Income Claim:

A "Disability Income Claim" means a claim for benefits that requires a claimant to prove a disability and for which the Plan will make its own determination of whether the Employee is disabled.

When Disability Income Claims Must Be Filed

A claim for payment of disability income benefits must be filed with the Plan by the Employee within 6 months after the date such disability begins. Failure to file such claim within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to file it within the required time period. However, in no event, except in the absence of legal capacity, will such claim be accepted later than one year after the time it was otherwise required. **Claims filed later than that date shall be denied.**

A Disability Income Claim is considered filed when the following information is received by the Claims Administrator, together with a Disability Income Claim Form:

1. The date the Injury or Sickness began;
2. The name, address and telephone number of the Physician;
3. The claimant's diagnosis;
4. The name of the Plan and Plan ID #;
5. The name and home address of the claimant;
6. The claimant's social security number;
7. The date the claimant last worked;
8. The expected length of the disability;
9. The cause of the disability; and
10. Appropriate documentation of the claimant's weekly earnings.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper processing of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days from receipt by the claimant of the request for additional information. Failure to do so will result in claims being declined.

NOTE: The Plan does not consider inquiries about benefits, eligibility or the circumstances under which benefits might be paid, to be claims. An inquiry does not become a claim unless the proper claim procedure is followed.

Initial Benefit Determination

The Plan Administrator shall notify the claimant of the initial benefit determination, in accordance with the provisions set forth below. The Plan Administrator will decide the claim within a reasonable period of time, but not to exceed 45 days from the date the claim was received, if the claimant has provided all of the necessary information.

This time period may be extended twice for matters beyond the Plan's control, including when a claim is incomplete. Each extension shall be for no more than 30 days and the Employee will receive a written notice of each extension. The notice will include the reason for the extension, a description of the specific information required, the date by which the Plan Administrator expects to render a decision, the specific standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and the additional information needed to resolve those issues. The Employee will be given 45 days in which to provide the requested information.

The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a claimant with a notice of an adverse benefit determination, either in writing or electronically, containing the following information:

1. The specific reason(s) the claim was denied, including an explanation of the basis for disagreeing with or not following:
   - the views that you presented to the Plan Administrator of health care professionals that treated you and vocational professionals that evaluated you;
   - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim denial, without regard to whether the Plan Administrator relied upon the advice in denying your claim; and
   - the disability determination made by the Social Security Administration, if you presented such a disability determination to the Plan Administrator.

2. Specific reference to the Plan provision(s) on which the denial was based.

3. A description of any additional material or information necessary to perfect your claim, and the reason this material or information is necessary.

4. If your claim was denied 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 to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

5. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying your claim or, alternatively, a statement that in denying your claim, the Plan Administrator did not rely upon any specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan in existence.

6. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

7. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, as outlined below.

Appeal of Adverse Benefit Determinations

A. Procedures for Review of Adverse Benefit Determinations

In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review relevant documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;

2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

3. For a review that is independent from the initial adverse benefit determination and is conducted by an appropriate named fiduciary of the Plan who is not the same individual who decided the claimant's initial adverse benefit determination and also who is not that individual's subordinate;

4. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;

5. That, if an adverse benefit determination is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with an independent health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is not the same person as the health care professional consulted in connection with the initial adverse benefit determination and also who is not that individual's subordinate;

6. For the identity of medical/vocational experts consulted in connection with the appeal, even if the Plan did not rely upon their advice; and

7. That a claimant will be provided, 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; information regarding any voluntary appeals procedures offered by the Plan; any rule, guideline, protocol or similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances.

B. Requirements for Appeal

The claimant must file the appeal in writing within 180 days following receipt of the notice of an initial adverse benefit determination. The claimant's appeal must be addressed as follows and mailed and/or faxed to the following number: *Attention: Appeal Dept. c/o EBSO, Inc. 215 Stanford Parkway, Findlay, OH 45840. Fax (419) 423-5834.* It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the claimant;
2. The claimant's social security number;
3. The group name and identification number;
4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal**;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that the Disability Income Claim will be eligible for payment under the Plan.

Before the Plan can issue an adverse benefit determination, on review of a claim, the Plan Administrator shall provide the Participant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or the Claims Administrator in connection with the claim; 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. Further, before the Plan can issue an adverse benefit determination on review of a claim based on a new or additional rationale, the Plan Administrator shall provide the Participant, free of charge, with the rationale; the rationale 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.

C. Notification of Benefit Determination on Review

The Plan Administrator shall notify the claimant of the Plan's benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the appeal.

This time period may be extended for matters beyond the Plan's control. The extension shall be for no more than 45 days and the Employee will receive a written notice of the extension. The notice will include the reason for the extension, a description of any additional information required and the date by which the Plan Administrator expects to render a decision. The Employee will be given 45 days in which to provide any requested information.

The period of time within which a benefit determination is required to be made shall begin at the time an appeal is deemed to be filed in accordance with the procedures of the Plan.

D. Manner and Content of Notification of Adverse Benefit Determination on Review.

The Plan Administrator shall provide a claimant with notification of a Plan's adverse benefit determination on review, in writing or electronically. The notification shall contain the following:

1. The specific reason(s) the appeal was denied, including an explanation of the basis for disagreeing with or not following:
   - the views that you presented to the Plan Administrator of health care professionals that treated you and vocational professionals that evaluated you;
   - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim denial, without regard to whether the Plan Administrator relied upon the advice in denying your claim; and
   - the disability determination made by the Social Security Administration, if you presented such a disability determination to the Plan Administrator.
2. Specific reference to the Plan provision(s) on which the denial was based.
3. A statement that you are entitled to receive, upon request and free of charge, all documents, records, and copies of all documents, records, and other information relevant to your claim for benefits under the Plan.
4. If your claim was denied 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 to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
5. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying your claim or, alternatively, a statement that in denying your claim, the Plan Administrator did not rely upon any specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan in existence.
6. The written notice will include a statement regarding your right to file suit in federal or state court to recover benefits under the terms of the Plan, including pursuant to ERISA Section 502(a) as applicable, together with a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for your claim.

E. Decision on Review to be Final

If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied and the Plan's internal review procedures have been exhausted. The decision by the Plan Administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.**

Appointment of Authorized Representative

A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. To appoint such a representative, the claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. **In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.**