Barry-Wehmiller Companies, Inc.
January 1, 2018

Barry-Wehmiller Companies, Inc. Short Term Disability Plan Summary

November 30, 2018

The information contained in this document is merely a compilation of the Company's short-term disability Plan provisions for use in administering claims and is not intended to be a Plan document on which a participant may rely for benefits. The Company has reviewed and approved the summary of the Plan's provisions contained herein. The Company is the Plan Fiduciary.

The Plan provides short term disability (STD) benefits to eligible participants under the terms and conditions of the Plan. The Plan is a self-funded welfare benefit Plan (Plan). The Plan is administered by Barry-Wehmiller Companies, Inc. (Company).

Liberty Life Assurance Company of Boston (Liberty) provides non-fiduciary claim processing services to the Plan. The Plan is not insured by Liberty, and Liberty has not issued any insurance policy that would fund benefits under the Plan. Liberty is not responsible to fund the payment of any benefits under the Plan.

This document provides a summarized explanation of the Plan benefits in effect as of the date on the front page of this document. The master Plan, if any, more fully describes the terms and conditions of the Plan. If the terms of this document and the master Plan differ, the master Plan will govern. A complete copy of the master Plan, if any, is in the possession of the Company and is available for your review upon request. In the event of any changes in benefits or Plan provisions, the Company will provide you a new summary Plan description, a statement of material modification, or a supplement that describes any changes.

Possession of this document does not necessarily mean you are a participant under the Plan. This document explains the requirements for becoming a participant under the Plan. The dates on which participation begins or ceases are explained within this document. The description of Eligible Classes, as that term is defined in this document, will help you determine what benefits, if any, may apply to you.

For information, contact Barry-Wehmiller Companies, Inc..

THE PLAN MAY BE AMENDED OR TERMINATED BY Barry-Wehmiller Companies, Inc. AT ANY TIME AND FOR ANY REASON.

SECTION 1 - PLAN SPECIFICATIONS

ELIGIBILITY REQUIREMENTS FOR PARTICIPATION

What is the Minimum Hourly Requirement?

Employees working a minimum of 30 regularly scheduled hours per week

Who is Eligible for Short Term Disability Benefits?

Class 1: All full-time regular Employees

Note: This policy does not cover the following Employees: Temporary and Seasonal Employees and Employees who are not legal residents working in the United States.

What is the Eligibility Waiting Period?

1. If you are employed by the Company on the Plan effective date - None

2. If you begin employment for the Company after the Plan effective date - None

Are Employee Contributions Required?

No

What is the Elimination Period?

The period for which a benefit is payable will commence following the Elimination Period shown below:

7 calendar days for Injury
7 calendar days for Sickness

Benefits will begin on the 1st day of Disability if you remain Disabled following the completion of the Elimination Period.

What is the Amount of Benefits?

100% of Covered Person's Basic Weekly Earnings for weeks 1-6.
60% of Covered Person's Basic Weekly Earnings for weeks 7-26.

What is the Maximum Benefit Period?

Applicable to Injury:

The period for which a benefit is payable, following completion of the Elimination Period, for any one Disability will end on the earliest of:

a. the end of the Disability; or

b. the end of the 26th week of Disability for which a benefit is payable.

Applicable to Sickness:

The period for which a benefit is payable, following completion of the Elimination Period, for any one Disability will end on the earliest of:

a. the end of the Disability; or

b. the end of the 26th week of Disability for which a benefit is payable.

SECTION 2 - DEFINITIONS

In this section the Company defines some basic terms needed to understand this Plan. The male pronoun whenever used in this Plan includes the female.

"Active Employment" means you must be actively at work for the Company:

1. on a full-time basis and paid regular earnings;

2. for at least the minimum number of hours shown in the Plan Specifications; and either perform such work:

    a. at the Company's usual place of business; or
    b. at a location to which the Company's business requires you to travel.

You will be considered actively at work if you were actually at work on the day immediately preceding:

1. a weekend (except where one or both of these days are scheduled work days);
2. holidays (except when the holiday is a scheduled work day);
3. paid vacations;
4. any non-scheduled work day;
5. an excused leave of absence (except medical leave for your own disabling condition and lay-off); and
6. an emergency leave of absence (except emergency medical leave for your own disabling condition).

"Appropriate Available Treatment" means care or services which are:

1. generally acknowledged by Physicians to cure, correct, limit, treat or manage the disabling condition;
2. accessible within your geographical region;
3. provided by a Physician who is licensed and qualified in a discipline suitable to treat the disabling Injury or Sickness;
4. in accordance with generally accepted medical standards of practice.

"Basic Weekly Earnings" means the Covered Person's weekly rate of earnings from the Sponsor in effect immediately prior to the date Disability or Partial Disability begins. However, such earnings will not include bonuses, commissions, overtime pay, and extra compensation other than shift or lead differential pay.

"Disability" or "**Disabled"** means you, as a result of Injury or Sickness, are unable to perform the Material and Substantial Duties of your Own Job.

"Eligibility Date" means the date you become eligible to participate in this plan. Eligibility Requirements are shown in the Plan Specifications.

"Eligibility Waiting Period" means the continuous length of time you must be in Active Employment in an eligible class to reach your Eligibility Date.

"Elimination Period" means a period of consecutive days of Disability for which no benefit is payable. The Elimination Period is shown in the Plan Specifications and begins on the first day of Disability.

"Employee" means a person in Active Employment with the Company who is participating in this Plan.

"Enrollment Form" is the document completed by you, if required, when enrolling for to participate in the Plan. This form must be satisfactory to the Company or its agent.

"Family and Medical Leave" means a leave of absence for the birth, adoption or foster care of a child, or for the care of your child, spouse or parent or for your own serious health condition as those terms are defined by the Federal Family and Medical Leave Act of 1993 (FMLA) and any amendments, or by applicable state law.

"Gross Weekly Benefit" means your Weekly Benefit before any reduction for Other Income Benefits and Other Income Earnings.

"Hospital" or **"Institution"** means a facility licensed to provide Treatment for the condition causing your Disability.

"Initial Enrollment Period" means one of the following periods during which you may first enroll to participate in this Plan:

1. if you are eligible on the Plan effective date, a period before the Plan effective date set by the Company.

2. if you become eligible after the Plan effective date, the period which ends 31 days after your Eligibility Date.

"Injury" means bodily impairment resulting directly from an accident and independently of all other causes. For the purpose of determining benefits under this Plan:

1. any Disability which begins more than 60 days after an Injury will be considered a Sickness; and

2. any Injury which occurs before you are a participant under this Plan, but which accounts for a medical condition that arises while you are participating in this Plan will be treated as a Sickness.

"Material and Substantial Duties" means responsibilities that are normally required to perform your Own Job and cannot be reasonably eliminated or modified.

"Own Job" means your job that you were performing when your Disability or Partial Disability began.

"Partial Disability" or "Partially Disabled" means you, as a result of Injury or Sickness, are able to:

1. perform one or more, but not all, of the Material and Substantial Duties of your Own Job or another job on an Active Employment or a part-time basis; or

2. perform all of the Material and Substantial Duties of your Own Job or another job on a part-time basis; and

3. earn between 20.00% and 80.00% of your Basic Weekly Earnings.

"Physician" means a person who:

1. is licensed to practice medicine and is practicing within the terms of his license; or

2. is a licensed practitioner of the healing arts in a category specifically favored under the health coverage laws of the state where the Treatment is received and is practicing within the terms of his license.

It does not include you, any family member or domestic partner.

"Plan Specifications" means the section of this plan which shows, among other things, the Eligibility Requirements, Eligibility Waiting Period, Elimination Period, Amount of Benefits, Minimum Benefit, and Maximum Benefit Period.

"Proof" means the evidence in support of a claim for benefits and includes, but is not limited to, the following:

1. a claim form completed and signed (or otherwise formally submitted) by you claiming benefits;

2. an attending Physician's statement completed and signed (or otherwise formally submitted) by your attending Physician; and

3. the provision by the attending Physician of standard diagnosis, chart notes, lab findings, test results, x-rays and/or other forms of objective medical evidence in support of a claim for benefits.

Proof must be submitted in a satisfactory form or format.

"Regular Attendance" means your personal visits to a Physician which are medically necessary according to generally accepted medical standards to effectively manage and treat your Disability or Partial Disability.

"Sickness" means illness, disease, pregnancy or complications of pregnancy.

"Treatment" means consulting, receiving care or services provided by or under the direction of a Physician including diagnostic measures, being prescribed drugs and/or medicines, whether you choose to take them or not, and taking drugs and/or medicines.

"Weekly Benefit" means the weekly amount payable by the Plan to you if you are Disabled or Partially Disabled.

SECTION 3 - ELIGIBILITY

Who is Eligible for Benefits?

The eligibility requirements for participation are shown in the Plan Specifications.

What is Your Eligibility Date for Benefits?

If you are in an eligible class you will qualify for benefits on the later of:

1. this Plan's effective date; or

2. the day after you complete the Eligibility Waiting Period shown in the Plan Specifications.

What Happens to Your Benefits During a Family and Medical Leave?

Your participation may be continued under this Plan for an approved family or medical leave of absence for up to 12 weeks following the date participation would have terminated, subject to the following:

1. the authorized leave is in writing;

2. the required contribution is made;

3. your benefit level, or the amount of earnings upon which your benefit may be based, will be that in effect on the date before said leave begins; and

4. continuation of participation will cease immediately if any one of the following events should occur:

    a. you return to work;
    b. this group benefit Plan terminates;
    c. you are no longer in an eligible class;
    d. fails to make the required contribution when due to the Company;
    e. your employment terminates.

SECTION 4 - DISABILITY INCOME BENEFITS

Disability Benefit

When is Your Disability Benefit Payable?

When the Plan receives Proof that you are Disabled due to Injury or Sickness and require the Regular Attendance of a Physician, you may be eligible to receive a Weekly Benefit after the end of the Elimination Period, subject to any other provisions of this Plan. The benefit will be paid for the period of Disability if you give to the Plan Proof of continued:

1. Disability;

2. Regular Attendance of a Physician; and

3. Appropriate Available Treatment.

The Proof must be given upon the Plan's request and at your expense. In determining whether you are Disabled, the Plan will not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, paycuts, job sharing and loss of a professional or occupational license or certification.

For purposes of determining Disability, the Injury must occur and Disability must begin while you are a participant of this Plan.

The Weekly Benefit will not:

1. exceed your Amount of Benefits; or

2. be paid for longer than the Maximum Benefit Period.

The Amount of Benefits and the Maximum Benefit Period are shown in the Plan Specifications.

How is the Amount of Your Disability Weekly Benefit Figured?

To figure the amount of Weekly Benefit:

1. Take the lesser of:

   a. your Basic Weekly Earnings multiplied by the benefit percentage shown in the Plan Specifications; or

   b. the Maximum Weekly Benefit shown in the Plan Specifications; and then

2. Deduct Other Income Benefits and Other Income Earnings, (shown in the Other Income Benefits and Other Income Earnings provision of this Plan), from this amount.

Partial Disability

When is Your Partial Disability Benefit Payable?

When the Plan receives Proof that you are Partially Disabled and have experienced a loss of earnings due to Injury or Sickness and require the Regular Attendance of a Physician, you may be eligible to receive a loss of earnings Weekly Benefit, subject to any other provisions of this Plan. To be eligible to receive Partial Disability benefits, you may be employed in your Own Job or another job, must satisfy the Elimination Period, and must be earning between 20.00% and 80.00% of your Basic Weekly Earnings.

A Weekly Benefit will be paid for the period of Partial Disability if you give to the Plan Proof of continued:

1. Partial Disability;

2. Regular Attendance of a Physician; and

3. Appropriate Available Treatment.

The Proof must be given upon the Plan's request and at your expense. In determining whether you are Partially Disabled, the Plan will not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, paycuts, job sharing and loss of a professional or occupational license or certification.

For purposes of determining Partial Disability, the Injury must occur and Partial Disability must begin while you are a participant of this Plan.

How is Your Loss of Earnings Partial Disability Benefit Figured using the Work Incentive Calculation?

The work incentive benefit will be an amount equal to your Basic Weekly Earnings multiplied by the benefit percentage shown in the Plan Specifications, without any reductions from earnings.

The work incentive benefit will only be reduced, if the Weekly Benefit payable plus any earnings exceed 100% of your Basic Weekly Earnings. If the combined total is more, the Weekly Benefit will be reduced by the excess amount so that the Weekly Benefit plus your earnings does not exceed 100% of your Basic Weekly Earnings.

The Weekly Benefit payable will not be more than the Disability benefit otherwise payable under this Plan.

Other Income Benefits and Other Income Earnings

What are Your Other Income Benefits and Other Income Earnings?

Other Income Benefits means:

1. The amount for which you are eligible under:

    a. any work loss provision in mandatory "No-Fault" auto coverage; or

    b. any governmental program or coverage required or provided by statute (including any amount attributable to your family).

2. any amount you receive from any unemployment benefits; or

3. any amount of Disability and/or Retirement Benefits under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar Plan or act, which:

    a. you receive or are eligible to receive; and
    b. your spouse, child or children receives or are eligible to receive because of your Disability; or
    c. your spouse, child or children receives or are eligible to receive because of your eligibility for Retirement Benefits.

Other Income Earnings means:

1. any amount you receive from any formal or informal sick leave or salary continuation Plan(s); and

2. the amount of earnings you earn or receive from any form of employment.

Other Income Benefits, except Retirement Benefits, must be payable as a result of the same Disability for which the Company pays a benefit. The sum of Other Income Benefits and Other Income Earnings will be deducted in accordance with the provisions of this Plan.

Estimation of Benefits

How will Your Benefits be Estimated?

Your Disability or Partial Disability benefits will be reduced by the amount of Other Income Benefits that the Plan estimates is payable to you and your dependents.

Your Disability benefit will not be reduced by the estimated amount of Other Income Benefits if you:

1. provide satisfactory proof of application for Other Income Benefits;

2. sign a reimbursement agreement under which, in part, you agree to repay the Plan for any overpayment resulting from the award or receipt of Other Income Benefits;

3. if applicable, provide satisfactory proof that all appeals for Other Income Benefits have been made on a timely basis to the highest administrative level unless the Plan determines that further appeals are not likely to succeed; and

4. if applicable, submit satisfactory proof that Other Income Benefits have been denied at the highest administrative level unless the Plan determines that further appeals are not likely to succeed.

In the event that the Plan overestimates the amount payable to you from any Plans referred to in the Other Income Benefits and Other Income Earnings provision of this Plan, the Plan will reimburse you for such amount upon receipt of written proof of the amount of Other Income Benefits awarded (whether by compromise, settlement, award or judgement) or denied (after appeal through the highest administrative level).

What Happens if You Receive a Lump Sum Payment?

Other Income Benefits from a compromise, settlement, award or judgement which are paid to you in a lump sum and meant to compensate you for any one or more of the following:

1. loss of past or future wages;
2. impaired earnings capacity;
3. lessened ability to compete in the open labor market;
4. any degree of permanent impairment; and
5. any degree of loss of bodily function or capacity;

will be prorated on a weekly basis as follows:

1. over the period of time such benefits would have been paid if not in a lump sum; or

2. if such period of time cannot be determined, over a period of 260 weeks.

What Happens when Your Benefit Period is Less than a Week?

For any period for which a Short Term Disability benefit is payable that does not extend through a full week, the benefit will be paid on a prorated basis. The rate will be 1/5th for each day for such period of Disability.

When will Your Short Term Disability Benefit be Discontinued?

The Weekly Benefit will cease on the earliest of:

1. the date you fail to provide Proof of continued Disability or Partial Disability and Regular Attendance of a Physician;

2. the date you fail to cooperate in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

3. the date you refuse to be examined or evaluated at reasonable intervals;

4. the date you refuse to receive Appropriate Available Treatment;

5. the date you refuse a job with the Company where workplace modifications or accommodations were made to allow you to perform the Material and Substantial Duties of the job;

6. the date you are able to work in your Own Job on a part-time basis, but choose not to;

7. the date your current Partial Disability earnings exceed 80.00% of your Basic Weekly Earnings;

   Because your current earnings may fluctuate, earnings will be averaged over three consecutive weeks rather than immediately terminating your benefit once 80.00% of Basic Weekly Earnings has been exceeded.

8. the date you are no longer Disabled according to this Plan;

9. the end of the Maximum Benefit Period; or

10. the date you die.

Successive Periods of Disability

What Happens if You Return to Work and Become Disabled Again?

With respect to this Plan, **"Successive Periods of Disability"** means a Disability which is related or due to the same cause(s) as a prior Disability for which a Weekly Benefit was payable.

A Successive Period of Disability will be treated as part of the prior Disability if, after receiving Disability benefits under this Plan, you:

1. return to your Own Job on an Active Employment basis for less than thirty continuous days; and

2. perform all the Material and Substantial duties of your Own Job.

To qualify for the Successive Periods of Disability benefit, you must experience more than a 20% loss of Basic Weekly Earnings.

Benefit payments will be subject to the terms of this Plan for the prior Disability.

If you return to your Own Job on an Active Employment basis for thirty continuous days or more, the Successive Period of Disability will be treated as a new period of Disability. You must complete another Elimination Period.

If you become eligible for benefits under any other group short term disability Plan, this Successive Periods of Disability provision will cease to apply to you.

SECTION 5 - EXCLUSIONS

GENERAL EXCLUSIONS

What Disabilities are Not Covered?

This Plan will not provide benefits for any Disability due to:

1. war, declared or undeclared, or any act of war;
2. intentionally self-inflicted injuries, while sane or insane;
3. active Participation in a Riot;
4. the committing of or attempting to commit an indictable offense;
5. cosmetic surgery unless such surgery is in connection with an Injury or Sickness sustained while the individual is an Employee;

No benefit will be payable during any period of incarceration.

With respect to this provision, **Participation** shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in defense of you, if such actions of defense are not taken against persons seeking to maintain or restore law and order including, but not limited to police officers and fire fighters.

With respect to this provision, **Riot** shall include all forms of public violence, disorder or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

Disability Benefit Exclusions

What Disabilities are Not Covered?

A Weekly Benefit will not be payable if you become Disabled due to:

1. Injury that arises out of or in the course of employment; or
2. Sickness when a benefit is payable under a Workers' Compensation Law, or any other act or law of like intent.

These exceptions will not apply to partners or proprietors who elect not to be covered under such laws.

SECTION 6 - TERMINATION

When will Your Benefits End?

You will cease to be covered on the earliest of the following dates:

1. the date this Plan terminates, but without prejudice to any claim originating prior to the time of termination;

2. the date you are no longer in an eligible class;

3. the date your class is no longer included for benefits;

4. the date employment terminates. Cessation of Active Employment will be deemed termination of employment, except the insurance will be continued for an Employee absent due to Disability during the Elimination Period.

5. the date you cease active work due to a labor dispute, including any strike, work slowdown, or lockout.

SECTION 7 - GENERAL PROVISIONS

Is Assignment Allowed?

No assignment of any present or future right or benefit under this Plan will be allowed.

What are the Examination Rights?

The Plan may have the right and opportunity to have you, whose Injury or Sickness is the basis of a claim, examined or evaluated at reasonable intervals deemed necessary by the Plan. This right may be used as often as reasonably required.

When can Legal Proceedings Begin?

A claimant or the claimant's authorized representative cannot start any legal action:

1. until 60 days after Proof of claim has been given; or

2. more than one year after the time Proof of claim is required.

When Must Liberty be Notified of a Claim?

a. Notice of claim must be given to the Plan within 30 days of the date of the loss on which the claim is based. If that is not possible, Liberty, on behalf of the Company, must be notified as soon as it is reasonably possible to do so. Such notice of claim must be received in a form or format satisfactory to the Plan.

b. When written notice of claim is applicable and has been received by the Plan you will be sent claim forms. If the forms are not received within 15 days after written notice of claim is sent, you can send to the Plan written Proof of claim without waiting for the forms.

When Must Liberty Receive Proof of Claim?

a. Satisfactory Proof of loss must be given to the Plan, no later than 30 days after the end of the Elimination Period.

b. Failure to furnish such Proof within such time shall not invalidate or reduce any claim if it was not reasonably possible to furnish such Proof within such time. Such Proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one year from the time Proof is otherwise required.

c. Proof of continued loss, continued Disability or Partial Disability, when applicable, and Regular Attendance of a Physician must be given to the Plan within 30 days of the request for such Proof.

The Plan reserves the right to determine if your Proof of loss is satisfactory.

What are the Rights of Recovery?

The Company has the right to recover any overpayment of benefits caused by, but not limited to, the following:

1. fraud;
2. any error made by the Company in processing a claim; or
3. your receipt of any Other Income Benefits.

The Company may recover an overpayment by, but not limited to, the following:

1. requesting a lump sum payment of the overpaid amount;
2. reducing any benefits payable under this Plan;
3. taking any appropriate collection activity available including any legal action needed; and
4. placing a lien, if not prohibited by law, in the amount of the overpayment on the proceeds of any Other Income Benefits, whether on a periodic or lump sum basis.

It is required that full reimbursement be made to the Plan.

What are the Rights of Subrogation and Reimbursement?

When your Injury appears to be someone else's fault, benefits otherwise payable under this Plan for loss of time as a result of that Injury will not be paid unless you or your legal representative agree(s):

1. to repay the Plan, for such benefits to the extent they are for losses for which compensation is paid to you by or on behalf of the person at fault;

2. to allow the Plan, a lien on such compensation and to hold such compensation in trust for the Plan; and

3. to execute and give to the Plan, any instruments needed to secure the rights under 1. and 2. above.

Further, when the Company has paid benefits to or on behalf of the injured Covered Person, the Company will be subrogated to all rights of recovery that you have against the person at fault. These subrogation rights will extend only to recovery of the amount the Company has paid. You must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to the Plan.

How does the Contract Affect Workers' Compensation?

This Plan and the benefits provided are not in lieu of, nor will they affect any requirements for coverage under any Workers' Compensation Law or other similar law.

SUMMARY PLAN DESCRIPTION

Name of Plan: Barry-Wehmiller Companies, Inc. Group Disability Income Plan

Plan benefits are provided under the terms of the Group Disability Income Policy No. PD3-840-444087-02 hereinafter referred to as "the policy", issued by Liberty Life Assurance Company of Boston, hereinafter referred to as "Liberty," to the Employer hereinafter referred to as "Sponsor".

Participants Included: See Schedule of Benefits

Name and Address of Sponsor:

Barry-Wehmiller Companies, Inc.
8020 Forsyth Blvd
St. Louis, MO 63100-5170

Who Pays For the Plan: Premiums are paid by the Sponsor.

The cost of the Plan is funded by Employer contributions.

Plan Identification Number:

a. Sponsor IRS Identification No.: 43-0172560

b. Plan No.: 501

Type of Plan: Self-Insured Short Term Disability Plan

Plan Year: December 31st-January 1st

Plan Administrator, Name, Address and Telephone No:

Barry-Wehmiller Companies, Inc.
8020 Forsyth Blvd
St. Louis, MO 63100-5170

Agent for Service of Legal Process on the Plan:

Same as above

Type of Administration: Insurer Administration

Funding Arrangement of the Plan: Benefits of the Plan are insured.

Amendment of the Sponsor's Plan:

The Plan Sponsor reserves the right to modify, amend or terminate in whole or in part, any or all provisions of the Plan. Amendments to the Plan are to be made by a written resolution adopted in accordance with the established procedures of the Board of Directors. Amendments may be adopted with retroactive effect to the extent permitted by ERISA and the Code.

Amendment of Liberty's Policy:

The policy may be changed in whole or in part by mutual agreement of the Sponsor and Liberty. Only an Officer of Liberty can approve a change. The approval must be in writing and endorsed on or attached to the policy. No consent of any participant or any other person referred to in the policy(ies) shall be required to modify, amend, or change the policy(ies).

NOTE: If you cease active employment, see your benefits administrator to determine what arrangements, if any, may be made to continue your coverage beyond the date you cease active employment.

When May The Policy Terminate?

1. If the Sponsor fails to pay any premium within the grace period, the policy will automatically terminate at 12:00 midnight of the last day of the grace period. The "grace period" is the 31 days following a premium due date during which premium payment may be paid.

2. The Sponsor may terminate the policy by advance written notice delivered to Liberty at least 31 days prior to the termination date. But the policy will not terminate during any period for which premium has been paid.

3. Liberty may terminate the policy on any premium due date by giving written notice to the Sponsor at least 31 days in advance if:

    a. The number of employees insured is less than 10;

    b. less than 100% of the Employees eligible for any non-contributory insurance are insured for it; or

    c. the Sponsor fails:

        i. to furnish promptly any information which Liberty may reasonably require; or
        ii. to perform any other obligations pertaining to this policy.

4. Termination may take effect on any earlier date when both the Sponsor and Liberty agree.

No consent of any participant or any other person referred to in the policy(ies) shall be required to terminate the policy(ies).

1. if the overall participation for all coverage options falls below 25.00% of the Employees eligible for benefits under this policy; and

2. if less than 25.00% of the Employees eligible for each coverage option are insured for it.

Termination may take effect on an earlier date if agreed to by the Sponsor and Liberty.

What Are Your Rights In The Event Of Policy Termination?

Termination of the policy under any conditions will not prejudice any payable claim which occurs while the policy is in force.

What Are Your Rights Under ERISA?

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

   a. Examine, without charge, at the Plan Administrator's office and at other specified locations, 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.

   b. 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 Plan Administrator may make a reasonable charge for the copies.

   c. 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.

2. 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.

3. 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.

4. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

5. 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.

6. 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 Administrator.

What Are Your Rights Under ERISA? (Continued)

7. 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 if, for example, it finds your claim is frivolous.

8. If you have any questions about your Plan, you should contact the Plan Administrator.

9. 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.

What is the Time Frame For Claim Decisions?

If your claim is denied, Liberty will notify you of the adverse decision within a reasonable period of time, but not later than 45 days after receiving the claim. This 45-day period may be extended for up to 30 days, if Liberty: (1) determines the extension is necessary because of matters beyond the Plan's control, and (2) notifies you, before the end of the 45-day period, why the extension is needed and the expected decision date. If, before the end of the first 30-day extension, Liberty determines, due to matters beyond the Plan's control, a decision cannot be rendered within that extension period, the determination period may be extended for up to an additional 30 days, provided Liberty notifies you, before the end of the first 30-day extension period, why the extension is needed and the expected decision date.

The notice of extension shall explain: (1) the standards on which benefit entitlement is based, (2) the unresolved issues that prevent a claim decision, and (3) the additional information needed. You have at least 45 days to provide the information.

The claim determination time frames begin when a claim is filed, without regard to whether all the information necessary to make a claim determination accompanies the filing.

If an extension is necessary because you failed to submit necessary information, the days from the date Liberty sends you the extension notice until you respond to the request for additional information are not counted as part of the claim determination period.

What If Your Claim Is Denied?

Liberty's notice of denial shall include:

1. The specific reason or reasons for denial with reference to those specific Plan provisions on which the denial is based;

2. A description of any additional material or information necessary to perfect the claim and an explanation of why that material or information is necessary;

3. A description of the Plan's appeal procedures and time frames, including a statement of the claimant's right to bring a civil action under ERISA following an adverse decision on appeal;

4. Either the specific internal rules, guidelines, protocols, standard or other similar criteria of the 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 do not exist;

5. If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request;

6. If applicable, the reason for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration;

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

8. Notice in a culturally and linguistically appropriate manner.

What Do You Do To Appeal A Claim Denial?

You, or your authorized representative, may appeal a denied claim within 180 days after you receive Liberty's notice of denial. You have the right to:

1. Submit to Liberty, for review, written comments, documents, records, and other information relating to the claim;

2. Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;

3. A review that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim decision;

4. A review that does not afford deference to the initial adverse decision and which is conducted neither by the individual who made the adverse decision nor the person’s subordinate;

5. If the appeal involves an adverse decision based on medical judgment, a review of your claim by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the adverse decision nor the subordinate of any such individual;

6. The identification of medical or vocational experts, if any, consulted in connection with the claim denial, without regard to whether the advice was relied upon in making the decision; and

7. A review and reasonable opportunity to respond to any new or additional evidence considered, relied upon, or generated, or any new or additional rationale in support of an adverse decision, before an adverse decision is rendered.

What Do You Do To Appeal A Claim Denial? (Continued)

Liberty will make a full and fair review of your appeal and may require additional documents as it deems necessary in making such a review. A final decision on the review will be made within a reasonable period of time but not later than 45 days following receipt of the written request for review unless Liberty determines that special circumstances require an extension. In such case, a written notice will be sent to you before the end of the initial 45-day period. The extension notice shall indicate the special circumstances and the date by which Liberty expects to render the appeal decision. The extension cannot exceed a period of 45 days from the end of the initial period.

The appeal time frames begin when an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing.

If an extension is necessary because you failed to submit necessary information, the days from the date of the extension notice until you respond to the request for additional information are not counted as part of the appeal determination period.

Liberty's notice of denial shall include:

1. The specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;

2. 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;

3. A statement describing any voluntary appeal procedures offered by Liberty and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA, including any applicable contractual limitations period that applies to your right to bring such an action and the calendar date on which the contractual limitations period expires;

4. Either the specific internal rules, guidelines, protocols, standard or other similar criteria of the Plan relied upon in making the adverse decision or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

5. If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request;

6. If applicable, the reason for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration; and

7. Notice in a culturally and linguistically appropriate manner.

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.