PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR
THE PRINCIPIA SHORT-TERM INCOME SECURITY PLAN
FOR FACULTY AND STAFF

Amended January 1, 2011
Restated April 1, 2018

TABLE OF CONTENTS

INTRODUCTION

This document is the plan and summary plan description of ***The Principia Short-Term Income Security Plan For Faculty and Staff (the "Plan")*** and is effective as of January 1, 2011. No oral interpretations can change this Plan. The Plan is designed to protect Participants against loss of income in the event they are unable to work due to illness or injury by paying Participants a portion of their Earnings for a limited period of time. The Plan is designed to provide a partial income replacement benefit if a Participant is unable to work due to a non-work related disability covered by the Plan. The benefits under this Plan are completely separate from The Principia Long Term Income Security Plan For Faculty and Staff (the **"Long Term Plan"**), which is a fully-insured plan. Receipt of benefits from this Plan does not guarantee receipt of benefits under the Long Term Plan.

The Principia Corporation ("Principia") fully intends to maintain this Plan indefinitely. However, Principia reserves the right to terminate, suspend, discontinue or amend the Plan, in whole or in part, at any time, for any reason and without advance notice thereof. If the Plan is terminated or amended, the rights of Participants are limited to benefit payments in effect before the effective date of amendment or termination.

Changes in the Plan may occur in any or all parts of the Plan including, but not limited to, eligibility, benefits, exclusions, funding, and definitions.

The Plan will pay benefits only during the period this coverage is in force. No benefits are payable for illness or injuries incurred before coverage begins or after coverage terminates.

This document contains the terms of the Plan and the rights and benefits for Participants and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan's benefit period, when benefits apply, benefit amounts, maximum benefits and exclusions.

Defined Terms. Defines those Plan terms that have a specific meaning.

Administrative Provisions. Explains the Plan's administrative procedures.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

ERISA Information. Explains Participant ERISA rights under the Plan and general plan information.

ELIGIBILITY, ENROLLMENT, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Eligibility Requirements for Employee Coverage. An Employee is eligible for coverage from the first day that he or she satisfies all of the following requirements:

(1) The Employee is a Christian Scientist. An Employee is considered a Christian Scientist if he or she meets all of the following requirements for a Christian Science position:

- The Employee is a member of The Mother Church.
- The Employee is or has been an active member of a local, The Christian Science Journal-listed Christian Science branch church or society. A new Employee meets this requirement if he or she has been an active member of a branch church or society within the prior twelve month period and, if not an active member as of the date of hire, intends to fulfill this requirement within one calendar year from date of hire.

For purposes of determining if an Employee is a Christian Scientist, Principia will make the determination as to whether an Employee is currently meeting the requirements for a Christian Science position.

(2) The Employee is an Active Employee of Principia. An Active Employee is an individual who has reported to and commenced work as an Employee and who is on a regular payroll of Principia; provided, however, a less-than-twelve-month contract Employee is an Active Employee if he is on the regular payroll of Principia. An Employee who is absent from work due to a health factor after first reporting to work as an Employee is considered an Active Employee.

(3) The Employee is classified by Principia as a "Full-Time" Employee in a qualifying benefits eligible position. An Employee is considered "Full-Time" if he or she is scheduled to work 20 or more hours per week over a 12-month period or at least 1,000 hours within a 12 month period on a regular basis and is on the regular payroll of Principia for that work.

Full-Time for College faculty means:

- Teaching load of 10 or more semester hours taught over two or more contiguous semesters.
- Semesters must be contiguous within the academic/fiscal year.
- Summer break may be considered a semester provided that a full load of courses is offered.
- Neither January nor May terms are considered semesters.

Ancillary Faculty members are eligible for the Plan provided they satisfy all eligibility requirements.

For purposes of determining Employee eligibility, Principia will make the determination as to whether an Employee is currently meeting the requirements per the plan document.

See the Employee Effective Date of Employee Coverage to determine when your coverage actually begins.

ENROLLMENT

Enrollment Requirements. An eligible Employee is automatically enrolled for coverage under the Plan.

FUNDING

The Plan is deemed funded 100% by Participants on an after-tax basis, making benefits received from the Plan tax free. Principia reserves the right to change the contribution rate in the future.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan (become a Participant) as of the first day the Employee becomes an Active Employee and satisfies the Eligibility Requirements.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

TERMINATION OF COVERAGE

When Coverage Terminates. Coverage will terminate on the earliest of these dates:

(1) the date the Plan is terminated; or

(2) the date the Participant ceases to be an eligible Employee as defined in the Eligibility section above; or

(3) the end of the period for which the benefit coverage has been paid to you; or

(4) the date the Participant fails to make a required contribution; or

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

SCHEDULE OF BENEFITS

MONTHLY INCOME BENEFIT: The Plan will pay Monthly Income Benefits, if a Participant:

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

(2) becomes disabled while covered by the Plan.

Monthly 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.

DAY BENEFITS BEGIN: Benefits, for one period of disability, will be paid as follows:

INJURY: The Plan will pay benefits starting with the 1st day of absence after the Participant has used all of his/her accumulated vacation, leave, illness leave and personal leave.

SICKNESS: The Plan will pay benefits starting with the 1st day of absence after the Participant has used all of his/her accumulated vacation, leave, illness leave and personal leave.

MONTHLY INCOME BENEFIT AMOUNT: The short-term Monthly Income Benefit Amount is equal to 60% of the Participant's Earnings or $7,500 gross per month, whichever is less.

In the event you are covered under any of the following Acts, the Monthly Income Benefit Amount payable under the Plan 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.

Monthly Income Benefits terminate at the earlier of (1) the end of the Maximum Benefit Period, (2) the last day of the month in which the Participant's Retirement date occurs, or (3) the last day of the month in which the Participant dies, or the date the Participant is no longer eligible to continue receiving the benefit.

BENEFIT MAXIMUM: Upon receipt of proof satisfactory to the Plan Administrator that a Participant, while covered under the Plan, has become disabled due to a non-occupational disability, the Plan will pay the monthly disability benefit for which he or she is eligible, subject to any elimination period. If benefits are payable for a period which is less than one month the amount payable for each day will be one-thirtieth (1/30).

Benefits are taxable in accordance with IRS mandates; however, provided the employee portion cost of coverage is paid 100% by Participants on an after-tax basis, any benefits received are not taxable.

Benefit payments will be reduced by the amount of Social Security payments made to the Participant and the Participant's family due to the Participant's disability. Changes to the Social Security law while a Participant is receiving benefits under the Plan will not affect benefits during that period of total disability.

MAXIMUM BENEFIT PERIOD: Benefits, for one period of disability, will be paid up to a maximum of 180 days from the date of the first absence from work due to the disabling condition. Receipt of benefits under this Plan does not guarantee the receipt of benefits from the Long Term Plan, which is a separate fully-insured plan.

PERIOD OF DISABILITY: Each period of disability starts from the first day the absence begins. It will end when:

- you are no longer disabled; or
- all benefits due have been paid.

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

- the same or related causes are not separated by two consecutive scheduled work weeks of active work; or
- a different and unrelated cause and are not separated by one full day of active work.

EXCLUSIONS: Monthly Disability Benefits are not paid for any period of disability caused by:

- An intentionally self-inflicted injury.
- An act of war, declared or undeclared.
- Any injury sustained as a result of doing any work for pay or profit for another employer.
- Any disability resulting from or sustained as a result of being engaged in an illegal occupation, commission of or attempted commission of an assault or a felonious act.
- Any sickness or injury which is covered by a Worker's Compensation Act, or other worker's disability law.
- Any disability which is due to Injury, Illness or medical condition arising out of or in the course of continuing activity, occupation or employment for wage or profit.
- Any fraudulently filed claim for disability benefits or a claim containing material misrepresentation or omitting material facts.
- Any disability, whether or not connected with prior employment, which was fraudulently omitted or misrepresented by the Employee in an application for employment, application for coverage or employment physical, if such disability would, in the Plan Administrator's judgment, have been a material factor in the initial hiring decision.
- Any disability for which the Participant is not treated by a Care Provider or licensed Physician as defined in the Plan.
- That portion of any period of disability during which the Participant is confined in a penal or correctional institution as a result of conviction for a criminal or other public offense.

Monthly Disability Benefits **will** be reduced by other income you receive or are eligible to receive due to your disability, such as:

- Social Security Disability Insurance
- Worker's Compensation
- Unemployment benefits
- Settlement of judgments for income loss

Monthly Disability Benefits **will not** be reduced by certain kinds of other income, such as:

- Retirement benefits if you were receiving them before you became disabled
- Retirement benefits you start to receive that are funded by your after-tax contributions
- Your personal savings, investments, IRAs or Keoghs
- Profit-sharing
- Personal disability policies
- Social Security increases

You must be under the regular care of a Christian Science care provider or a physician to receive benefits.

DEFINED TERMS

"Active Employee" means an individual who has reported to and commenced work as an Employee and who is on a regular payroll of Principia; provided, however, a less-than-twelve-month contract Employee is an Active Employee if he is on the regular payroll of Principia. An Employee who is absent from work due to a health factor after first reporting to work as an Employee is considered an Active Employee.

"Care Provider" means a Journal-listed Christian Science practitioner or Journal-listed Christian Science nurse. This also includes any duly licensed health care or medical care 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 "Care Provider" may not be you or a member of your immediate family.

"Christian Science Care" means treatment by an individual listed in The Christian Science Journal as a Christian Science Practitioner and/or a Christian Science Nurse at the time the services are rendered.

"Christian Science Nurse" means a nurse certified in the practice of Christian Science nursing, as evidenced by the individual being listed in The Christian Science Journal as a Christian Science Nurse at the time nursing services are rendered. The Christian Science Nurse may not be you or a member of your immediate family.

"Christian Science Practitioner" means an individual in the Christian Science healing practice who is certified as a Christian Science Practitioner as evidenced by the individual being listed in The Christian Science Journal as a Christian Science Practitioner at the time the practitioner services are rendered. The Christian Science Practitioner may not be you or a member of your immediate family.

"Christian Science Nursing Care Facility" means a sanatorium which employs Journal-listed Christian Science nurses, who practice Christian Science nursing.

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

"Disabled" means a Participant is:

(1) unable to perform the substantial and material duties of his regular occupation; ***and***
(2) under the regular care of a Christian Science Care provider including a Christian Science Practitioner and/or a Christian Science Nurse or a physician.
(3) Because a Christian Science Practitioner or Christian Science Nurse does not diagnose physical claims, Principia reserves the right to require a medical diagnosis.

"Earnings" as used in the SCHEDULE OF BENEFITS section, means the Participant's rate of monthly earnings in effect as of the start of the total disability. Covered monthly earnings do not include the following payments made by Principia to the Participant: overtime pay, commissions, bonuses, other special compensation, or any salary increase the Participant might have earned if he/she had been at work.

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 Earnings.

"ERISA" means the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time.

"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.

"Participant" means an individual who meets the eligibility requirements of the Plan and is enrolled in this Plan and also sometimes referred to as **"You",** "**your**" and "**yours**".

"Physician" means any duly licensed health care or medical care 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.

"Principia" means The Principia Corporation. It is also sometimes referred to as **“We”, “us”** and **“our”.**

“Retirement” means the effective date a Participant is eligible for retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act.

“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.

PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The Principia Corporation shall serve as the Plan Administrator. If all members of the Plan Administrator die, resign or are otherwise removed from the position, The Principia Corporation shall serve as the Plan Administrator and shall 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 shall 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 Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The Plan Administrator shall perform its duties as the Plan Administrator in its sole discretion, and shall determine what is appropriate in light of the reason and purpose for which the Plan is established and maintained. In particular, the interpretation of all Plan provisions, and the determination of whether a Participant or beneficiary is entitled to any benefit pursuant to the terms of the Plan shall be exercised by the Plan Administrator in its sole discretion. Any construction of the terms of the Plan for which there is a rational basis that is adopted by the Plan Administrator shall be final and binding on all parties.

Any interpretation of the Plan or other action of the Plan Administrator made in good faith in its sole discretion shall be subject to review only if such an interpretation or other action is without a rational basis. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of the review. Any employer that adopts and maintains the Plan, and any employee who performs services for an employer that are or may be compensated for in part by benefits payable pursuant to the Plan, hereby consents to actions of the Plan Administrator made in its sole discretion and agrees to this narrow standard of review.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To delegate to any person such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Participants and their beneficiaries, and defraying reasonable expenses of administering the Plan. These duties must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

FUNDING THE PLAN AND PAYMENT OF BENEFITS. The cost of the Plan is funded as follows:

A portion of the funding is derived from the funds of the Employer, which are imputed to the participant on a taxable basis, and a portion from Employees. All funding is deemed paid by Employees on an after-tax basis. Benefits are paid directly from the Plan Sponsor through the Plan Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT. The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan benefit payment, the Plan retains a contractual right to the overpayment. The person receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDMENT AND TERMINATION. The Principia Corporation reserves the right to amend, change, modify or terminate the Plan in whole or in part, at any time and for any reason, without advance notice thereof. Amendment or termination of the Plan shall be effective if it is approved by a duly authorized officer or committee of The Principia Corporation, or if it is adopted pursuant to the company’s procedures allocating or delegating authority to act on behalf of The Principia Corporation, as such procedures exist from time to time.

CLAIMS AND REVIEW PROCEDURES

HOW TO SUBMIT A CLAIM: Claims for benefit shall be received and processed by the Plan Administrator and Claims Administrator pursuant to the forms, instructions, directions and rules established by the Claims Administrator from time to time. When a Participant has a claim that individual must:

(1) Obtain a claim form from the Human Resources Department.
(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
(3) Send the claim form to the Human Resources Department at the following address:

Human Resources
The Principia
13201 Clayton Road
St. Louis, MO 63131

WHEN CLAIMS SHOULD BE FILED: Claims should be filed within 30 days from the date of the onset of the illness or injury for which the Participant is claiming he is Disabled. Benefits are based on the Plan's provisions on the date of the claim is filed. Claims filed later than that date will be declined unless (a) it was not reasonably possible to submit the claim in that time; and (b) the claim is submitted within one year from the date of the onset of the disability.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Participant seek a second medical opinion.

PAYMENT OF CLAIMS: Principia will pay any benefits due. Benefit payments will be paid for each month or portion thereof during which a Participant is Disabled. Benefits payment will be paid to the Participant, if living, and if not living, to the Participant's surviving spouse, if any, and if none, to the Participant's children, per stirpes, if any, and if none, to your estate.

PHYSICAL EXAMINATION: At the expense of the Plan, the Plan has the right to have a Participant examined as reasonably necessary when a claim is pending. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. In addition, the Plan can direct that an autopsy be made unless prohibited by law.

CLAIMS PROCEDURES: The Plan Administrator administers all claims and appeals under the Plan. An authorized representative may act on a claimant’s behalf in pursuing a benefit claim or appeal. The Plan will follow reasonable procedures for determining whether an individual has been authorized to act on a claimant’s behalf.

If a Claim is denied, in whole or in part, the claimant will receive a written notice within 45 days of receiving the claim, with the following information:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions on which the denial is based;
- 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;
- A description of the Plan’s claims review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under ERISA following a denial of an appeal;
- Any specific guideline that was relied upon in issuing the denial, or a statement that such guideline will be provided to the claimant free of charge upon request; and
- If the denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant’s medical circumstances, or a statement that such explanation will be provided to the claimant free of charge upon request.

If additional information is needed to process the claim, the Claims Administrator shall notify the claimant prior to the end of the 45-day period. The claimant shall then have 45 days to provide the requested information, and during the time that a request for information is outstanding, the claim and time period applicable thereto shall be suspended. If, for reasons beyond the control of the Claims Administrator, an extension of time is required to process the claim, the

Administrator shall send to the claimant a notice of the extension, an explanation of the circumstances requiring the extension and the expected date of the decision prior to the end of the initial period. The extension shall not exceed a period of an additional 30 days from the end of the initial 45-day period. If at the end of the 30-day extension, the Claims Administrator requires additional time to process the claim, the Claims Administrator may again extend the time limit by an additional 30 days from the end of the first 30 day extension period, if the Claims Administrator provides prior notice to the claimant (that includes an explanation of the circumstances requiring extension and the expected date of the decision). However, in all cases the Claims Administrator shall notify the claimant of its benefit decision within 105 days after the initial claim is received by the Claims Administrator.

FILING AN APPEAL: If a claim for a benefit is denied, in whole or in part, the claimant must file an appeal with the Plan Administrator within 180 days after receiving the denial. If the claimant fails to file an appeal within 180 days, the claimant shall be deemed to have waived any right to appeal the denial of the claim. The claimant is entitled to a full and fair review of the claim and the denial, which means:

- The review does not afford deference to the initial adverse benefit determination and will be conducted by an appropriate fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual;
- The claimant may submit written comments, documents, records, and other information relating to the claim for benefits;
- The claimant may obtain upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- The review will take into account all comments, documents, records, and other information the claimant submits, without regard to whether such information was submitted or considered with respect to the initial claim;
- The review will be conducted by someone who is neither the individual who made the initial determination, nor the subordinate of such individual;
- In the case of an appeal involving medical judgment, the Claims Administrator or Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither the individual who was consulted on the initial claim determination, nor the subordinate of such individual; and
- Any medical or vocational experts whose advice was obtained in connection with the initial determination will be identified, regardless of whether the advice was relied upon in the initial determination.

DECISION ON APPEAL: The claimant will receive a written decision on the appeal within 60 days. Any denial of an appeal will contain the following information:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions on which the denial is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A statement of the claimant's right to bring a civil action under ERISA;
- Any specific guideline that was relied upon in issuing the denial, or a statement that such guideline will be provided to the claimant free of charge upon request; and
- If the denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

NOT IN LIEU OF WORKER'S COMPENSATION: The coverage is not a Worker's Compensation Policy. It does not provide Worker's Compensation Benefits.

LIMITATIONS ON ACTIONS AND VENUE

No action shall be brought against the Plan in any court unless the ERISA claims and appeals procedures described herein have been fully exhausted. A Participant, beneficiary or claimant asserting any action under 29 U.S.C. §1132, 29 U.S.C. §1140 or any other provision of ERISA, shall do so, if at all, within one year after the cause of action accrued. A cause of action shall be deemed to have accrued the earliest of when the Participant, beneficiary or claimant has exhausted his administrative remedies under the Plan, when the Plan Administrator fails to produce documents in the time or manner required by ERISA in response to the Participant's, beneficiary's or claimant's written request, when the claimant first was advised that he was an independent contractor, or when the Participant, beneficiary or claimant first knew or should have known of the action allegedly violating 29 U.S.C. §1140. Failure to bring an action in court within this time frame shall preclude a Participant, beneficiary or claimant from bringing any action in court.

Any action in connection with the Plan, whether brought under 29 U.S.C. §1132 or any other provision of ERISA, by a Participant or beneficiary under the Plan or any other person, may only be brought in a federal district court sitting within the Eastern District of Missouri.

STATEMENT OF ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA specifies that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

- Review 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 Action by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including Principia or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

Enforce Your Rights

If a Plan Participant's claim for a welfare benefits is denied or ignored, in whole or in part, the Participant has 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 a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the Participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

Assistance With Your Questions

If a Participant has any questions about the Plan, he or she should contact the Plan Administrator. If a Participant has any questions about this statement or his or her rights under ERISA, that Participant should contact either the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in the 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, DC 20210. A Participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION:

The Plan is a self-funded welfare benefit plan. The Plan is administered by the Plan Sponsor. The funding for the benefits is derived from the funds of the Employer and Participants. The Plan is not insured.

PLAN NAME:

The Principia Short-Term Income Security Plan for Faculty and Staff, which is part of The Principia Corporation Welfare Benefit Plan

PLAN NUMBER: 511

PLAN SPONSOR TAX ID NUMBER: 43-0652667

PLAN YEAR FOR FORM 5500 REPORTING PURPOSES: July 1 – June 30

PLAN SPONSOR:
The Principia Corporation
13201 Clayton Road
St. Louis, Missouri 63131-1099
(314) 434-2100

PLAN ADMINISTRATOR:
The Principia Corporation
13201 Clayton Road
St. Louis, Missouri 63131-1099
(314) 434-2100

AGENT FOR SERVICE OF LEGAL PROCESS:
The Principia Corporation
General Counsel
13201 Clayton Road
St. Louis, Missouri 63131-1099

Service of legal process may also be made upon the Plan Administrator.

CLAIMS ADMINISTRATOR:
The Principia Corporation
13201 Clayton Road
St. Louis, Missouri 63131-1099
(314) 434-2100

BY THIS AGREEMENT, The Principia Short-Term Income Security Plan for Faculty and Staff is hereby amended as shown.

IN WITNESS WHEREOF, this instrument is executed by The Principia Corporation on the day and year written below, and is effective as of April 1, 2018.

THE PRINCIPIA CORPORATION

By:_____

Name:_____

Title:_____

Date:_____

Witness:_____

Name:_____

Date:_____