WELCH SYSTEMS, INC.

SHORT TERM DISABILITY PLAN

Document and Summary Description

Effective: January 1, 2018

Table of Contents

ESTABLISHMENT OF THE PLAN

ADOPTION OF THE PLAN DOCUMENT AND SUMMARY DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Welch Systems, Inc. (the "Sponsor") as of January 1, 2018 hereby sets forth the provisions of the Welch Systems, Inc. Short Term Disability Plan (the "Plan").

Effective Date

The Plan Document is effective as of the date first set forth above, and any amendment is effective as of the date set forth in the amendment.

Adoption of the Plan Document

Welch Systems, Inc. as the settler of the Plan, hereby adopts this Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1 et seq. ("ERISA").

IN WITNESS WHEREOF, the Plan Sponsor has caused this Document to be executed.

Welch Systems, Inc.

By: _____

Print Name: Jeffrey A Martin

Title: President

INTRODUCTION AND PURPOSE and GENERAL PLAN INFORMATION

Introduction and Purpose

Welch Systems, Inc. has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Participants in the Plan may be required to contribute toward their benefits.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for replacement of part of Your income if You become Disabled due to a covered Illness or Injury. What We pay is governed by all the terms of this Plan.
Capitalized terms within the text are defined with special meanings. See the Definitions Section of this Plan. Other terms with special meanings are defined where they are used.
The Plan Document is maintained by Welch Systems, Inc. and may be inspected at any time during normal working hours by any Participant.

General Plan Information

Name of Plan:	**Welch Systems, Inc.** **Short Term Disability Plan**
Plan Sponsor:	**Welch Systems, Inc.** **7206 N Terra Vista Dr.** **Peoria, IL 61614** **Phone: (309) 692-4336**
Plan Administrator: **(Named Fiduciary)**	**Welch Systems, Inc.** **7206 N Terra Vista Dr.** **Peoria, IL 61614** **Phone: (309) 692-4336**
Plan Sponsor ID No.	**37-1024158**
Source of Funding:	**Self-Funded**
Applicable Law:	**ERISA**
Calendar/Plan Year:	**January 1 through December 31**
Plan Number:	**504**
Plan Type:	**Short Term Disability Income Plan**
Effective Date:	**January 1, 2018**
Third Party Administrator:	**Group Plan Solutions Benefit Administration,** **a Division of Pekin Insurance** **2505 Court Street** **Pekin, IL 61558** **Phone: 888-301-0747** **Fax: 855-545-7165** **Email: inquiry@groupplansolutions.com** **Website: www.groupplansolutions.com**

Agent for Service of Process: **Welch Systems, Inc.**
7206 N. Terra Vista Dr.
Peoria, IL 61614
Phone: (309) 692-4336

Legal Entity and Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time.

Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with employee and/or employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right:

- to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents
- to make determinations in regards to issues relating to eligibility for benefits
- to decide disputes that may arise relative to a Participant's rights, and
- to determine all questions of fact and law arising under the Plan.

SCHEDULE OF BENEFITS

This schedule provides a brief overview of Plan benefits and is not a complete description. Refer to the text of this Plan for a detailed description of Your Plan benefits.

BENEFIT DESCRIPTION	
Gross Weekly Benefit * Maximum Benefit per Week Maximum Payment Period for Illness or Injury Elimination Period for Illness or Injury	66 2/3% of Basic Weekly Salary ** $2,500 13 weeks 14 Days

*Gross Weekly Benefit is 66 2/3% of Your Earned Income, rounded to the nearest $1.00, if not already a multiple thereof, limited to a maximum of $2,500.00. Note: We integrate Your Gross Weekly Benefit with certain other income You may receive. Read the terms of the Plan to see what income We integrate with, and how.

** Basic Weekly Salary means the Employee's weekly Earned Income excluding overtime, expense accounts, and any other extra compensation. Earnings include the average of the Employees bonuses and commissions for the previous 12 months prior to Your Disability. If the Employee is disabled for only part of a week the payment will be $1/7^{th}$ of the benefit to which You would be entitled for the full week times the number of days You are disabled.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document

Active Work, Actively-at-Work or Actively Working

You are able to perform and are performing all of the regular duties of Your work for Your Employer, on a full-time basis at: (a) one of Your Employer's usual places of business; (b) some place where Your Employer's business requires You to travel; or (c) any other place You or Your Employer have agreed on for Your work.

Adverse Benefit Determination

Adverse Benefit Determination shall mean any of the following:

- A denial in benefits;
- A reduction in benefits;
- A rescission of coverage;
- A termination of benefits; or
- A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

Appeal

Means a review of an adverse benefit determination by the Third Party Administrator, as required under this Plan's Claims and internal appeals procedures.

Once an Authorized Representative is appointed, the Third Party Administrator will direct all information and notification regarding the Claim to the Authorized Representative. You will be copied on all notifications regarding decisions, unless You provide specific written direction otherwise.

Authorized Representative

Means:

- a person to whom You have given express written consent to represent You in an external review, and includes Your health care provider, or
- a person authorized by law to provide substituted consent for You, or
- Your health care provider when You are unable to provide consent.

An Appointment of Authorized Representative form may be obtained from the Third Party Administrator. The completed form must be submitted to our Third Party Administrator at:

Group Plan Solutions
2505 Court Street
Pekin, IL 61558
FAX # 855-545-7165
Email Address: healthclaimappeal@groupplansolutions.com

Basic Weekly Salary

Means the Participant's weekly earnings excluding overtime, expense accounts, and any other extra compensation. Earnings include the average of the Employees bonuses and commissions for the previous 12 months prior to Your Disability. If You are a partner, earnings means Your partnership earnings that are reported on Your IRS Form 1040 Schedule E for the prior calendar or tax year. If the Employee is disabled for only part of a week the payment will be $1/7^{th}$ of the benefit to which You would be entitled for the full week times the number of days You are disabled.

Claim

Means any request for a Plan benefit or benefits made in accordance with the Claim procedures. A communication regarding benefits that is not made in accordance with the claim procedures will not be treated as a Claim.

Claimant

Means a Participant person who makes a request for a Plan benefit or benefits in accordance with the Claim and appeals procedures. Any reference to Claimant in the section titled FILING A CLAIM, CLAIM PROCEDURES, APPEAL PROCEDURES also refers to an Authorized Representative of the Participant.

Disability or Disabled

These terms mean that a current Illness or Injury causes physical or mental impairment to such a degree that You are: (a) not able to perform, on a full-time basis, all of the substantial and material duties of Your Own Job and (b) not able to earn more than this Plan's maximum allowed Disability Earnings.

You are not Disabled if You perform any work for wage or profit during the Elimination Period.

You may be required, on average, to work more than 40 hours per work. In this case, You are not Disabled if You are able to work for 40 hours per week.

Neither: (a) loss of a professional or occupational license; or (b) receipt of or entitlement to Social Security disability benefits; in and of themselves constitute Disability under this Plan.

Disability Earnings

The weekly income You earn from working while Disabled. It includes salaries, wages, commissions, bonuses and any other compensation earned or accrued while working including pension, profit sharing contributions, sick pay, paid time off, holiday and vacation pay. When You have an ownership interest in the business, Disability Earnings also includes business profits, attributable to You, whether received or not. It includes any income You earn while Disabled and return to Your Employer, partnership, or any other similar business arrangement to cover any business or overhead expenses. If You have the ability to work on a part-time or full-time basis, following the earlier of the date You; (a) have been terminated from employment with the Employer; (b) have been disabled for 3 months in a row; or (c) have been offered a job or workplace modification by the Employer and You do not return to work; Disability Earnings also includes Maximum Capacity Earnings.

Doctor

Means a medical doctor (M.D.). He or she must: (a) be properly licensed or certified by the laws of the state where he or she practices; and (b) provide services that are within the lawful scope of his or her practice.

Earned Income

Means a Participant's compensation earned for services that he/she perform for the Employer. Earned Income includes, but is not limited to, wages, salaries, commissions, and bonuses, overtime pay, expense accounts, stock options and any other extra compensation. We do not include pay for hours worked or billed over 40 per week. Earnings based on excluded income and Employer contributions deposited into such 401 (k); 403(b); 457; or similar plan are excluded. Earned Income also includes the Participant's contributions deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account. Earned Income does not include bonuses, commissions, overtime We will not consider federal, state or local taxes of any kind in determining the Participant's Earned Income. We have the right to require reasonable proof of the Participant's income during any disability.

Earned Income does not include capital gains, dividends interest, rent, royalties, annuities, investment income, deferred compensation plan income or other forms of income realized from sources not requiring Your performance of actual services.

We calculate benefit amounts and limits based on the amount of the Participant's Earned Income as of the Redetermination date immediately prior to the start of his or her Disability. See the "Redetermination" section of this Plan.

Elimination Period

Means the number of consecutive days You must be Disabled before benefits begin to accrue and become payable.

Employee

Means a person employed by Welch Systems, Inc. on a permanent full-time basis. The person must be regularly scheduled to work at least 30 hours per week.

Employer

Means Welch Systems, Inc.

Government Plan

Any of the following: (1) the United States Social Security Act; (2) the Railroad Retirement Act; (3) the Canadian Pension Plan; or (4) any other plan provided under the laws of a state, province or any other political subdivision. It also includes: (a) any public employee retirement plan; or (b) any plan provided in place of the above named plan or acts. It does not include: (i) any Workers' Comp Act or similar law; (ii) the Jones' Act; (iii) the Longshoreman's and Harbor Workers' Compensation Act; or (iv) the Maritime Doctrine of Maintenance, Wages, or Cure.

Gross Weekly Benefit

This Plan's Weekly Benefit as shown on the Schedule of Benefits before it is integrated with other income and earnings.

Illness

Any condition, disease, or sickness which causes loss and affects normal bodily function, other than a condition caused by Injury. It also includes a pregnancy or complication of pregnancy.

Injury

A bodily Injury due to an accident that occurs, independent of disease or bodily infirmity, while the Plan is in force. We will consider a Disability to be caused by an Injury when the Disability starts within 90 days of the date of such Injury.

Maximum Capacity Earnings

The income You could earn if working to the fullest extent You are able to in Your Own Job. We decide the fullest extent of work You are able to do based on objective data provided by any or all of the following sources: (a) Your treating doctor; (b) impartial medical or vocational exams; (c) peer review specialists; (d) functional capacities exams; and (e) other medical and vocational specialists whose area of expertise is appropriate to Your disability.

Maximum Payment Period

The longest period of time, beyond the Elimination Period, that You may receive benefits paid by this Plan for any one period of Disability as shown on the Schedule of Benefits.

Objective Medical Evidence

May include but is not limited to: (a) diagnostic testing; (b) laboratory reports; and (c) medical records of a Doctor's exam documenting: (i) clinical signs; (ii) presence of symptoms; and (iii) test results consistent with generally accepted medical standards supported by nationally recognized authorities in the health care field.

Own Job

Means the position or profession at Your Employer that You receive Earned Income from at the time the Disability begins. We use the job description provided by the Plan Sponsor to determine the duties and requirements of Your Own job.

Participant

Means any Employee who is covered for benefits under this Plan.

Proof of Loss

Means any information that We consider necessary to establish Your Disability benefits. This includes, but is not limited to, Claim forms, medical records, financial records, and tax returns.

Reasonable Accommodation

Any modification or adjustment to: (i) a job; (ii) an employment practice; (iii) a work process; or (iv) the work place; that an employer willingly provides. The modification or adjustment must make it possible for a Disabled person to: (1) reach the same level of performance as a similarly situated non-disabled person; or (2) enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person. The modification or adjustment must not place an undue hardship on the Employer.

Recurring Disability

A later Disability that: (a) is related to an earlier Disability for which this Plan paid benefits; and (b) meets the conditions described in "Recurring Disability."

Regular and Appropriate Care

Means, with respect to Your: (a) disabling condition; and (b) any other condition which, if left untreated, would adversely affect Your disabling condition; You (i) visit a Doctor as frequently as medically required, according to generally accepted medical standards, to effectively manage these conditions; and (ii) are receiving the most appropriate treatment, according to generally accepted medical standards, designed to achieve maximum medical improvement in these conditions. Treatment must be provided by a Doctor(s) whose specialty is most appropriate for Your; (a) disability; and (b) any other conditions which left untreated would adversely affect Your disabling condition; according to generally accepted medical standards. Generally accepted medical standards are those supported by nationally recognized authorities in the health care field including: the American Medical Association (AMA); the AMA Board of Medical Specialties; the Food and Drug Administration; the Centers for Disease Control; the National Cancer Institute; the National Institutes of Health; the Department of Health and Human Services; and any other agency of similar repute.

Retirement Plan

A defined benefit or defined contribution plan funded wholly or in part by the Employer's deposits for Your benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans; (d) individual retirement accounts; (e) tax sheltered annuities; (f) 401(k), 403(b), 457 or similar plans; or (g) stock ownership plans.

Retirement Plan "retirement benefits" are lump sum or periodic payments at normal or early retirement. Some Retirement Plans make payments for disability (as defined by those plans) that start before normal retirement age. When such payments reduce the amount that would have been paid at normal retirement age, they are Retirement Benefits. When such payments do not reduce the normal retirement amount, they are "disability benefits."

Valid Loss of Time Coverage

Means any coverage that provides a benefit for the loss of Your income. Such coverages include but are not limited to disability insurance policies, employer, association or union sponsored disability plans, salary continuation or replacement disability plans, or any other plan that provides benefits for disability. In addition, workers' compensation benefits, and benefits provided by governmental agencies, such as unemployment compensation, and Social Security benefits.

Weekly Benefit

This Plan's Gross Weekly Benefit reduced by other income. If You are working while Disabled, Your Weekly Benefit will be further reduced based on the amount of Your Disability Earning.

We, Our, Us

Means the Plan, the Plan Sponsor, or their designated Third Party Administrator.

You, Your

Means a Participant.

ELIGIBILITY AND EFFECTIVE DATE FOR COVERAGE

Eligibility for Employee Coverage

All Employees of Welch Systems, Inc. are eligible to become covered under the Plan once they have completed 30 consecutive days as an Employee of Welch Systems, Inc.

Effective Date for Employee Coverage

An eligible Employee will become covered under the Plan the first of the month following 30 consecutive days of employment. An eligible Employee is automatically enrolled by the Employer.

TERMINATION OF COVERAGE

The coverage of any Employee under this Plan will end on the earliest of the following dates:

- the date this entire Plan terminates;
- the date he/she requests coverage be terminated, as long as the request is made on or before the date requested;
- the date he/she ceases to be eligible for coverage under the Plan (except to the extent that event is because of a Disability and only for the time period Weekly Benefits are being paid from the Plan);
- the date his/her employment is terminated (except to the extent that event is because of a Disability and only for the time period Weekly Benefits are being paid from the Plan); or
- immediately after an Employee or his/her Dependent submits, or has knowledge of the submission of, a fraudulent Claim or any fraudulent information to the Plan.

WEEKLY INCOME BENEFITS

How Payments Start

To start getting payments from this Plan, You must meet all of the conditions listed below:

a) You must: (i) become Disabled while covered by the Plan; and (ii) remain Disabled for this Plan's Elimination Period.
b) You must provide Proof of Loss, as described in this Plan's Claim Provisions section.

Benefits accrue as of the first day following the end of the Elimination Period, subject to all Plan terms.

You may not satisfy the Plan's Elimination Period while working.

Benefits

A Participant who incurs a Disability while covered under the Plan is entitled to a benefit of 66 2/3% of his Basic Weekly Salary for each full calendar week of Disability ("Weekly Benefit"). Weekly Benefits are further limited to a maximum of $2,500 per week reduced by any Other Income received by the Participant during such period.

Benefits are payable after completion of an Elimination Period of 14 days during which the Participant is suffering from Disability from an Illness or an Injury and are payable for a maximum of 13 weeks per period of Disability.

When Payments End

Your benefits from this Plan will end on the earliest of the dates shown below:

(a) The date You are no longer Disabled.
(b) The date You fail to provide Proof of Loss as required by this Plan.
(c) The date You earn, or are able to earn, the maximum earnings allowed while Disabled under this plan.
(d) The date You are able to perform the major duties of Your Own Job on a full-time basis with Reasonable Accommodation.
(e) The date You have been outside the United States or Canada for more than 2 months in a 12 month period.
(f) The date You fail to take a physical exam required by the Plan.
(g) The date You become incarcerated for a period greater than seven days.
(h) The date of Your Retirement.
(i) The date of Your death.
(j) The end of the Maximum Payment Period.
(k) The date You are no longer receiving Regular and Appropriate care from a doctor.

Maximum Payment Period

The Maximum Payment Period is the longest time that benefits are paid by this Plan for Your Disability

For Disability due to Injury, the Maximum Payment Period is 13 weeks.
For Disability due to Illness, the Maximum Payment Period is 13 weeks.

Recurring Disability

Benefits from this Plan end if You cease to be Disabled. But, a later disability may be treated as a Recurring Disability, if all of the terms listed below are met.

(a) You must return to Active Work right after Your benefits end;
(b) The Disability must recur less than two weeks after You were last entitled to benefits;
(c) The later Disability must be due to the same or related cause of Your earlier Disability;

(d) This Plan must not end during Your return to Active Work;
(e) You must not become covered under any other similar group income replacement plan during the time You return to Active Work;
(f) During the time You return to Active Work, You must: (i) stay covered by this Plan and (ii) any contributions required from You, if any, must be paid;
(g) Your benefits must not have ended because You have used up the Maximum Payment Period.

If the later Disability is a Recurring Disability, You will not need to complete a new Elimination Period. The Recurring Disability, will be subject to all the terms of the Plan in effect on the date the earlier Disability began.

If all of the terms listed above are not met, the later Disability will be treated as a new period of Disability. You will be required to complete a new Elimination Period. The new period of Disability will be subject to all the terms of the Plan in effect on the date the new period of Disability occurs.

Calculation of Weekly Benefit

Your benefit is governed by the terms of the Plan in effect on the date Disability occurs. Any changes to this Plan that take place: (a) while You are Disabled; or (b) during a period of Active Work that occurs between an initial period of Disability and a Recurring Disability; will not affect Your benefit.

We calculate Your Gross Weekly Benefit according to the Schedule of Benefits.

From Your Gross Weekly Benefit, subtract the amount of any income listed in Other Income Benefits that You receive or are entitled to receive. The result is Your Weekly Benefit.

Redetermination

This Plan redetermines Earned Income for each Participant on the date a change in a Participant's Earned Income occurs. The Employer must report updates to all Participants' Earned Income as they occur.

Other Income Benefits

The Weekly Benefit amount payable under this Plan may be reduced.

We will reduce Your Gross Weekly Benefit by Valid Loss of Time Coverages that You are entitled to receive without regard to the reason You are entitled to receive it.

Our right to integrate/reduce Your benefit by such income shall not be negated by a transfer of Claim liability to a third party. Payment by such third party by law, settlement, judgement, waiver or otherwise shall not negate our right.

Other Income Not Subject to Deduction

We will not reduce Your Gross Weekly Benefit by any income You receive or are entitled to receive from the list below.

- Deferred compensation arrangements such as 401(k), 403(b) or 457 plans;

- Profit sharing plans;
- Thrift plans;
- Tax sheltered annuities;
- Stock ownership plans;
- Individual Retirement accounts (IRA);
- Individual disability income plans;
- Credit disability insurance;
- Non-qualified plans of deferred compensation;
- Pension plans for partners;
- Retirement Plans of another employer not affiliated with this plan;
- Military pension and disability plans;
- Income from a sick leave, salary continuance, or Paid Time Off plan.

Lump Sum Payments of Other Income

Income with which We integrate may be paid in a lump sum. In this case, We take the equivalent weekly rate stated in the award into account when We determine Your Weekly Benefit. If no weekly rate is given, We divide the lump sum payment by the number of calendar days in the period for which it was awarded. This will determine the daily rate. Then, multiply the daily rate by seven. The result is the prorated weekly rate.

Cost of Living Freeze

You may receive a cost of living increase in other income with which We integrate. In this case, We do not further reduce Your Weekly Benefit by the amount of such increase.

Application for Other Income

You must apply for other income benefits to which You may be entitled. If these benefits are denied, You must appeal until: (a) all possible appeals have been made; or (b) We notify You that no further appeals are required.

If We feel You are entitled to receive such income benefits, We will estimate the amount due to You and Your spouse and children. We will take this estimated amount into account when We determine Your Weekly Benefit. But, We will not take this estimated amount into account when We determine Your Weekly Benefit. But, We will not take this estimated amount into account if You sign our reimbursement agreement. In this agreement You promise: (a) to apply for any benefits for which You may be eligible; (b) to appeal any denial of such benefits until all possible appeals have been made; and (c) to repay any amount We overpaid due to an award of such benefits.

If We reduce Your Gross Weekly Benefit by an estimated amount, We will adjust Your Weekly Benefit when We receive written proof: (a) of the amount awarded; or (b) that the other income benefits have denied; and no further appeals are possible. If We underpaid You, We pay the full amount of the underpayment in a lump sum.

Adjustment of Weekly Benefit for Disability Earnings

This Plan will not pay benefits if You work during the Elimination Period.

We reduce Your Weekly Benefit by 50% of Your Disability Earnings.

Maximum Allowable Disability Earnings

This Plan limits the amount of income You may earn, or may be able to earn, and still be considered disabled.

If Your Disability Earnings are more than 80% of Your Earned Income, payments from this Plan will end. Payments from this Plan will also end if You are able to earn more than 80% of Your Earned Income.

Exclusions

This Plan does not pay benefits for disability caused by:

Declared or undeclared war, act of war, or armed aggression;

(a) Service in the armed forces, National Guard, or military reserves of any state or country;
(b) You taking part in a riot or insurrection:
(c) Your commission of, or attempt to commit a felony, for which You have been convicted;
(d) Your voluntary use of any poison chemical, prescription, or non-prescription drug or controlled substance unless: (a) it was prescribed for You by a Doctor; and (b) it was prescribed. In the case of a non-prescription drug, We do not pay for any loss resulting from Your use in a manner inconsistent with package instructions, A controlled substance is anything called a controlled substance in a Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time;
(e) Intentional self-inflicted Injuries; or
(f) Job related or on-the-job Injury.

We do not pay any benefits for any period of Disability:

1) During which You are confined to a facility as a result of Your conviction of a crime;
2) During which You are receiving medical treatment or care outside the United states or Canada unless authorized by Us;
3) Which starts before You are covered by this Plan; or
4) During which Your loss of earnings is not solely due to Your Disability.

CLAIM PROVISIONS

Notice: You must send Us written notice of Your intent to file a Claim under this Plan as described below. If You have questions You can call Your Employer or the Third Party Administrator listed in the General Plan Information section.

Proof of Loss

When We receive Your notice, We will provide You with a Claim form for filing Proof of Loss. This form requires data from Your Employer, You and the Doctor(s) treating You for Your Illness or Injury. Proof of Loss must be given to us within the time stated in FILING A CLAIM, CLAIM PROCEDURES, APPEAL PROCEDURES section. If You do not receive a Claim form within 15 days of the date You sent Your notice, You should send us written Proof of Loss without waiting for the form.

Proof of Loss, provided at Your expense, consists of the following. Failure to provide this information may delay, suspend, reduce or terminate Your benefits.

(a) The date Disability began;
(b) Your last day of Active Work;
(c) The cause of Disability;
(d) The extent of Disability, including limitations and restrictions preventing You from performing Your Own Job;
(e) If Your occupation requires that You carry liability or malpractice insurance, any changes to such insurance that become effective on or after the date of Disability;
(f) Objective Medical Evidence in support of Your limitations and restrictions, beginning with the date Disability began;
(g) The prognosis of Disability;
(h) The name and address of all Doctors, hospitals and health care facilities where You have been treated for Your Disability since the date the Disability began;
(i) Proof that You: (i) are currently; and (ii) have been receiving Regular and Appropriate care from a Doctor, from the date Disability began;
(j) Proof of Earned Income, and, if applicable, Disability Earnings;
(k) Payroll or absence data from the Employer for the three months prior to the date l Disability began, or other period We specify;
(l) Proof of application for all other sources of income to which You may be entitled, that may affect Your payment from this Plan;
(m) Proof of receipt of other income that may affect Your payment from this Plan; and
(n) any other information necessary for the Plan to determine benefits.

You must provide Objective Medical Evidence from a Doctor who is not Yourself, Your spouse, child, parent, sibling or business associate.

Proof of Earned Income and Disability Earnings may consist of: (1) copies of Your W-2 forms; (2) payroll records from Your Employer(s); (3) copies of Your U.S. Individual Income Tax Returns; (4) copies of the U.S. income tax returns from any business in which You hold an ownership or shareholder interest; (5) a statement from a certified public accountant; (6) copies of any income records accepted or required by the IRS; or (7) any other records We deem necessary.

Proof of Loss and other Claim data should be submitted to the Third Party Administrator listed in the General Plan Information section.

Authorization Required

You must provide us with written, unaltered authorizations to obtain medical, financial, vocational, occupational, and governmental information required to determine our liability under this Plan. You must provide us with such authorizations as often as We may require, in order that they remain current. Failure to provide such authorizations may delay, suspend or terminate Your benefits.

Right to Request Medical, Financial or Vocational Assessment

We may ask You to take part in a medical, financial vocational or other assessment that we feel is necessary to determine whether the terms of the Plan are met. We may require this as often as We feel is reasonably necessary. We will pay for all such assessments. But, if you postpone a scheduled assessment without Our approval, You will be responsible for any

rescheduling fees. If You do not take part in or cooperate with the assessment, we have the right to stop or suspend Your payments under this Plan.

Right to Request Medical, Financial or Vocational Assessment

We may ask You to take part in a medical, financial, vocational or other assessment that We feel is necessary to determine whether the terms of the Plan are met. We may require this as often as We feel is reasonably necessary. We will pay for all such assessments. But, if You postpone a scheduled assessment without our approval You will be responsible for any rescheduling fees. If You do not take part in or cooperate with the assessment, We have the right to stop or suspend Your payments under this Plan.

Ongoing Proof of Loss

To continue to receive payments from this Plan, You must give Us current Proof of Loss as often as We may reasonably require. Ongoing Proof of Loss must be provided within 30 days of the date We request it.

Payment of Benefits

We pay benefits to You, if You are legally competent. If You are not, We pay benefits to the legal representative of Your estate. Benefits are paid in US dollars.

We pay benefits on the date of Your regular payroll date at the end of the period for which they are payable.

No benefits are payable for this Plan's Elimination Period.

Benefits to which You are entitled may remain unpaid at Your death. Such benefits may be paid at our discretion to: (a) Your estate; or (b) Your spouse, parents, children, or brothers and sisters.

FILING A CLAIM, CLAIM PROCEDURES, APPEAL PROCEDURES

The procedures outlined below must be followed by Participants to obtain payment of benefits under this Plan.

Claims

All Claims and questions regarding Claims should be directed to the Third Party 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 ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. The responsibility to process Claims in accordance with the Plan Document may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Participant claiming benefits under the Plan shall be responsible for supplying Proof of Loss consisting of (1) a properly completed claim form; and (2) any other information needed to process the Claim; at such times and in such manner as the Plan Administrator in

its sole discretion may require written proof of a Claim or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Participant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the Participant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Participant who wants to know if an individual is covered under the Plan or if an event is covered by the Plan, prior to providing treatment is not a "Claim," since an actual Claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions**. Once incurred, a Claim must be filed with the Plan. At that time, a determination will be made as to what benefits are payable under the Plan.

A Participant has the right to request a review of an Adverse Benefit Determination. If the Claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a final Adverse Benefit Determination. .If the Participant receives notice of a final Adverse Benefit Determination.

The claims procedures are intended to provide a full and fair review. This means, among other things, that Claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to the Participant.

When Claims Must Be Filed

Claims must be filed with the Third Party Administrator within 12 months of the date of the commencement of the Disability. Benefits are based upon the Plan's provisions at the time the Disability commenced. **Claims filed later than that date shall be denied.**

Timing of Claim Decisions

The Plan Administrator shall notify the Participant, in accordance with the provisions set forth below, of any Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the Claim, unless an extension has been requested, then prior to the end of the 15-day extension period. If the Participant has not provided all of the information needed to process the Claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant. The extension period shall not be for a period longer than 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or

similar method, with written or electronic notice). The notice will contain the following information:

- Information sufficient to allow the Participant to identify the Claim involved;
- A reference to the specific portion(s) of the plan provisions upon which a denial is based;
- Specific reason(s) that was used in denying the Claim;
- A description of any additional information necessary for the Participant to perfect the Claim and an explanation of why such information is necessary;
- A description of the Plan's internal appeals and external review processes and the time limits applicable to the processes. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;
- A statement that the Participant 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 Participant's Claim for benefits;
- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request; and
- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a Claim for benefits is denied, in whole or in part, and the Participant believes the Claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a reasonable opportunity for a full and fair review of a Claim and Adverse Benefit Determination. More specifically, the Plan provides:

- Participants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;
- Participants the opportunity to submit written comments, documents, records, and other information relating to the Claim for benefits;

- Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process;

- For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

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

- That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claim, even if the Plan did not rely upon their advice;

- That a Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's Claim in possession of the Plan Administrator or Third Party Administrator; ; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances; and

- That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Participant to respond to such new evidence or rationale.

Requirements for Appeal

The Participant must file the appeal in writing (although oral appeals are permitted for pre-service urgent care claims) within 180 days following receipt of the notice of an Adverse Benefit Determination. To file an appeal in writing, the Participant's appeal must be addressed as follows and mailed or faxed as follows:

Group Plan Solutions Benefit Administration,
a Division of Pekin Insurance
2505 Court Street
Pekin, IL 61558
Phone: 888-301-0747
Fax: 855-545-7165
Email: inquiry@groupplansolutions.com
Website: www.groupplansolutions.com

It shall be the responsibility of the Participant to submit proof that the Claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the employee/Participant;
- The employee/Participant's social security number;
- The group name or identification number;
- 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 Participant will lose the right to raise factual arguments and theories which support this Claim if the Participant fails to include them in the appeal;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the Claim; and
- Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Participant of the Plan's benefit determination on review a reasonable period of time, but not later than 60 days after receipt of the appeal.

Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Participant with notification, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

- Information sufficient to allow the Participant to identify the Claim involved;
- A reference to the specific portion(s) of the plan provisions upon which a denial is based;
- Specific reason(s) for the denial;
- A description of any additional information necessary for the Participant to perfect the Claim and an explanation of why such information is necessary;

- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- A statement that the Participant 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 Participant's Claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a Claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and

- The following statement: "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."

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review

If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan 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.**

Independence

The Plan Administrator shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. As a result, the Plan Administrator and Third Party Administrator shall not make any decisions regarding hiring, compensation, termination, promotion, or similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) based on the likelihood that the individual will support the denial of benefits.

GENERAL PROVISIONS

Right to Recovery

If the Plan made a payment in error, the Plan can recover the Plan's payment from another plan, the Participant, or anyone else to whom the Plan has made payment.

Physical Examinations

The Plan Administrator reserves the right to have a Physician of the Plan's choosing examine any Participant whose condition, Illness or Injury is the basis of a Claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a Claim. The Participant must comply with this requirement as a necessary condition to coverage.

Payment of Benefits

All benefits under this Plan are payable to the Participant whose Illness or Injury, or whose covered dependent's Illness or Injury, is the basis of a Claim. In the event of the death or incapacity of a Participant and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Plan, is or was providing the care and support of such Employee.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon a misstatement in a Proof of Loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid or from the Participant. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or the Participant on whose behalf such payment was made.

A Participant or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will

repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any Claims for benefits by the Participant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Any person or entity accepting payment from the Plan agrees to be bound by the terms of this Plan. Any payments made on Claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Participant or other person or entity to enforce the provisions of this section, then that Participant or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services.

Plan Administrator

The Plan is administered by the Plan Administrator within the purview of ERISA, and in accordance with the plan provisions. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator have maximum legal discretionary authority to:

- construe and interpret the terms and provisions of the Plan
- to make determinations regarding issues which relate to eligibility for benefits
- to decide disputes which may arise relative to a Participant's rights, and
- to decide questions of Plan interpretation and those of fact relating to the Plan.

The decisions of the Plan Administrator as to the facts related to any Claim for benefits and the meaning and intent of any provision of the Plan, or its application to any Claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

- to administer the Plan in accordance with its terms;
- to determine all questions of eligibility, status and coverage under the Plan;
- to interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- to make factual findings;
- to decide disputes which may arise relative to a participant's rights and/or availability of benefits;
- to prescribe procedures for filing a Claim for benefits, to review Claim denials and appeals relating to them and to uphold or reverse such denials;
- to keep and maintain the Plan documents and all other records pertaining to the Plan;
- to appoint and supervise a Third Party Administrator to process Claims;
- to pay the Claim;
- to perform all necessary reporting as required by ERISA;
- to delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- to perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settler of the Plan, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents.

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

PARTICIPANT'S RIGHTS

As a Participant in the Plan, You are entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to:

Receive Information About the Plan and Benefits (if required)

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 copies 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 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 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.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 Participants and beneficiaries. No one, including Your Employer, Your union (if any), 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. 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 Pension and Employee Benefits Security Administration.