GROUP SHORT TERM DISABILITY PLAN

Curt G. Joa, Inc.

Exhibit A

BENEFIT HANDBOOK

Provided that you belong to a class described on the Schedule of Benefits you are entitled to the benefits which apply to your class, under the Curt G. Joa, Inc. self-funded Plan.

The Administrative Service Agreement Number assigned to Curt G. Joa, Inc. for Reliance Standard Life purposes is ASW 516438.

GROUP WEEKLY INCOME HANDBOOK

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SCHEDULE OF BENEFITS

EFFECTIVE DATE: January 1, 2020

ELIGIBLE CLASSES: Each active full-time employee, except any person employed on a temporary or seasonal basis.

WAITING PERIOD: 30 days of employment.

INDIVIDUAL EFFECTIVE DATE: The day following completion of the waiting period.

WEEKLY INCOME BENEFIT

DAY BENEFITS BEGIN: Benefits, for one period of disability, will be payable on the later of:

The 1st day of disability for injury; or
The 8th consecutive day of disability for sickness.

However, in the event the Insured is hospital confined, benefits will become payable from the first day the Insured is hospital confined, if earlier.

MAXIMUM BENEFIT PERIOD: Benefits, for one period of disability, will be paid up to a maximum of 26 weeks.

WEEKLY INCOME BENEFIT: The Weekly Income Benefit will be 66.67% of Earnings to a minimum of $175.00 up to a maximum benefit of $1,250.

In the event that you are covered under any of the following Acts, your Benefit will be reduced by any benefit payable under these Acts: California Unemployment Compensation Disability Insurance, the Hawaii Temporary Disability Insurance Law, the New Jersey Temporary Disability Benefits Law, the New York Disability Benefits Law or Rhode Island disability benefits.

Weekly Income Benefits terminate at retirement.

Changes in Weekly Income Benefit: Increases in the benefit amount are effective on the date of the change, provided you are actively at work on the effective date of the change. If you are not actively at work on that date, the effective date of the change will be deferred until the date you return to active work.

Decreases in the benefit amount are effective on the date the change occurs

CONTRIBUTIONS: You are not required to contribute toward the cost of this plan.

DEFINITIONS

"We", "us" and "our" means Curt G. Joa, Inc.

"You", "your" and "yours" means a person who meets the eligibility requirements of the Plan and is enrolled for coverage under the Plan.

"Actively at work" and "active work" means actually performing on a full-time basis each and every duty pertaining to your job in the place where and the manner in which the job is normally performed. This includes approved time off such as vacation, jury duty and funeral leave, but does not include time off as a result of injury or illness.

"Full-time" means working for us for a minimum of 30 hours during your regular work week.

"Disabled" means you are:

(1) unable to do the material duties of your job; and

(2) not doing any work for payment; and

(3) under the regular care of a physician.

"Injury" means bodily injury resulting directly from an accident, independent of all other causes. The injury must cause disability which begins while you are covered under the Plan.

"Sickness" means illness or disease causing disability which begins while you are covered under the Plan. Sickness includes pregnancy, childbirth, miscarriage or abortion, or any complications there from.

"Earnings" as used in the SCHEDULE OF BENEFITS section, means your weekly salary received from us on the day just before the date of disability, prior to any deductions to a 401(k) and Section 125 plan. Earnings does not include commissions, overtime pay, bonuses or any other special compensation not received as basic salary.

If hourly employees are covered, the number of hours worked during a regular work week, not to exceed 40 hours per week, will be used to determine weekly earnings.

"Physician" means any duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to treat the type of injury or sickness for which claim is made. The physician may not be you or a member of your immediate family.

"Claimant" means you or a duly authorized representative who makes a claim for benefits under the Plan for a loss covered by the Plan as a result of your injury or sickness.

"Retirement" means the effective date of your:

(1) retirement pension benefits under any plan of a federal, state, county or municipal retirement system, if such pension benefits include any credit for employment with us;

(2) retirement pension benefits under any plan which we sponsor, or make or have made contributions;

(3) retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act.

GENERAL PROVISIONS

NOT IN LIEU OF WORKER'S COMPENSATION

The Plan is not a Worker's Compensation Policy. It does not provide Worker's Compensation benefits.

CLAIMS PROVISIONS

NOTICE OF CLAIM

Written notice must be given to Curt G. Joa, Inc. within 31 days after the loss occurs, or as soon as reasonably possible. The notice should be sent to us at the Personnel Services Department. The notice should include your name, and the Administrative Service Agreement Number.

CLAIMS FORMS

When we receive the notice of claim, we will send the claimant the forms to file the proof of loss. If we do not send them within 15 days after we receive notice, then the proof of loss requirements will be met by giving us a written statement of the nature and extent of the loss within 90 days after the loss began.

WRITTEN PROOF OF LOSS

For any covered loss, written proof must be sent to the Personnel Services Department within 90 days. If it is not reasonably possible to give proof within 90 days, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within 1 year, unless the claimant is legally incapable of doing so.

PAYMENT OF CLAIMS

When written proof of loss is received, payment for any benefits due will be made. Benefits that provide for periodic payment will be paid for each period as liability occurs. Benefits will be paid to you, if living, or else to your estate.

If you have died and we have not paid all benefits due, we may pay up to $1,000.00 to any relative by blood or marriage, or to the executor or administrator of your estate. The payment will only be made to persons entitled to it. An expense incurred as a result of your last illness, death or burial will entitle a person to this payment. The payments will cease when a valid claim is made for the benefit. We will not be liable for any payment we have made in good faith.

Curt G. Joa, Inc. shall serve as the claims review fiduciary with respect to the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

PHYSICAL EXAMINATION

At our own expense, Curt G. Joa, Inc. will have the right to have you examined as reasonably necessary when a claim is pending. We can have an autopsy made unless prohibited by law.

LEGAL ACTIONS

No legal action may be brought against us to recover on the self-insured plan within 60 days after written proof of loss has been given as required by the self-insured plan. No action may be brought after three (3) years from the time written proof of loss is required to be given.

EFFECTIVE DATE AND TERMINATION

EFFECTIVE DATE OF INDIVIDUAL COVERAGE: Your coverage will go into effect on the date stated on the Schedule of Benefits.

Changes in your amount of coverage are effective as shown on the Schedule of Benefits.

If you are not actively at work on the day your coverage is to go into effect, the coverage will go into effect on the first full day you return to active work.

TERMINATION OF INDIVIDUAL COVERAGE: Your coverage will terminate on the first of the following to occur:

(1) the date the Plan terminates; or

(2) the date you cease to be in a class eligible for this coverage; or

(3) the end of the period for which contributions have been made on your behalf; or

(4) the date you enter military service (not including Reserve or National Guard).

WEEKLY INCOME BENEFIT

BENEFITS PAYABLE

We will pay Weekly Income Benefits if you:

(1) are disabled due to sickness or injury; and

(2) become disabled while covered under the Plan.

Weekly Income Benefits are paid from the Day Benefits Begin as shown on the Schedule of Benefits. Benefits are paid up to the Maximum Benefit Period as shown on the Schedule of Benefits, for one period of disability.

The Weekly Income Benefit is shown on the Schedule of Benefits.

PERIOD OF DISABILITY

Each period of disability starts from the first day benefits are due. It will end when:

(1) you are no longer disabled; or

(2) all benefits due have been paid.

Two or more disabilities will be deemed the same period of disability if they are from:

(1) the same or related causes and are not separated by two weeks of active work; or

(2) a different cause and are not separated by one full day of active work.

EXCLUSIONS

Weekly Income Benefits are not paid for any period of disability caused by:

(1) an intentionally self-inflicted injury; or

(2) an act of war, declared or undeclared; or

(3) your committing a felony; or

(4) sickness which is covered by a Worker's Compensation Act, or other worker's disability law; or

(5) injury which occurs out of or in the course of work for wage or profit.

EXTENSION OF COVERAGE UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Military Services Leave of Absence:

We will continue your coverage in accordance with our policies regarding Military Services Leave of Absence under USERRA if the premium for you continues to be paid during the leave.

As long as the above requirement is satisfied, we will continue coverage until the end of the period required by USERRA.

The Plan, while coverage is being continued under the Military Services Leave of Absence extension, does not cover any loss which occurs while on active duty in the military if such loss is caused by or arises out of such military service, including but not limited to war or any act of war, whether declared or undeclared.

While you are on a Military Services Leave of Absence you will be considered Actively at Work. Any changes such as revisions to coverage due to age, class or salary changes, as applicable, will apply during the leave except that increases in the Weekly Benefit, whether automatic or subject to election, will not be effective if you are not considered Actively at work until you have returned to active work for one (1) full day.

A leave of absence taken in accordance with USERRA will run concurrently with any other applicable continuation provision in the Plan.

Your coverage will cease under this extension on the earliest of:

(1) the date the Plan terminates; or
(2) the end of the period for which premium has been paid for you; or
(3) the date such leave should end in accordance with our policies regarding Military Services Leave of Absence in compliance with USERRA. Coverage will not be terminated if you become Disabled during the period of the leave and are eligible for benefits according to the terms of the Plan. Any Weekly Benefit which becomes payable will be based on your Earnings immediately prior to the date of Disability.

Should we choose not to continue your coverage during a Military Services Leave of Absence, your coverage will be reinstated.

PARTIAL DISABILITY BENEFIT

We will pay Partial Disability Benefits if:

1) you are Totally Disabled;
2) you accept Rehabilitative Employment.

Partial Disability Benefits are paid from the Day Benefits Begin as shown on the Schedule of Benefits. Benefits are paid up to the Maximum Benefit Period as shown on the Schedule of Benefits for one period of disability.

Partial Disability Benefits will equal the Weekly Income Benefits payable under the Plan but in no event will the sum of:

1) the Partial Disability Benefit;
2) income from Rehabilitative Employment; and
3) income from all Other Sources;

exceed 100% of your Earnings. If it does, the Partial Disability Benefit will be reduced by one dollar for every dollar the sum exceeds 100%. The Partial Disability Benefit is subject at the Maximum Benefit Period shown in the Schedule of Benefits for any one period of disability.

"Rehabilitative Employment" means working in any gainful occupation for which your training, education or experience will reasonably allow. The Rehabilitative Employment and a plan of rehabilitation must be supervised by a Physician or licensed rehabilitation specialist, and both must be approved by us. Rehabilitative Employment includes performing all of the material duties of your regular occupation on a part-time basis or some of the material duties on a full-time basis. It does not include performing all of the material duties of your regular occupation on a full-time basis.

"Totally Disabled", for the purpose of this Benefit only, means that you are unable to perform the material duties of your own job and are under the regular care of a Physician.

"Other Sources" include benefits resulting from the same disability for which benefits are payable under the Plan, other than Retirement benefits. These Other Sources include:

1) disability income benefits you are eligible to receive under any group insurance plan;
2) disability income benefits you are eligible to receive under any governmental retirement system, except benefits payable
   under a federal government employee pension benefit;
3) all permanent as well as temporary disability benefits, including any damages or settlement made in place of such benefits (whether or not liability is admitted), you are eligible to receive under:
   (a) Worker's Compensation Laws;
   (b) occupational disease laws;
   (c) any other laws of like intent as (a) or (b) above; and
   (d) any compulsory benefit law;
4) any of the following that you are entitled to receive:
   (a) any salary continuance plan;
   (b) wages, excluding the amount allowed under this Partial Disability Benefit; and
   (c) commissions or monies, including vested renewal commission, but excluding commissions or monies that you earned prior to disability which are paid after disability has begun;
5) that part of disability or Retirement benefits paid for by us that you are eligible to receive under a group retirement plan; and
6) disability or Retirement benefits under the United States Social Security Act, the Canadian pension plans, federal or provincial plans, or similar law which:
   (a) you are eligible to receive because of your disability or eligibility for Retirement benefits; and
   (b) your dependents are eligible to receive due to (a) above.

CLAIM PROCEDURES FOR CLAIMS FILED WITH RELIANCE STANDARD LIFE INSURANCE COMPANY ON OR AFTER APRIL 1, 2018

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed form along with any requested information to:

Robyn Wiegand
Curt G. Joa, Inc.
100 Crocker Street
Sheboygan Falls, WI 53085

Claim forms are available from your benefits representative or may be requested by writing to the above address or by calling (920) 467-7343.

In the event of any Adverse Benefit Determination (defined below), the claimant (or their authorized representative) may appeal that Adverse Benefit Determination in accordance with the following procedures.

TIMING AND NOTIFICATION OF BENEFIT DETERMINATION

In the case of a claim for disability benefits, the claimant shall be notified of the Adverse Benefit Determination within a reasonable period of time, but not later than 45 days after our receipt of the claim. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to matters beyond our control and that notification is provided to the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claimant is notified, prior to the expiration of the first 30-day extension period of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

A Claimant shall be provided with written notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
   a) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
   b) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
   c) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;
5. Either the specific internal rules, guidelines, protocols, standards 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;
6. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to a claim for benefits; and
7. The notification shall be provided in a Culturally and Linguistically Appropriate (defined below) manner.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of adverse benefit determinations may be submitted in accordance with the following procedures to:

Curt G. Joa, Inc.
100 Crocker Street
Sheboygan Falls, WI 53085

1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an Adverse Benefit Determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant'' claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial Adverse Benefit Determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's Adverse Benefit Determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination; and
8. In deciding the appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:
   a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and
   b) 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.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but no later than 45 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall the extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

A claimant must be provided with written notification of the determination on review. In the case of an Adverse Benefit Determination on Review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to the claimant’s claim for benefits;
4. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    a) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
    b) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant’s Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
    c) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;
5. Either the specific internal rules, guidelines, protocols, standards 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;
6. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to a claim for benefits; and
7. The notification shall be provided in a Culturally and Linguistically Appropriate (defined below) manner.

REQUESTS CONCERNING ALLEGED VIOLATION OF THESE PROCEDURES

In the event that a claimant requests a written explanation of any alleged violation of these procedures, such explanation should be provided within 10 days, including a specific description of any basis for asserting that any violation should not cause any administrative remedies available under the plan to be exhausted (where applicable).

DEFINITIONS

The term "Adverse Benefit Determination" means any of the following: a denial, reduction, or termination of, 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 participant's or beneficiary's eligibility to participate in a plan.

The term "Culturally and Linguistically Appropriate Manner" means:

- Oral language services (such as telephone customer assistance hotline) that includes answering questions in any Applicable Non-English Language and providing assistance with filing claims and appeals in any Applicable Non-English Language must be provided;
- A notice in any Applicable Non-English Language must be provided upon request; and
- A statement prominently displayed in any Applicable Non-English Language clearly indicating how to access the language services provided must be included in the English versions of all notices.

The term "Applicable Non-English Language" means:

With respect to an address in any United States county to which a notice is sent, a non-English language is an Applicable Non-English Language if ten percent or more of the population residing in the county is literate only in the same non-English language as determined in guidance published by the United States Secretary of Health and Human Services.

The term "us" or "ours" refers to Curt G. Joa, Inc.

The term "Relevant" means:

A document, record, or other information shall be considered relevant to a claimant’s claim if such document, record or other information:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
- Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or
- In the case of a plan providing disability benefits constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit of the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.