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Pentagon Technologies Group, Inc.  
Employee Health & Welfare Plan

# Master Summary Plan Description

Amended/Restated Effective July 1, 2025

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This document, together with the additional documents provided along with it, constitute the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102.

**If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the notice reproduced in Appendix B for more details.**

## Table of Contents

1. Definitions .....	1
2. Introduction .....	1
3. General Information about the Plan.....	2
4. Eligibility and Participation Requirements.....	4
5. Summary of Plan Benefits.....	6
6. Non-Grandfathered Status under the Affordable Care Act .....	8
7. How the Plan Is Administered .....	9
8. Circumstances Which May Affect Benefits .....	10
9. Amendment or Termination of the Plan .....	11
10. No Contract of Employment .....	11
11. No Assignment .....	11
12. Claims Procedure .....	12
13. Statement of ERISA Rights.....	13
14. General Information .....	14
15. Benefit Program Information .....	18
Appendix A: COBRA Continuation .....	23
Appendix B: Medicare Part D Notice .....	31
Appendix C: Cafeteria Plan and FSA Provisions .....	34
Appendix D: Authorized Representatives .....	63

## 1. Definitions

Capitalized terms used in this document have the following meanings:

**"AD&D"** means accidental death and dismemberment insurance.

**"Affordable Care Act"** means the Patient Protection and Affordable Care Act, as amended.

**"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**"Code"** means the Internal Revenue Code of 1986, as amended.

**"Company"** means Pentagon Technologies Group, Inc. or any successor thereto, and any affiliated entity within the same controlled group, as that term is defined under section 414(b) of the Internal Revenue Code, that participates in the plan.

**"Employee"** means any common-law employee of the Company who satisfies the eligibility provisions of in this document and is not excluded from participation by the terms of an applicable benefit program, except individuals classified or treated by the Company as independent contractors (regardless of any subsequent reclassification), or as an employee of an employment agency.

**"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended.

**"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended.

**"NMHPA"** means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

**"Plan"** means the Pentagon Technologies Group, Inc. Employee Health & Welfare Plan and includes this document, written amendments and updates to this document, and the terms of all policies and component benefit programs listed in Section 15.

**"Plan Administrator"** means the Company.

**"SPD"** means the Summary Plan Description required by ERISA § 102 summarizing this Plan and includes this document, information booklets supplied by insurance carriers, and other benefits descriptions provided to participants with this document or at any other period as appropriate to provide updates to the document, such as during open enrollment.

**"WHCRA"** means the Women's Health and Cancer Rights Act of 1998, as amended.

## 2. Introduction

The Company maintains the Plan for the exclusive benefit of eligible Employees and eligible family members or "dependents." It is important that you share this document and the materials referenced here in with your covered dependents. The Plan provides health and welfare benefits through the benefit programs listed in Section 15. See Section 15 for a listing of benefit programs and the entities that help administer the programs.

Each of these benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another document (a "Benefit Description"). A Benefit Description will be available from the insurer (if the benefit is fully-insured) or Plan Administrator (if the benefit is self-funded). Whether a benefit program is fully-insured or self-funded is noted in Section 15.

This document and its attachments constitute the plan document required by ERISA § 402. This document and its attachments, coupled with the information booklets and other descriptive materials provided for benefits as described in Section 15 constitutes the wrap Summary Plan Description as required by ERISA § 102.

### 3. General Information about the Plan

<b>Plan Name:</b>	Pentagon Technologies Group, Inc. Employee Health & Welfare Plan
<b>Type of Plan:</b>	Welfare plan providing coverages listed in Section 15. The Plan also includes funding through a cafeteria plan under Code § 125.
<b>Plan Year:</b>	July 1 to June 30.
<b>Plan Number:</b>	501
<b>Effective Date:</b>	July 1, 2004. The Plan has been amended several times since its original effective date, most recently as of July 1, 2025.
<b>Funding Medium and Type of Plan Administration:</b>	<p>All benefits under the Plan are fully-insured. See Section 15 for a description of the benefit programs and whether they are self-funded or fully-insured.</p> <p>For benefit programs which are fully-insured, benefits are insured under a group contract entered into between the Company and insurance companies or HMO.</p> <p>The insurance companies and/or HMO, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the insurance companies and/or HMO for administering these program benefits, as described below.</p> <p>Premiums for Employees and their eligible family members may be paid in part by the Company out of its general assets and in part by Employees' post-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the benefit programs, as applicable.</p>

**Plan Sponsor:** The employer is the Plan Sponsor.  
Pentagon Technologies Group, Inc.  
21031 Alexander Court  
Hayward, CA 94545  
1-800-379-3361

**Plan Sponsor's Employer Identification Number:** 31-1622360

**Insurance Companies/HMO:** See a complete list under the heading Plan Provider Information later in this document.

**Plan Administrator:** Attention: Human Resources Manager  
Pentagon Technologies Group, Inc.  
21031 Alexander Court  
Hayward, CA 94545  
1-800-379-3361

**Named Fiduciary:** Pentagon Technologies Group, Inc.  
21031 Alexander Court  
Hayward, CA 94545  
1-800-379-3361

**Agent for Service of Legal Process:** Cogency  
Cogency Global Inc  
1325 J St, Suite 1550  
Sacramento, CA 95814  
sop@cogencyglobal.com

Language assistance is available. If you have difficulty understanding any part of this Summary Plan Description contact the Plan Administrator, at 1-800-379-3361.

Benefits hereunder may be provided pursuant to an insurance contract or pursuant to a governing document adopted by the Company. If so, these contracts are made a part of this Plan document, and the contracts and Plan document should be construed as consistent, if possible. If the terms of this Plan document conflict with the terms of such insurance contract or other governing document, then the terms of the insurance contract or governing document will control, with the exception of defining eligible employees and dependents, which is determined by the Company, unless otherwise required by law.

## 4. Eligibility and Participation Requirements

### Eligibility and Participation

An eligible Employee with respect to the Plan will be an Employee who is eligible to participate in and receive benefits under one or more of the benefit programs. To determine whether you or your family members are eligible to participate in a benefit program, please see Section 15. Reclassification from non-employee to employee status by a court or any agency or by the Company will not create any retroactive right to coverage.

Certain benefit programs require that you make an annual election to enroll for coverage.

**Generally, you cannot enroll, drop coverage, or change your or your dependents coverage under the plan except during annual Open Enrollment.** However you may be able to add or drop coverage for yourself or a dependent during the plan year if you experience an event that triggers a HIPAA Special Enrollment Right (see discussion below) or if you have a Status Change Event (see Appendix C for an explanation of Status Change Events). Please review the rules for changing your benefits elections described in Appendix C very carefully as the rules regarding making benefits changes mid-year must be strictly enforced.

Information about enrollment procedures is provided by the Company. Information about when your participation begins in various benefit programs is found under Section 15. You must follow any required enrollment procedures. **Always make sure the Company has your current home address and other contact information for you and your covered dependent to correctly administer your benefits and to send you important benefits information.**

### Eligible Dependent Status

Section 15 describes whether your spouse, domestic partner, and or child can participate in a particular benefit program. Section 15 also describes any limits on such participation. For example, children covered under the Medical benefit program generally can be covered until the end of the month during which they reach age 26. However, coverage may end earlier for other benefits (or may not be available at all). For specifics on eligibility for each benefit offered refer to Section 15. Note that the definition of dependent may be different for the different benefits offered under the Plan.

You cannot be covered both as an employee and as a dependent under the plan.

### Full Time Status and the ACA

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee who works on average 130 hours per month. Employers may also face penalties if they do not offer major medical coverage to substantially all full-time employees or if the coverage they offer is unaffordable or does not meet a minimum value standard. The Company determines full-time status using the “Look-back” method. ACA full-time status is not a guarantee of major medical benefits eligibility. Benefits eligibility is described in Section 15.

### Special Enrollment Provisions under HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a special enrollment period for the Medical benefit program (or similar benefit programs providing medical

benefits) may be available, usually if you lose medical coverage under certain conditions or when you acquire a new dependent by marriage, birth, or adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you declined enrollment in the Plan for yourself or your dependents (including a spouse) because of coverage under Medicaid or a State Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

Finally, if you declined enrollment in the Plan for yourself or your dependents (including a spouse), and you or a dependent later becomes eligible for state “premium assistance” through Medicaid or a State Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance. ***Medicaid and State Children's Health Insurance Program premium assistance are not available with respect to coverage under a high-deductible health plan. Thus, this special enrollment event will not apply to such plans.***

### **Coverage during Certain Leaves of Absence**

Certain Federal (and State) statutes like the Family and Medical Leave Act (FMLA) require that eligibility for medical benefits continue for employees on those protected leaves of absence under the same terms as active employees. When wages continue during such a leave, your contributions will be deducted from those wages on a pre-tax basis. When such a leave is unpaid, you are still required to pay your portion of the premium. Your portion of the premium may be paid as regular monthly intervals during the leave on a post-tax basis.

You may also generally discontinue coverage at the beginning of such an unpaid leave and when you return your benefits will either be reinstated or you may re-enroll for the remainder of the coverage period or plan year.

Human Resources must determine whether or not you are eligible for a statutory or other leave of absence.

### **Terms of Participation**

Your participation and the participation of your spouse and dependents in a benefit program will terminate according to the terms of the specific benefit program. Generally, coverage for most benefit programs terminates on the last day of the month in which you terminate employment, but certain benefit programs may provide coverage only through the date your employment terminates. Please see Section 15 for further information on the date participation in a specific benefit program will terminate.

Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below the required hourly threshold for the particular benefit, if you engage in fraud or make an intentional misrepresentation of a material fact, or for any other reason as set forth in the attached documents. You should consult Section 15 for a general summary and the attached documents for specific termination events and information.

Coverage may be terminated retroactively in the normal course of business due to a participant's termination of employment, nonpayment of premiums, loss of dependent eligibility or other, similar factors. When you or a dependent lose eligibility for benefits, regardless of whether or not you timely report that loss of eligibility, a change to any existing salary reduction election will be made automatically. To the extent that the coverage at issue does not allow for retroactive termination of that coverage and election to the date of the loss of eligibility, such changes will be prospective. If coverage can be terminated retroactively to the date of the loss of eligibility, or sometime thereafter, excess salary reduction contributions will be refunded on a post-tax basis to the date the termination of coverage can be made effective.

Any person claiming benefits under the Plan shall furnish the Company, any insurance company or other entity working on behalf of the Plan or a benefit program with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan or a benefit program. This may include but is not limited to providing social security numbers, birth certificates, marriage certificates, or proof of dependent eligibility. Failure to cooperate and provide such information will lead to a loss of eligibility for benefits.

Knowingly enrolling an ineligible dependent in plan benefits constitutes fraud and is considered a material misrepresentation that will result in termination of coverage as well as other disciplinary action up to and including termination of employment. Eligibility for benefits is described in Section 15. If you have questions about whether a dependent is eligible you must contact Human Resources before enrolling that dependent.

## **COBRA Rights**

You may be eligible for COBRA continuation coverage or conversion policies when your coverage for a medical benefit program under this Plan terminates. Information about continuation coverage or conversion is contained in Appendix A. If you have questions about this law or these rights, please contact the Plan Administrator (for benefit programs that are self-funded) or the insurance carrier (if the benefit is fully-insured). You can determine whether a benefit program is self-funded or fully-insured by consulting Section 15.

## **5. Summary of Plan Benefits**

### **Benefits and Contribution**

The Plan provides you and your eligible spouse and dependents with the benefit programs listed in Section 15. A summary of each benefit program provided under the Plan may be provided in the attached documents (such as a certificate of insurance booklet, summary plan description for a specific benefit program or other governing document). Note that some of the attached documents may be labeled as a "summary

plan description." If so, that document will only be a summary of the specific benefit program to which it relates. Notwithstanding any of the terms of such a document, that document is not the formal, single "Summary Plan Description" for this Plan. Rather, this document constitutes the formal, single "Summary Plan Description."

The cost of the benefits provided through the benefit programs may be funded in part by Company contributions and in part by pre-tax and/or post-tax employee contributions. The Company will determine and periodically communicate your share of the cost, if any, of the benefit programs. The Company reserves the right to change that determination.

The Company will make its contributions, if any, in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and your contributions to any insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to, or on behalf of, you or your eligible family members from the Company's general assets. Your contributions toward the cost of a particular benefit program will be used in their entirety prior to using Company contributions to pay for the cost of such benefit program.

Medical benefits under this Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, annual or lifetime limits, pre-authorization requirements or utilization review. There may also be limitations on the selection of primary care or network providers, limits on emergency medical care, or limited coverage for preventive services, drugs, medical tests, medical devices or medical procedures. These limitations are set forth in the attached documents.

Certain prescription drug benefits are considered "Creditable Coverage" under Medicare Part D. The attached documents provide details regarding this coverage and an annual notice (attached and incorporated by reference in Appendix B) explains how this creditable coverage works for these prescription drug benefit programs.

The Plan will provide benefits in accordance with the requirements of all applicable Federal laws regulating group health plans, such as COBRA, HIPAA, NMHPA, WHCRA and the Affordable Care Act. A brief summary of some of these laws is below.

#### **Newborns' and Mothers' Health Protection Act (NMHPA) of 1996**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

#### **Women's Health and Cancer Rights Act (WHCRA) of 1998**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals

receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Protheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

#### **Qualified Medical Child Support Orders**

Group health plans and health insurance issuers generally must provide benefits as required by any qualified medical child support order, or "QMCSO." The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

#### **Lifetime and Annual Limits**

Lifetime or annual limit on the dollar value of "essential health benefits" are no longer permitted under the major medical plans offered by the Plan. For more information on "essential health benefits" refer to the terms of policies and benefit program materials listed in Section 15. These documents are provided to you during enrollment and are available from Human Resources, the insurer (if the benefit is fully-insured), or Plan Administrator (if the benefit is self-funded).

## **6. Non-Grandfathered Status under the Affordable Care Act**

The following benefit programs that provide health benefits are not "grandfathered health plans" under the Affordable Care Act:

- UnitedHealthcare Base PPO
- UnitedHealthcare Buy Up PPO
- UnitedHealthcare HDHP
- Kaiser Permanente Deductible HMO

These benefit programs must, under the Affordable Care Act, provide additional protections. The protections provided by the Affordable Care Act include the following:

#### **Preventive Services covered at 100%**

In-network preventive care services will be covered at 100% with no cost sharing (e.g., copayment, coinsurance percentage, deductible, etc.). Preventive services include those services outlined in the US Preventive Services Taskforce recommendations (services

rated “A” or “B”). Please see the attached documents for the preventive services included at no cost share.

### **Non-Network Emergency Services covered as In-Network**

Emergency services must be covered without the need for prior authorization, regardless of the participating status of the provider or facility, and at the in-network cost sharing level.

### **Access to Primary Care Physicians**

The Affordable Care Act generally allows participants the right to designate any primary care provider who participates in the network and who is available to accept the participant and his or her family members. If the benefit program requires that a primary care provider be designated, but one is not designated, the benefit program or a health insurance issuer will designate one until the participant or family member makes such a designation.

- For children, you may designate a pediatrician as the primary care provider.
- You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

## **7. How the Plan Is Administered**

### **Plan Administration**

The administration of the Plan is under the supervision of the Plan Administrator. The Plan Administrator is a named fiduciary within the meaning of ERISA § 402 and has full discretionary authority to administer the Plan, to interpret the Plan, and to determine eligibility for participation and for benefits under the terms of the Plan. However, insurers and parties that have entered into administrative service agreements (Third Party Service Providers or TPAs) assume sole responsibility for their performance under applicable policies or administrative services agreements and, under ERISA, may be fiduciaries with respect to their performance.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. (However, as noted below, one or more insurance companies may have these responsibilities with respect to fully-insured benefits.)

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility

and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

### **Power and Authority of Insurance Company**

As detailed in Section 15, certain benefits under the Plan may be fully insured. The insurance companies are responsible for: (1) determining eligibility for and the amount of any benefits payable under their respective benefit programs, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective benefit programs.

### **Questions**

If you have any general questions regarding the Plan, or your eligibility for or the amount of any benefit payable under any benefit program, please contact the Plan Administrator or the appropriate insurance company as applicable.

## **8. Circumstances Which May Affect Benefits**

### **Denial or Loss of Benefits**

Your benefits (and the benefits of your eligible spouse and dependents) will cease when your participation in the Plan terminates. See Section 15. Your benefits will also cease on termination of the Plan.

### **Right to Recover Benefit Overpayments and Other Erroneous Payments**

The Plan and its benefit programs (including any insurance company on behalf of a benefit program) have all necessary or helpful rights to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan, the recipient of such benefit (the "Recipient") shall be responsible for refunding the overpayment to the Plan or insurance company to the fullest extent permitted by law. In addition, if the Plan or insurance company makes any payment that, according to the terms of the Plan, policy or contract should not have been made, the insurance company, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurance company's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Plan Administrator or insurance company, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Any benefit payments or reimbursements made by check must be cashed or deposited within one year after the check is issued. If any check or other payment for a benefit is not cashed or

deposited within one year of the date of issue, the Plan will have no liability for the benefit payment and the amount of the check will be deemed a forfeiture. No funds will escheat to any state.

## **9. Amendment or Termination of the Plan**

### **Amendment or Termination**

The Plan and any benefit program under the Plan may be amended or terminated at any time, in the sole discretion of the Company as Plan sponsor, by a written instrument signed by an authorized individual. Some benefit programs may also be amended or terminated by an insurance carrier, as more fully described in any attached documents from an insurance carrier. The policies and agreements may also be amended or terminated at any time in accordance with their terms. No individual (including a retired employee) shall have a right to continuing benefits except to the extent required by law.

## **10. No Contract of Employment**

The Plan is not intended to be, and may not be construed as, constituting a contract or other arrangement between you and the Company to the effect that you will be employed for any specific period of time.

## **11. No Assignment**

Except as may otherwise be specifically provided in this Plan, the benefit programs, or applicable law, an individual's rights, interests or benefits under this Plan or the benefit programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the benefit programs, and any such attempt shall be void.

Specifically, participants and beneficiaries covered under this plan cannot assign their rights to medical providers to pursue direct payment of claims either as the participant or beneficiaries' agent or under power of attorney. Under the terms of this plan, medical providers cannot take action enforcing a patient's right to recover benefits under ERISA or assert any claims under ERISA on behalf of patients, even where the patient(s) have assigned their rights to their medical providers.

## **12. Claims Procedure**

### **Claims for Fully-Insured Benefits**

For purposes of determining of the amount of, and entitlement to, benefits of the benefit programs provided under insurance contracts or policies, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to benefits.

To obtain benefits from the insurer of a benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form.

The insurance company will decide your claim in accordance with its reasonable claims procedures as required by ERISA.

See the appropriate certificate of insurance or booklet for details regarding the insurance company's claims procedures. You must fully follow and exhaust these claims procedures before you can file a lawsuit in state or federal court. You may have a right to seek external review of your claims, if so noted in the applicable insurance contract or policy.

### **Claims for Self-Funded Benefits**

For purposes of determining the amount of, and entitlement to, benefits under the benefit programs which are self-funded, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan.

To obtain benefits from a benefit program which is self-funded you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence, as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. You may have a right to seek external review of your claims, if so noted in the applicable attached document for the self-funded benefit program.

See the appropriate benefits description for information about how to file a claim and for details regarding the claims procedures applicable to your claim. You must fully follow and exhaust these claims procedures before you can file a lawsuit in court.

### **The Role of Authorized Representatives**

Under ERISA and the ACA participants and beneficiaries have the right to designate an Authorized Representative for certain purposes. These purposes are generally limited to requesting documents or other information on behalf of a participant or beneficiary or acting on their behalf during claims and appeals procedures that can follow an adverse benefits determination. In any situation that does not constitute an urgent care claim, to designate any third party as an Authorized Representative a participant or beneficiary must use the signed statement included as an appendix of this document with the required witness signature. A medical provider will not become a participant or beneficiary's Authorized Representative as a

result of an attempt to secure an assignment of benefits. The Plan does not guarantee that any purported assignment will be valid under the terms of the Plan.

## **13. Statement of ERISA Rights**

This Statement of ERISA Rights applies to those benefit programs which are subject to ERISA. Not all benefit programs which are part of this Plan will be subject to ERISA. The following benefit programs are not subject to ERISA: Health Savings Account (HSA) and Employee Assistance Program (EAP).

### **Your Rights**

As a participant in an ERISA plan you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;
- obtain copies of the benefit program documents and other program information on written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies);
- receive a summary of the Plan's annual financial report, if any (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report);
- continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

### **Fiduciary Obligations**

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the benefit program. These people, called "fiduciaries" of the program, have a duty to operate the program prudently and in the interest of you and other program participants. Fiduciaries who violate ERISA may be removed and may be required to reimburse the Plan for any losses they have caused the program.

### **No Discrimination**

No one, including the Company or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.

## **Right to Review**

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan Administrator review and reconsider your claim.

## **Filing Suit**

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a court.

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of the internal claims and appeals procedure is required prior to filing suit.

If it should happen that benefit program fiduciaries misuse the Program'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 (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

## **Questions**

If you have any questions about this statement or your rights under ERISA, 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.

## **14. General Information**

### **COBRA**

Benefit programs which provide health benefits generally are subject to the federal law known as COBRA. COBRA generally allows covered participants and beneficiaries to continue in the benefit program, even after a "qualifying event" occurs. You may also have state law continuation or conversion rights.

### **Subrogation and Reimbursement**

If an individual has a claim for benefits under this Plan or any benefit program, and that individual acquires any right or action against a third party for the person's injury, sickness or other illness which is so covered, then: (a) the Plan shall be entitled to reimbursement for such benefits from such third party up to 100% of the benefits paid by the Plan; and (b) the Plan is automatically subrogated to all such rights or claims of the covered person. The covered person

shall cooperate fully with the Plan in the enforcement of the Plan's subrogation and reimbursement rights. In addition, the person shall permit suit to be brought in the person's name under the direction of and at the expense of the Company if the Company so chooses. The Plan shall not be liable for such a person's attorney's fees absent prior written approval from the Plan. The Plan Administrator may require the receipt of a signed and dated subrogation and reimbursement agreement from the person before advancing any monies.

The failure or refusal of a covered person to fully cooperate with the Plan in the enforcement of the Plan's subrogation and reimbursement rights shall result in a forfeiture of all benefits payable to that person, even if such benefits have already been paid, in which event the Company shall retain a right to recover paid benefits which are forfeited in such a manner.

The Company, on behalf of this Plan, shall have a first priority right to recover from and a lien against any payment, whether designated as a payment for medical benefits or any other type of damages, from the proceeds of any recovery, including but not limited to any settlement, award or judgment which results from a claim or lawsuit by or on behalf of a covered person who received benefits under this Plan (even if such covered person is not made whole). The plan is not required to contribute to any expenses or fees (including attorney's fees or costs) incurred in obtaining the funds. The plan's recovery will not be limited or reduced by doctrines (equitable or other) including but not limited to, the make-whole doctrine, contributory or comparative negligence, or the common fund doctrine. The plan's right to full recovery is not reduced if settlement funds or other payments to you are spent or no longer in an individual's possession or control. Notice of the Plan's claim shall be sufficient to establish this Plan's lien against the third party or insurance carrier. The Company shall be entitled to deduct the amount of the lien from any future claims payable to or on behalf of the covered person or payee if the covered person or payee fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to this Plan's subrogation and reimbursement rights.

In the event that the Plan obtains a recovery against a third party in excess of payments made to or on behalf of the covered person and reasonable out of pocket expenses of the recovery, then the Plan shall pay to the covered person that excess amount recovered by the Plan.

In the event of any direct conflict between this Section 13 and the subrogation and reimbursement provisions in any benefit program, the subrogation and reimbursement provisions in the benefit program shall control. Otherwise, the provisions of this Section 13 shall apply and may supplement those contained in any benefit program.

The above provisions of this "Subrogation and Reimbursement" section apply with respect to a benefit program that is self-funded and does not, in its governing documents (but excluding this Plan document) have a subrogation and reimbursement section. If the benefit program does have such a section that section shall control. With respect to a fully-insured benefit program, the contract or policy from the insurer shall control with respect to subrogation and reimbursement matters.

### **No Vesting of Benefits**

Nothing in the Plan, nor anything in any benefit program, shall be construed as creating any vested rights to benefits in favor of any employee, former employee or covered person.

## Waiver and Estoppel

No term, condition, or provision of this Plan or any benefit program shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan or benefit program, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No covered person other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purposes.

## Effect on Other Benefit Plans

Amounts credited or paid under this Plan or any benefit program shall not be considered to be compensation for purposes of any benefit program hereunder or any qualified or nonqualified pension plan maintained by the Company unless expressly provided in such benefit program or qualified or nonqualified pension plan, as applicable, or if required by applicable law. The treatment of amounts paid under this Plan or any benefit program for purposes of any other employee benefit plan maintained by the Company shall be determined under the provisions of the applicable employee benefit plan.

## Severability

If any provision of this Plan or any benefit program is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

## Rebates

In some situations, a rebate may be paid by an insurance company which provides coverage under the Plan. For example, a rebate may be provided under the Medical Loss Ratio ("MLR") rules, which are part of the Affordable Care Act. Except as specifically and unambiguously provided in a Benefit Description, or as otherwise required by applicable law, any rebate from any source will be:

- Considered an asset of the Company, not the Plan. The Company does not need to use such a rebate to benefit Employees, participants or beneficiaries. The Company can use such a rebate for the Company's own purposes
- An asset of the Plan in proportion to how much of the rebate relates to Employee, participant, or beneficiary contributions. The portion relating to Company contributions shall not be considered a Plan asset. The Company will have the ability to make certain assumptions or minor changes (such as rounding to the nearest \$1 or \$10) when determining the amount which is considered a plan asset. The Company shall have discretion to determine how to use all amounts. Amounts which are plan assets will be used to benefit individuals selected by the Company. This group of individuals may not be identical to the group which relates to the rebate. In addition, certain individuals can receive the rebate (or the benefit of the rebate) even if the rebate related to a different benefit, to the extent allowed by applicable law.
- The entire amount shall be an asset of the Plan, to be used for the benefit of individuals covered by the Plan.

In all situations where ERISA applies the use of any ERISA-covered plan assets will be governed by applicable law, including but not limited to U.S. Department of Labor Technical Release 2011-04.

### **Controlling Law**

This Plan shall be administered, construed, and enforced according to the federal law and the laws of the State of California, to the extent not preempted by federal law. However, with respect to a fully-insured benefit program, the applicable insurance policy or contract will control with respect to which state's laws apply.

## 15. Benefit Program Information

### Summary of Eligibility and Participation Provisions

Note: If you have any questions about eligibility or participation, contact the Plan Administrator

<b>Benefit Program</b>	<b>Fully-insured or self-funded? if fully-insured, carrier name</b>	<b>Policy or Group #, if fully-insured</b>	<b>Who is eligible</b>	<b>When Participation begins</b>	<b>When Participation Ends<sup>1</sup></b>	<b>To File a Claim, Contact:</b>
<b>Medical HMO (Northern CA) + Rx</b>	Fully-Insured / Kaiser Permanente	39880	<p>Full time employees working in California 30+ hours per week. Spouses, domestic partners, and children generally are covered</p> <p>Employees with variable hours and seasonal schedules may be considered eligible for benefits.</p>	<p><u>Salaried Employees:</u> first of the month following date of hire (if enrolled within 30 days of being eligible)</p> <p><u>Hourly Employees:</u> first of the month following 30 days of employment</p>	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	<p>Kaiser Permanente at:</p> <p>Phone: (800) 464-4000 Website: www.kp.org</p>
<b>Medical HMO (Southern CA) + Rx</b>	Fully-Insured / Kaiser Permanente	231360	<p>Full time employees working in California 30+ hours per week. Spouses, domestic partners, and children generally are covered</p> <p>Employees with variable hours and seasonal schedules may be considered eligible for benefits.</p>	<p><u>Salaried Employees:</u> first of the month following date of hire (if enrolled within 30 days of being eligible)</p> <p><u>Hourly Employees:</u> first of the month following 30 days of employment</p>	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	<p>Kaiser Permanente at:</p> <p>Phone: (800) 464-4000 Website: www.kp.org</p>

<sup>1</sup> Other Events (such as fraud or intentional misrepresentation of a material fact) can also terminate coverage -- see the benefit program details.

<b>Benefit Program</b>	<b>Fully-insured or self-funded? if fully-insured, carrier name</b>	<b>Policy or Group #, if fully-insured</b>	<b>Who is eligible</b>	<b>When Participation begins</b>	<b>When Participation Ends<sup>1</sup></b>	<b>To File a Claim, Contact:</b>
<b>Medical PPO + Rx</b>	Fully-Insured / UnitedHealthcare	911464	<p>Full time employees working 30+ hours per week. Spouses, domestic partners, and children generally are covered</p> <p>Employees with variable hours and seasonal schedules may be considered eligible for benefits.</p>	<p><u>Salaried Employees:</u> first of the month following date of hire (if enrolled within 30 days of being eligible)</p> <p><u>Hourly Employees:</u> first of the month following 30 days of employment</p>	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	<p>UnitedHealthcare at:</p> <p><u>Medical PPO:</u> Phone: (866) 633-2446 Website: www.myuhc.com</p> <p><u>Medical HDHP:</u> Phone: (866) 314-0335 Website: www.myuhc.com</p>
<b>Dental</b>	Fully-Insured / UnitedHealthcare	911464	<p>Full time employees working 30+ hours per week. Spouses, domestic partners, and children generally are covered</p> <p>Employees with variable hours and seasonal schedules may be considered eligible for benefits.</p>	<p><u>Salaried Employees:</u> first of the month following date of hire (if enrolled within 30 days of being eligible)</p> <p><u>Hourly Employees:</u> first of the month following 30 days of employment</p>	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	<p>UnitedHealthcare at:</p> <p><u>Dental PPO:</u> Phone: (877) 816-3596 Website: www.myuhc.com</p>
<b>Vision</b>	Fully-Insured / Vision Service Plan	30076094	<p>Full time employees working 30+ hours per week. Spouses, domestic partners, and children generally are covered</p> <p>Employees with variable hours and seasonal</p>	<p><u>Salaried Employees:</u> first of the month following date of hire (if enrolled within 30 days of being eligible)</p>	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	<p>Vision Service Plan at:</p> <p>Phone: (800) 877-7195 Website: www.vsp.com</p>

<b>Benefit Program</b>	<b>Fully-insured or self-funded? if fully-insured, carrier name</b>	<b>Policy or Group #, if fully-insured</b>	<b>Who is eligible</b>	<b>When Participation begins</b>	<b>When Participation Ends<sup>1</sup></b>	<b>To File a Claim, Contact:</b>
			schedules may be considered eligible for benefits.	<u>Hourly Employees:</u> first of the month following 30 days of employment		
<b>Life/AD&amp;D</b>	Fully-Insured / Lincoln Financial Group	10121071	Full time employees working 30+ hours per week.	<u>Salaried Employees:</u> first of the month following date of hire (if enrolled within 30 days of being eligible)  <u>Hourly Employees:</u> first of the month following 30 days of employment	Immediately upon termination of employment. Continuation coverage may be available.	Lincoln Financial Group at:  Phone: (800) 423-2465 Website: www.lfg.com
<b>Short-Term Disability (Non-CA)</b>	Fully-Insured / Lincoln Financial Group	10121073	Full time employees working 30+ hours per week.	<u>Salaried Employees:</u> first of the month following date of hire (if enrolled within 30 days of being eligible)  <u>Hourly Employees:</u> first of the month following 30 days of employment	Immediately upon termination of employment. Continuation coverage may be available.	Lincoln Financial Group at:  Phone: (800) 423-2465 Website: www.lfg.com
<b>Long-Term Disability</b>	Fully-Insured / Lincoln Financial Group	10121072	Full time employees working 30+ hours per week.	<u>Salaried Employees:</u> first of the month following date of hire (if enrolled within 30	Immediately upon termination of employment. Continuation coverage may be available.	Lincoln Financial Group at:  Phone: (800) 423-2465 Website: www.lfg.com

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends <sup>1</sup>	To File a Claim, Contact:
<b>Voluntary Life/AD&amp;D</b>	Fully-Insured / Lincoln Financial Group	400001000 10815	Full time employees working 30+ hours per week. Spouses, domestic partners, and children generally are eligible.	<p>days of being eligible)</p> <p><u>Hourly Employees:</u> first of the month following 30 days of employment</p> <p><u>Salaried Employees:</u> first of the month following date of hire (if enrolled within 30 days of being eligible)</p> <p><u>Hourly Employees:</u> first of the month following 30 days of employment</p>	Immediately upon termination of employment. Continuation coverage may be available.	Lincoln Financial Group at: Phone: (800) 423-2465 Website: www.lfg.com

**Additional Information on ACA FT Status Determination**

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee who works on average 130 hours per month. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility.

New employees hired to work full-time. If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for the Company’s medical plan coverage as of the first of the month following date of hire for Salaried Employees and the first of the month following 30 days of employment for Hourly Employees.

**New employees hired to work a part-time, variable hour or seasonal schedule.** If you are hired into a part-time position, a position where your hours vary and Pentagon Technologies Group, Inc. is unable to determine — as of your date of hire — whether you will be a full-time employee (work on average 130 or more hours a month), or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 3 months to determine whether you are a full-time employee. Your 3-month IMP will begin on the first of the month following your date of hire and will last for 3 months. If, during your IMP, you average 130 or more hours a month over that 3 month period, you will be full time and, if otherwise eligible for benefits, you will be offered coverage by the first of the second month after your IMP ends. Your full-time status will remain in effect during an associated stability period that will last 12 months from the date that status is determined. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

**Ongoing employees.** Pentagon Technology Group, Inc. uses the look-back measurement method to determine the Company’s medical plan eligibility for ongoing employees. An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12-month period of time over which Pentagon Technologies Group, Inc. counts employee hours to determine which employees work full-time. An employee is deemed full-time if he or she averages 130 or more hours a month over the 12-month standard measurement period. Those employees who average 130 or more hours a month over the 12-month standard measurement period will be full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect for a 12-month stability period. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

Pentagon Technologies Group, Inc. uses the standard measurement period and associated stability period annual cycle set forth below.

<b>Plan Year</b>	<b>Measurement Period</b>	<b>Administrative Period</b>	<b>Stability Period</b>
July 1 – June 30	June 1 – May 31	June 1 – June 30	July 1 – June 30

## Appendix A: COBRA Continuation

**Paycom COBRA  
PO Box 735814  
Dallas, TX 75373-5814**

## **Continuation Coverage Rights Under COBRA**

### **Introduction**

You're getting this notice because you recently gained coverage under PENTAGON TECHNOLOGIES GROUP INC Group Health Plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. This notice does not fully describe COBRA continuation coverage or other rights under the Plan. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's summary plan description or contact the Plan Administrator.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

### **What is COBRA continuation coverage?**

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

### **Retiree Health Coverage**

If this plan provides retiree health coverage, then sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to PENTAGON TECHNOLOGIES GROUP INC, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

### **When is COBRA continuation coverage available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer, if the Plan provides retiree health coverage; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

### **You Must Give Notice of Some Qualifying Events**

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the later of: (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You must provide this notice in accordance with the notice procedures found in the "Notice Procedures" section at the end of this notice. If the notice is not provided in accordance with these notice procedures during the 60-day notice period, then all qualified beneficiaries will lose their right to elect COBRA.**

### **Electing COBRA**

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. **Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice will lose his or her right to elect COBRA.**

### **How Long Does COBRA Coverage Last?**

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. These "36-month" qualifying events include the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of the Medicare entitlement, which is equal to 27 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months *before* the termination or reduction in hours.

Otherwise, when the qualifying event is the end of employment or reduction in the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods described in this notice for several reasons, which are described in the Plan's summary plan description.

There are also ways (described in the following paragraphs) in which the period of COBRA coverage resulting from a termination of employment or reduction in hours can be extended.

#### *Disability extension of 18-month period of COBRA continuation coverage*

If a qualified beneficiary is determined by Social Security to be disabled and you notify the COBRA Administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction in hours. The disability must have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage that would be available without the disability extension.

**The disability extension is available only if you notify the COBRA Administrator in writing of the Social Security Administration's determination of disability no later than 18 months after the covered employee's termination of employment or reduction in hours and within 60 days after the latest of:**

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

**You must provide this notice in accordance with the notice procedures found in the "Notice Procedures" section at the end of this notice. If the notice is not provided in accordance with these notice procedures during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, then there will be no disability extension of COBRA coverage.**

#### *Second qualifying event extension of COBRA continuation coverage*

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family receiving COBRA coverage can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the COBRA Administrator is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; gets divorced or

legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**This extension due to a second qualifying event is available only if you notify the COBRA Administrator in writing of the second qualifying event within 60 days after the date of the second qualifying event. You must provide this notice in accordance with the notice procedures found in the "Notice Procedures" section at the end of this notice. If the notice is not provided in accordance with these notice procedures during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event.**

**Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

**Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period ( <https://www.medicare.gov/sign-up-change-plans/how-dso-i-get-parts-a-b/part-a-part-b-sign-up-periods>.) to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

<https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

**If you have questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

**Keep your Plan informed of address changes**

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or COBRA Administrator.

**Plan Contact Information**

You may obtain information about the Plan and COBRA coverage on request from:

Plan Administrator  
DANA CAMDEN

PENTAGON TECHNOLOGIES GROUP INC  
21325 CABOT BLVD  
HAYWARD, CA 94545  
+1 (510) 901-0067

This contact information for the Plan Administrator may change from time to time. The most recent information will be included in the Plan's most recent summary plan description (if you do not have a copy, you may request one from PENTAGON TECHNOLOGIES GROUP INC).

### Notice Procedures

**Important: If a notice is late or these notice procedures are not followed, the right to elect COBRA (or the right to an extension of COBRA as applicable) will be lost.**

**Notices must be Written:** Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable.

**How, When, and Where to Send Notices:** You must mail or email your notice to:

Plan Administrator  
DANA CAMDEN  
PENTAGON TECHNOLOGIES GROUP INC  
21325 CABOT BLVD  
HAYWARD, CA 94545

COBRA Administrator  
Paycom COBRA  
PO Box 735814, Dallas, TX 75373-5814

Or

COBRA@paycomonline.com

However, if a different address for COBRA-related notices appears in a more recently dated Plan's summary plan description, you must mail your notice to that address (if you do not have a copy of the Plan's most recent summary plan description, you may request one from the Plan Administrator).

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled "You Must Give Notice of Some Qualifying Events," "Disability extension of 18-month period of COBRA continuation coverage," and "Second qualifying event extension of COBRA continuation coverage".)

**Information Required for All Notices:** Any notice you provide must include: (1) the name of the Plan (PENTAGON TECHNOLOGIES GROUP INC Group Health Plan); (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiar(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the signature, name, address, and telephone number of the person providing the notice.

**Additional Information Required for Notice of Qualifying Event:** If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying Plan Administrator that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to Plan Administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

**Additional Information Required for Notice of Disability:** Any notice of disability that you provide must include: (1) the name and address of the disabled qualified beneficiary; (2) the date the qualified beneficiary became disabled; (3) the names and addresses of all

qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination; (5) a copy of the Social Security Administration's determination; and (6) a statement addressing whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

**Additional Information Required for Notice of Second Qualifying Event:** Any notice of a second qualifying event that you provide must include: (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

**Who May Provide Notices:** The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.



## **Cal-COBRA Continuation Coverage for Certain California Insured Plans**

Insured medical plans with Contracts based in California are required to offer COBRA-qualified beneficiaries who are enrolled in their plans and exhaust their 18 or 29 months of federal COBRA an additional period of continuation coverage for a combined total of 36 months of continuation coverage from the date federal COBRA began. The premium charged for this additional coverage (after the maximum COBRA period has expired) will generally be 110% of the current premium rate. Contact your insurance carrier for further information on Cal-COBRA. Your insurance carrier will be able to supply you with further information regarding how to enroll, deadlines for enrollment, premium amounts, and deadlines for submitting premiums.

## Appendix B: Medicare Part D Notice

### Important Notice from Pentagon Technologies Group, Inc. Health & Welfare Plan About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Pentagon Technologies Group, Inc. Health & Welfare Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Pentagon Technologies Group, Inc. has determined that the prescription drug coverage offered by the UnitedHealthcare plans:
  - UnitedHealthcare Base PPO
  - UnitedHealthcare Buy Up PPO
  - UnitedHealthcare HDHP

And that the prescription drug offered by Kaiser:

- Kaiser Permanente Deductible HMO

is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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### When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

### What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Pentagon Technologies Group, Inc. Health & Welfare Plan coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Pentagon Technologies Group, Inc. Health & Welfare Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Pentagon Technologies Group, Inc. Health & Welfare Plan prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

### **When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with Pentagon Technologies Group, Inc. Health & Welfare Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

### **For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Pentagon Technologies Group, Inc. Health & Welfare Plan changes. You also may request a copy of this notice at any time.

### **For More Information About Your Options Under Medicare Prescription Drug Coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit [medicare.gov](http://medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [socialsecurity.gov](http://socialsecurity.gov), or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

**Date:** 7/1/2025  
**Name of Entity/Sender:** Pentagon Technologies Group, Inc.  
**Contact-Position/Office:** HR Manager  
**Address:** 21031 Alexander Ct., Hayward, CA 94545  
**Phone Number:** 800-379-3361

## **Appendix C: Cafeteria Plan and FSA Provisions**

**PENTAGON TECHNOLOGIES GROUP, INC. CAFETERIA PLAN  
TABLE OF CONTENTS**

	<b>Page</b>
ARTICLE 1	OVERVIEW..... 3
ARTICLE 2	DEFINITIONS..... 3
2.1	Definitions..... 3
ARTICLE 3	ELIGIBILITY AND PARTICIPATION ..... 6
3.1	Eligibility..... 6
3.2	Termination of Participation..... 6
3.3	Participation After Termination of Employment or Loss of Eligibility..... 6
3.4	FMLA Leaves of Absence..... 7
3.5	Non-FMLA Leaves of Absence..... 8
ARTICLE 4	BENEFIT ELECTIONS ..... 8
4.1	Elections Upon Initial Eligibility..... 8
4.2	Elections During Open Enrollment Period ..... 8
4.3	Irrevocability of Elections ..... 9
ARTICLE 5	BENEFITS OFFERED AND METHOD OF FUNDING ..... 9
5.1	Benefits Offered..... 9
5.2	Employer and Participant Contributions ..... 9
5.3	Salary Reduction Contributions ..... 9
5.4	Funding ..... 10
ARTICLE 6	PREMIUM PAYMENTS..... 10
6.1	Benefits..... 10
6.2	Contributions for Cost of Coverage ..... 11
6.3	COBRA..... 11
ARTICLE 7	IRREVOCABILITY OF ELECTIONS: EXCEPTIONS..... 11
7.1	Irrevocability of Elections ..... 11
7.2	Procedure for Making New Election If Exception to Irrevocability Applies ..... 11
7.3	Change in Status Defined..... 12
7.4	Events Permitting Exception to Irrevocability Rule for Benefits ..... 12
7.5	Election Modifications Required by Plan Administrator ..... 20

**TABLE OF CONTENTS**  
(continued)

		<b>Page</b>
ARTICLE 8	APPEALS PROCEDURE .....	21
	8.1 Claim Procedures for Health Benefits.....	21
	8.2 Claim Procedures for Salary Reduction Benefits .....	21
	8.3 Claims and Appeals Procedures Chart .....	22
ARTICLE 9	RECORDKEEPING AND ADMINISTRATION .....	22
	9.1 Plan Administrator .....	22
	9.2 Powers of the Plan Administrator.....	22
	9.3 Reliance on Participant, Tables and Other Data.....	23
	9.4 Provision for Third-Party Plan Service Providers .....	24
	9.5 Fiduciary Liability .....	24
	9.6 Compensation of Plan Administrator .....	24
	9.7 Inability to Locate Payee.....	24
	9.8 Effect of Mistake .....	24
ARTICLE 10	GENERAL PROVISIONS .....	25
	10.1 Expenses.....	25
	10.2 No Contract of Employment .....	25
	10.3 Amendment and Termination .....	25
	10.4 Code and ERISA Compliance .....	25
	10.5 No Guarantee of Tax Consequences.....	25
	10.6 Indemnification of Employer .....	25
	10.7 Headings.....	26
	10.8 Plan Provisions Controlling .....	26
	10.9 Severability.....	26
	10.10 Applicable Law; Military Leave .....	26

## **Adoption Agreement**

### **Plan Name**

**Pentagon Technologies Group, Inc. Cafeteria Plan**

### **Plan Type**

This Plan is designed to permit an Eligible Employee to pay for his or her share of Premiums under any of the group health plans maintained by the Employer in which such Eligible Employee participates on a pre-tax Salary Reduction basis. This Plan is intended to qualify as a cafeteria plan under Code Section 125.

### **Employer & Plan Administrator**

**Pentagon Technologies Group, Inc.  
21031 Alexander Court  
Hayward, CA 94545  
1-800-379-3361**

### **Benefits Offered Under the Plan**

This Plan offers Premium Payment Benefits for the Employer's:

- Medical Plan(s)
- Dental Plan(s)
- Vision Plan(s)
- Health Savings Account(s)

### **Plan Eligibility**

Only Employees may participate in the Plan. The following classes of Employees shall be eligible to participate:

All full time Employees working at least 30 hours per week or 130 hours per month.

Any individual whom the Plan Sponsor determines is not an Eligible Employee shall not be treated as an Eligible Employee hereunder solely because he has been classified or reclassified as an employee of the Employer by any arbitrator, court or other governmental entity.

**Participation**

An Eligible Salaried Employee shall begin Plan participation on the first of the month after hire. An Eligible Hourly Employee shall begin Plan participation on the first of the month after 30 days of employment.

**Claims Procedure**

The Plan is not required to have a claims procedure as the Plan is not subject to ERISA. However, the Employer may choose to adopt one simply to have a procedure in plan in the event a benefits dispute occurs. The Employer hereby does not adopt the claims procedure in Section 8.2.

**Plan Year**

The Plan Year shall begin on July 1<sup>st</sup> and end on June 30<sup>th</sup>.

**Effective Date**

The Effective Date of this Plan shall be July 1<sup>st</sup>, 2025.

**Governing Law**


This Plan shall be construed, administered, and enforced according to the laws of the State of California, to the extent not superseded by the Code, ERISA, or any other federal law, as applicable.

Adopted this 10 day of March, 2026.

Printed Name: Daichi Otsuka

Signature: 

Title: CFO

Witness Signature: 

## ARTICLE 1. OVERVIEW

This Plan is designed to provide the benefits specified in the Adoption Agreement and described in more detail in the Plan. This Plan is intended to constitute a “cafeteria plan” under Code Section 125 and applicable guidance thereunder (including regulations and cases) and shall be interpreted to accomplish that objective.

## ARTICLE 2. DEFINITIONS

### 2.1 Definitions

“**Adoption Agreement**” means the document executed in connection with this Plan that contains optional features selected by the Employer.

“**Benefit Package Option**” means a qualified benefit under Code Section 125(f) that is offered under the Plan, or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option, or a PPO option under an accident or health plan).

“**Change in Status**” has the meaning described in Section 7.3.

“**COBRA**” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“**Code**” means the Internal Revenue Code of 1986, as amended.

“**Compensation**” means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under this Plan; (b) any salary reduction election under any other cafeteria plan; and (c) any compensation reduction under any Code Section 132(f)(4) plan; but determined after (d) any salary deferral elections under any Code Section 401(k), 403(b), 408(k), or 457(b) plan or arrangement. Thus, “Compensation” generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the preceding sentence.

“**Dependent**” means (a) a dependent as defined as in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, (b) any child (as defined in Code Section 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (c) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year).

“**Effective Date**” of this Plan is the date specified in the Adoption Agreement.

**“Eligible Employee”** means an Employee eligible to participate in this Plan, as provided in Section 3.1.

**“Employee”** means an individual that the Employer classifies as a common-law employee and who is on the Employer’s W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code Section 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer’s W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any self-employed individual; (d) any partner in a partnership; and (e) any more-than-2% shareholder in a Subchapter S corporation. The term “Employee” does include “former Employees” for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

**“Employer”** means the Employer identified in the Adoption Agreement and any Related Employer. However, for purposes of Article 9 and Section 10.3, “Employer” means only the Employer identified in the Adoption Agreement.

**“Employment Commencement Date”** means the first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

**“ERISA”** means the Employee Retirement Income Security Act of 1974, as amended.

**“Exchange”** means a federally or state operated marketplace that makes available Qualified Health Plans to qualified individuals and employers.

**“Exchange Special Enrollment”** means a period of time outside of open enrollment during which an individual is eligible to enroll in Exchange coverage. Events triggering Exchange Special Enrollment rights include but are not limited to: Gain of a dependent by marriage, birth, adoption or placement for adoption; An individual who was not previously a citizen, national, or lawfully present individual gains such status; Leaving incarceration; An individual gains access to new QHPs as a result of a permanent move; An individual who has a change in eligibility for advance payments or the premium tax credit or cost-sharing reductions; An individual who demonstrates to the Exchange that the individual meets other exceptional circumstances as defined by the Exchange.

**“FMLA”** means the Family and Medical Leave Act of 1993, as amended.

**“Health Benefits”** means the Employee’s group health coverage under the Employer’s Health and Welfare Plan for purposes of this Plan.

**“Health and Welfare Plan”** means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical, dental and vision benefits, as amended from time to time. The Employer may substitute, add, subtract or revise at any time the menu of such coverage options and/or the benefits, terms and conditions of any such plans. Any such substitution, addition, subtraction or revision will automatically be incorporated by reference under this Plan.

**“HIPAA”** means the Health Insurance Portability and Accountability Act of 1996, as amended.

**“HMO”** means a health maintenance organization Benefit Package Option under the Health and Welfare Plan.

**“Minimum Essential Coverage”** means coverage sufficient to satisfy the Affordable Care Act mandate to have health insurance. Minimum Essential Coverage includes but is not limited to government sponsored programs such as Medicare, Medicaid, CHIP, and TRICARE; individual health coverage; employer sponsored health coverage; and other coverage as may be recognized by the Department of Health and Human Services. Minimum Essential Coverage does not include certain excepted benefits, such as limited scope coverage (such as dental or vision coverage).

**“Open Enrollment Period”** with respect to a Plan Year means a month or other time period chosen by the Employer in the year preceding the Plan Year.

**“Participant”** means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article 3. Participants include those who elect one or more of the Health Benefits and who authorize Salary Reductions to pay for such Health Benefits.

**“Period of Coverage”** means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.

**“Plan”** means this Plan, as amended from time to time.

**“Plan Administrator”** means the Plan Administrator specified in the Adoption Agreement.

**“Plan Year”** means the time period specified in the Adoption Agreement. A short Plan Year is possible if the Adoption Agreement is modified to so reflect the short Plan Year.

**“Premium”** means the amount contributed to pay for the cost of Health Benefits.

**“Premium Payment Benefits”** means the Premium Payment Benefits described in Section 6.1.

**“QMCSO”** means a qualified medical child support order, as defined in ERISA Section 609(a).

**“Related Employer”** means any employer affiliated with the Employer that, under Code Section 414(b), Section 414(c), or Section 414(m), is treated as a single employer with the Employer for purposes of Code Section 125(g)(4).

**“Salary Reduction”** means the amount by which the Participant’s Compensation is reduced and applied by the Employer under this Plan to pay for the Health Benefits, before any applicable state and/or federal taxes have been deducted from the Participant’s Compensation (i.e., on a pre-tax basis).

**“Spouse”** means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code), including a same sex spouse.

### **ARTICLE 3. ELIGIBILITY AND PARTICIPATION**

#### **3.1 Eligibility**

An individual shall be eligible to participate in this Plan if the eligibility criteria in the Adoption Agreement are satisfied. An individual’s eligibility for a particular plan or benefit may be subject to additional eligibility criteria specified in the underlying Health and Welfare Plan.

#### **3.2 Termination of Participation**

A Participant will cease to be a Participant in this Plan upon the earlier of:

- the expiration of the Period of Coverage for which the Employee has elected to participate;
- the termination of this Plan;
- the date on which the Employee ceases to be an Eligible Employee because of retirement, termination of employment, layoff, reduction in hours, or any other reason, provided that eligibility may continue beyond such date for purposes of providing pre-tax payments of COBRA coverage, as may be permitted by the Plan Administrator on a uniform and consistent basis, but not beyond the end of the current Plan Year, under Section 6.3; or

- the date the Participant revokes his or her election to participate under a circumstance when such change is permitted under the terms of this Plan.

Termination of participation in this Plan or loss of eligibility to participate will automatically revoke the Participant's elections. The Health Benefits will terminate as of the date specified in the Health and Welfare Plan.

### **3.3 Participation After Termination of Employment or Loss of Eligibility**

If a former Salaried Employee is rehired after termination of previous employment and is otherwise eligible to participate in the Plan, then the individual may make a new election as a new hire as described in Section 3.1.

If an Hourly Employee terminates his or her employment for any reason and then is rehired within 1 year after the date of a termination of employment, the Hourly Employee can begin participation again on the first of the month after the date of rehire.

If a former Hourly Employee is rehired more than 1 year following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make a new election as a new hire as described in Section 3.1. Notwithstanding the above, an election to participate in this Plan will be reinstated only to the extent that coverage under the Health and Welfare Plan is reinstated. If an Employee, whether or not a Participant, ceases to be an Eligible Employee for any reason other than for termination of employment, including, but not limited to, a reduction in hours, and then becomes an Eligible Employee again, the Employee must complete any waiting period described in the Adoption Agreement before again becoming eligible to participate in the Plan.

### **3.4 FMLA Leaves of Absence**

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Health Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her Health Benefits coverage while on leave, the Employer will continue to pay its share of the Premium for such coverage.

An Employer may require Participants to continue all Health Benefits coverage for Participants while they are on paid leave provided that Participants on non-FMLA paid leave are required to continue coverage. If so, the Participant's share of the Premium shall be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave, or paid FMLA leave where coverage is not required to be continued, a Participant may elect to continue his or her Health Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Premiums in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- with pre-tax dollars, by either (1) having such amounts withheld from the Participant's ongoing Compensation, if any, or (2) pre-paying all or a portion of the Premium for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Premium, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available. The Participant may only pre-pay the applicable Premium for the current Plan Year and may not pre-pay any applicable Premium for the next Plan Year; or
- under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If the Employer requires all Participants to continue Health Benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required Premiums until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Premiums not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant.

If a Participant's Health Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Health Benefits upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose Health Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage.

### **3.5 Non-FMLA Leaves of Absence**

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant can: (1) continue to participate and the Premiums due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator, or (2) drop coverage if all of the criteria in election change rule Section 7.4(j) are satisfied. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 7.4(c) will apply.

## **ARTICLE 4. BENEFIT ELECTIONS**

### **4.1 Elections Upon Initial Eligibility**

An Employee who first becomes eligible to participate in the Plan after the beginning of a Plan Year may elect to commence participation at the time specified in the Adoption Agreement, provided that all required forms have been submitted to the Plan Administrator in the time frame specified by the Plan Administrator. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 7.4. Eligibility for Premium Payment Benefits shall be subject to the additional requirements, if any, specified in the Health and Welfare Plan. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Health and Welfare Plan.

### **4.2 Elections During Open Enrollment Period**

During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide an opportunity to participate in this Plan through completion of paper enrollment forms or electronically to each Employee who is eligible. The opportunity shall enable the Employee to elect to participate in this Plan for the next Plan Year and any election authorizes the necessary Salary Reductions to pay for the Health Benefits elected. The paper enrollment forms must be returned to the Plan Administrator or electronic elections completed on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year. If an Eligible Employee fails to complete their elections during the Open Enrollment Period, then the Employee may not elect any Benefits under this Plan until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 7.4.

### **4.3 Irrevocability of Elections**

Unless an exception applies as described in Article 7, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

## **ARTICLE 5. BENEFITS OFFERED AND METHOD OF FUNDING**

### **5.1 Benefits Offered**

When first eligible or during the Open Enrollment Period as described under Article 4, Participants will be given the opportunity to elect to make Premium Benefit Payments described in Article 6.

### **5.2 Employer and Participant Contributions**

- (a) *Employer Contributions.* For Participants who elect Health Benefits described in Article 6, the Employer may contribute a portion of the Premium under this Plan.

- (b) *Participant Contributions.* Participants who elect any Benefits may pay for the cost of such Benefits on a pre-tax Salary Reduction basis.

### **5.3 Salary Reduction Contributions**

- (a) *Salary Reductions per Pay Period.* The Salary Reduction for a pay period for a Participant is, for the Health Benefits elected, an amount equal to (1) the annual Premium for such Health Benefits, as described in Section 6.2, divided by the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage in reducible Compensation, amounts withheld may fluctuate).
- (b) *Considered Employer Premiums for Certain Purposes.* Salary Reductions are applied by the Employer to pay for the Participant's share of the Premiums for the Premium Payment Benefits and, for the purposes of this Plan and the Code, are considered to be Employer contributions.
- (c) *Salary Reduction Balance Upon Termination of Coverage.* If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Premiums for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation, as applicable.
- (d) *After-Tax Premiums for Premium Payment Benefits.* Participants may request to pay their share of the Premiums for any of the Health Benefits with after-tax deductions by contacting the Plan Administrator. If approved, both the Employee and Employer portions of such Premiums will be paid outside of this Plan.

### **5.4 Funding**

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in any applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Health Benefits are paid. While the Employer has complete responsibility for the payment of Health Benefits out of its general assets, except for Premium Payment Benefits paid as provided in the applicable insurance policy, it may hire an unrelated third-party paying agent to make Health Benefit payments on its behalf. The maximum contribution that may be made under this Plan for a Participant is the total of the

maximums that may be elected as Employer and Participant Premiums for Premium Payment Benefits, as described in Section 6.2.

## **ARTICLE 6. PREMIUM PAYMENTS**

### **6.1 Benefits**

The only Health Benefits that are offered under this Plan are Health Benefits under the Health and Welfare Plan and such Health Benefits are subject to the terms and conditions of the Health and Welfare Plan. No changes can be made with respect to such Health Benefits under this Plan, such as mid-year changes in election, if such changes are not permitted under the applicable Health and Welfare Plan. An Eligible Employee can (a) elect benefits under the Plan by electing to pay for his or her share of the Premiums for Health Benefits on a pre-tax Salary Reduction basis (“Premium Payment Benefits”); or (b) elect no benefits under the Plan and, if permitted by the Employer, to pay for his or her share of the Premiums for Health Benefits with after-tax deductions outside of this Plan.

Notwithstanding the foregoing, Participants who do not earn sufficient Compensation in any pay period to pay for Health Benefits on a pre-tax Salary Reduction basis will be required to pay for their share of the Premiums on an after-tax basis outside of the Plan for such pay period under an arrangement determined by the Administrator in its discretion. Failure to pay any such required Premiums on an after-tax basis in the time required will result in such Participant losing Health Benefits coverage under the Health and Welfare Plan, unless otherwise required by applicable law.

### **6.2 Contributions for Cost of Coverage**

The annual Premium for a Participant’s Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance carrier.

### **6.3 COBRA**

COBRA continuation of Health and Welfare Plan benefits may be available under the Health and Welfare Plan. If so, contributions for COBRA coverage may be paid on a pre-tax basis for current Employees receiving taxable compensation unless determined otherwise by the Plan Administrator on a uniform and consistent basis, but not beyond the current Plan Year, where COBRA coverage arises because: (a) the Employee ceases to be eligible because of a reduction in hours; or (b) the Employee’s Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Premiums for COBRA coverage for Health Benefits shall be paid on an after-tax basis unless determined otherwise by the Plan Administrator on a uniform and consistent basis but not beyond the current Plan Year.

## ARTICLE 7. IRREVOCABILITY OF ELECTIONS: EXCEPTIONS

### 7.1 Irrevocability of Elections

Except as described in this Article 7, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

- participation in this Plan;
- Salary Reduction amounts; or
- election of particular Benefit Package Options.

### 7.2 Procedure for Making New Election If Exception to Irrevocability Applies

- (a) *Timeframe for Making New Election.* A Participant, or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period under Section 3.2, declined to be a Participant, may make a new election within 30 days of the occurrence of an event described in Section 7.4, as applicable, but only if the election is made on account of and is consistent with the event and if the election is made within any specified time period. Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a Dependent's loss of eligibility) that results in a beneficiary becoming ineligible for coverage under the Health and Welfare Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.
- (b) *Effective Date of New Election.* Elections made pursuant to this Section 7.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 7.4(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later).

### 7.3 Change in Status Defined

A Participant may make a new election upon the occurrence of certain events as described in Section 7.4, including a Change in Status. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code Section 125 or regulations issued thereunder, which the Plan Administrator, in its sole

discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

- (a) *Legal Marital Status.* A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;
- (b) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;
- (c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes or ceases to be eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time, or vice versa, with the consequence that the employee ceases to be eligible for the Plan; See Section 7.4(j) for status changes resulting in a reduction in hours with no loss of eligibility.
- (d) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age; and
- (e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents.

#### **7.4 Events Permitting Exception to Irrevocability Rule for Benefits**

A Participant may change an election as described below upon the occurrence of the following events:

- (a) *Open Enrollment Period.* A Participant may change an election during the Open Enrollment Period in accordance with Section 4.2.
- (b) *Termination of Employment.* A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.3 and 3.4, as applicable.
- (c) *Leaves of Absence.* A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.

- (d) *Change in Status.* A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 7.3), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer. A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change In Status:
- (1) *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA or similar health plan continuation coverage under state law under the Employer's plan, and if the Participant remains a Participant under this Plan in accordance with Section 3.2, then the Participant may increase his or her election to pay for such coverage; provided that, however, this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation.
  - (2) *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or

will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(e) *HIPAA Special Enrollment Rights.* If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code Section 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election, including, when required by HIPAA, an election to enroll in another benefit package under a group health plan, provided that the election change corresponds with such HIPAA special enrollment right. As required by applicable law, a special enrollment right will arise if:

(1) A Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had other coverage, and eligibility for such other coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions for such coverage were terminated;

(2) A new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption. An election to add previously eligible dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 31 days);

(3) The Participant's or Dependent's coverage under a Medicaid plan or state children's health insurance program is terminated as a result of loss of eligibility for such coverage; or

(4) The Participant or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan.

(f) *Certain Judgments, Decrees and Orders.* If a judgment, decree, or order, including a QMCSO (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody requires accident or health coverage for a Participant's child, then a Participant may (1) change his or her election to provide coverage for the child, provided that the Order requires the Participant to provide coverage; or (2) change his or her election to revoke

coverage for the child if the Order requires that another individual, including the Participant's Spouse or former Spouse, provide coverage under that individual's plan and such coverage is actually provided.

- (g) *Medicare and Medicaid.* If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines, then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility.
- (h) *Change in Cost.* For purposes of this Section 7.4(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) an HMO and a PPO are considered to be similar coverage; and (2) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.
- (1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their Salary Reductions to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their Salary Reductions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' Salary Reductions on a prospective basis.
- (2) *Significant Cost Increases.* If the Plan Administrator determines that the cost charged to an Employee for a Participant's Benefit Package Option, such as a PPO, significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her Salary Reductions; (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage, such as an HMO, if offered; or (c) drop coverage prospectively if there is no other

Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

- (3) *Significant Cost Decreases.* If the Administrator determines that the cost of any Benefit Package Option, such as a PPO, significantly decreases during a Period of Coverage, the Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option, such as an HMO, other than the Benefit Package Option that has decreased in cost may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost, such as a PPO; and (b) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost, such as a PPO, on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

- (i) *Change in Coverage.*

The definition of “similar coverage” under Section 7.4(h) applies also to this Section 7.4(i).

- (1) *Significant Curtailment.* If coverage is “significantly curtailed,” as defined below, Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a “Loss of Coverage,” as defined below, then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is “significant,” and whether a Loss of Coverage has occurred.
- (A) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that a Participant’s coverage under a Benefit Package Option under this Plan, or the Participant’s Spouse’s or Dependent’s coverage under his or her employer’s plan, is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan, such as a PPO) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides

similar coverage, such as an HMO. Coverage under a plan is deemed to be “significantly curtailed” only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(B) *Significant Curtailment With a Loss of Coverage.* If the Plan Administrator determines that a Participant’s coverage under a Benefit Package Option under this Plan, such as a PPO, or the Participant’s Spouse’s or Dependent’s coverage under his or her employer’s plan, is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage, such as an HMO, or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(C) *Definition of Loss of Coverage.* For purposes of this Section 7.4(i)(1), a “Loss of Coverage” means a complete loss of coverage, including the elimination of a Benefit Package Option, an available HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of any permissible overall lifetime or annual limitation. In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Package Option, such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in a PPO or in an HMO, to the extent such arrangements are offered;
- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
- any other similar fundamental loss of coverage.

(2) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan

Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

- (3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including, but not limited to, the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government as defined in Code Section 7701(a)(40), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).
- (4) *Change in Coverage Under Another Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan, including a plan of the Employer or a plan of the Spouse's or Dependent's employer, so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

(j) Reduction in Hours

A Participant whose hours are reduced below 30 hours per week as a result of a change in employment status may drop coverage mid-year (whether or not eligibility is affected) if Participant intends to enroll in another plan offering minimum essential coverage (including the plan of a spouse or coverage through an Exchange, if Exchange Open Enrollment or Special Enrollment is available). See Section 2.1 for information about events that create Exchange Special Enrollment rights.

(k) Exchange Enrollment

A Participant who is eligible for and enrolls or intends to enroll in Exchange coverage (during an Exchange Special Enrollment period or open enrollment period) may drop coverage midyear. See Section 2.1 for information about events that create Exchange Special Enrollment rights.

A Participant entitled to change an election as described in this Section 7.4 must do so in accordance with the procedures described in Section 7.2.

**7.5 Election Modifications Required by Plan Administrator**

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

**ARTICLE 8. APPEALS PROCEDURE**

**8.1 Claim Procedures for Health Benefits**

Claims and reimbursement for Health Benefits shall be administered in accordance with the claims procedures for the Health Benefits, as set forth in the plan documents and/or summary plan description for the Health and Welfare Plan.

**8.2 Claim Procedures for Salary Reduction Benefits**

(a) *Initial Determination.* If a claimant's claim for eligibility under the Plan or change in election under Section 7.4 is denied, the person will receive written notice from the Plan

Administrator of the denial. The time frame in which a claimant will receive this notice is described in the Claims and Appeal Procedure Chart in Section 8.3 below.

(b) *Extension of Time.* The Plan Administrator, for reasons beyond its control, may take an extension of time in which to review a claim. If the reason for the extension is that the claimant needs to provide additional information, the claimant will be given a certain amount of time in which to obtain the requested information. The time period during which the Plan Administrator must make a decision will be suspended until the earlier of the date that claimant provides the information or the end of the applicable information-gathering period described in the Claims and Appeal Procedure Chart below.

(c) *Notice of Denial.* If the Plan Administrator denies the claim, it will send a notice of denial containing:

- (i) The reason(s) for the denial and the Plan provisions on which the denial is based;
- (ii) A description of any additional information necessary for the claimant to perfect the claim, why the information is necessary, and the time limit for submitting the information;
- (iii) The claimant's right to request, free of charge, all documents that are relevant to the claim;
- (iv) A description of the Plan's appeal procedures and the time limits applicable to such procedures;
- (v) A statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and that a copy of that rule, guideline or protocol will be provided free of charge upon request.

(d) *Appeal.* If the claimant does not agree with the decision of the Plan Administrator, the claimant may file a written appeal with the Plan Administrator within 60 days of receipt of the notice of denial.

(e) *Denial of Appeal.* If the claim is again denied, the Plan Administrator will notify the claimant within the time period applicable to the type of claim as described in the Claims and Appeal Procedures Chart in Section 8.3.

(f) *Extension of Time on Appeal Review.* The Plan Administrator, for reasons beyond its control, may take an extension of time in which to review a claim. If the reason for the extension is that the claimant needs to provide additional information, the claimant will be given a certain amount of time in which to obtain the requested information. The time period during which the Plan Administrator must make a decision will be suspended until the earlier of the date that claimant provides the information or the end of the applicable information-gathering period.

(g) *Notice of Denial*. The denial notice will contain the information listed in 8.2(c), to the extent applicable.

### 8.3 Claims and Appeals Procedures Chart

The following chart lists the time limit for claimants to submit appeals, and for the Administrator to respond to a claim or appeal.

<b>Claimant will be notified of determination as soon as possible but no later than</b> ....	<b>Extension period</b> ...	<b>Claimant must file appeal within</b> ...	<b>Notification of determination as soon as possible but no later than</b> ...	<b>Extension period</b> ...
90 days from receipt of claim	One extension of 90 days	60 days of claim denial	60 days from receipt of appeal	One extension of 60 days

## ARTICLE 9. RECORDKEEPING AND ADMINISTRATION

### 9.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator.

### 9.2 Powers of the Plan Administrator

The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

- (a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;
- (b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;
- (c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;
- (d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

- (e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;
- (f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;
- (g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;
- (h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;
- (i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal for Health Benefits; and
- (j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

### **9.3 Reliance on Participant, Tables and Other Data**

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

### **9.4 Provision for Third-Party Plan Service Providers**

The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

### **9.5 Fiduciary Liability**

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

#### **9.6 Compensation of Plan Administrator**

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

#### **9.7 Inability to Locate Payee**

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

#### **9.8 Effect of Mistake**

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code Section 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

## **ARTICLE 10. GENERAL PROVISIONS**

### **10.1 Expenses**

All reasonable expenses incurred in administering the Plan will be paid for by the Employer.

### **10.2 No Contract of Employment**

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

### **10.3 Amendment and Termination**

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

### **10.4 Code and ERISA Compliance**

It is intended that this Plan meet all applicable requirements of the Code and the regulations issued thereunder. As a premium-only plan, this Plan is not subject to ERISA and the regulations issued thereunder and thus does not comply with the ERISA requirements that are applicable to ERISA-covered plans. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

### **10.5 No Guarantee of Tax Consequences**

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

### **10.6 Indemnification of Employer**

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

### **10.7 Headings**

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

### **10.8 Plan Provisions Controlling**

In the event that the terms or provisions of any summary or description of this Plan are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

### **10.9 Severability**


Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

### **10.10 Applicable Law; Military Leave**

The Plan shall be administered in accordance with all applicable law, including but not limited to the Uniformed Services Employment and Reemployment Rights Act ("USERRA").

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument, the Employer has caused this Plan to be executed in its name and on its behalf, on this 10 day of March, 2026.

Printed Name: Daichi Otsuka

Signature:  \_\_\_\_\_

Title: CFO

# Appendix D: Authorized Representatives

## Appointment of Authorized Representative

I, \_\_\_\_\_

[name of claimant]

hereby appoint \_\_\_\_\_ to act on my behalf

[name of Authorized Representative]

or on behalf of \_\_\_\_\_

[name of patient: plan participant or beneficiary]

in connection with any claim for coverage or benefits, including receipt of any approvals or authorizations that are required before medical services are provided under the plan named above ("Plan"). I authorize my representative to receive any and all information that is provided to me, and to act for me and for my covered spouse or dependent, if named above as the patient, in providing any information to the Plan that relates to any claim for coverage or benefits under the Plan.

This form does not constitute an assignment of rights for direct payment.

Distribute to me and to my Authorized Representative: All information and notifications should be distributed to me and to my Authorized Representative.

\_\_\_\_\_

Claimant's signature

\_\_\_\_\_

Date

Accepted: \_\_\_\_\_

Authorized Representative's signature

\_\_\_\_\_

Date

Witness: \_\_\_\_\_

Witness signature

\_\_\_\_\_

Date