SUMMARY PLAN DESCRIPTION

FOR THE

FULLY-INSURED WELFARE BENEFITS PROVIDED UNDER THE

USUI INTERNATIONAL GROUP
HEALTH & WELFARE BENEFIT PLAN

EFFECTIVE

APRIL 15, 2019

THIS DOCUMENT SHOULD BE PROVIDED TO ALL PARTICIPANTS AND BENEFICIARIES WHENEVER A BENEFITS SUMMARY AND/OR CERTIFICATE DESCRIBING INSURED BENEFITS IS PROVIDED UNDER THE PLAN

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THE PLAN

Usui International Corporation (the "Employer") has established the Usui International Group Health & Welfare Benefit Plan (the "Plan"). This Summary Plan Description is intended, in combination with the applicable Benefits description(s) and/or certificate(s) provided by the Insurer(s), to describe applicable Plan terms with respect to the fully-insured benefits provided under the Plan. If you do not have a copy of the related Benefits description(s) or certificate(s), you should request one from the Plan Administrator at 44780 Helm Street, Plymouth MI 48170, (734) 354-3626.

THIS BOOKLET, ALONG WITH THE APPLICABLE BENEFIT DESCRIPTION BOOKLET AND/OR CERTIFICATE PREPARED BY THE INSURER(S), COVERS THE HIGHLIGHTS OF THE PLAN, AND ATTEMPTS TO DO SO IN AN EASY-TO-UNDERSTAND MANNER. IT IS PREPARED WITH THE DETAIL THE GOVERNMENT REQUIRES. IF THERE IS ANYTHING YOU DO NOT UNDERSTAND, YOU SHOULD CONTACT THE EMPLOYER (THE "PLAN ADMINISTRATOR"). ALSO, SINCE THIS IS A SUMMARY, YOU SHOULD KNOW THAT IF THIS BOOKLET SAYS ANYTHING THAT DISAGREES WITH THE INSURANCE CONTRACT THAT GOVERNS THE PLAN, THE CONTRACT IS THE ONE THAT MUST BE FOLLOWED.

PART I – Information About Plan Benefits and Eligibility

WHAT IS THE PURPOSE OF THE PLAN?

The Plan has been established by the Employer to provide you with an opportunity to receive the benefits described in the applicable benefit description booklet, benefit summary and/or certificate provided with this document. Applicable deductibles, coinsurance or co-payments, and annual or lifetime caps, and other exceptions and limitations should also be described there.

WHAT TYPE OF PLAN IS IT?

The Plan is a welfare benefit plan governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The benefits provided under the Plan and described in this SPD are fully-insured.

WHO RUNS THE PLAN?

The Employer is the Plan Sponsor. The Employer is the Plan Administrator.

The Employer may select and/or remove the Insurer(s), enter(s) into policies with the Insurer(s), and amend or terminate the Plan or any benefit under the Plan at any time in its sole discretion.

The Plan Administrator has responsibility for administration of the Plan, except that the Insurer(s) shall be the administrator of, and have sole responsibility, authority, and discretion with respect to benefits provided pursuant to the Plan insurance policy (and/or HMO contract, if applicable) which that Insurer insures. The Plan Administrator may delegate its duties to other individuals or entities.

The decisions of the Plan Administrator and, with regard to a particular Plan benefit and/or benefit level, of the applicable Insurer shall be final and binding on all persons.

WHAT BENEFITS ARE PROVIDED UNDER THE PLAN?

The benefits currently offered to eligible Employees under the Plan are listed below:

- Group Term Life and AD&D Insurance
- Group Long Term Disability Insurance
- Group Short Term Disability Insurance
- Group Voluntary Life Insurance

A description of the benefits (and applicable deductibles, co-payments and co-insurance and applicable limits) provided by the Plan is provided to you along with this document in the applicable benefits booklet(s) and/or certificate(s) of insurance provided with this document. If you do not have those, you can get a copy from the Plan Administrator.

In addition, each year during Open Enrollment, the Employer will provide you with the applicable information on your benefits choices for the upcoming Plan Year.

WHAT DETERMINES YOUR ELIGIBILITY?

Subject to applicable Policy terms, you are eligible to participate in the Plan if you are an Employee of the Employer and a United States citizen or permanent residents of the US, or who are lawfully and legally able to work in the U.S. pursuant to applicable federal and state laws working for the Employer within the United States (excluding rotating staff from affiliated companies) if you satisfy the following:

Benefit	Eligibility Standard
Group Term Life and AD&D Insurance	Employees performing the normal duties of his/her regular job on a regular and continuous basis of 30 or more hours each week
Group Long Term Disability Insurance	Employees performing the normal duties of his/her regular job on a regular and continuous basis of 30 or more hours each week
Group Short Term Disability Insurance	Employees performing the normal duties of his/her regular job on a regular and continuous basis of 30 or more hours each week
Group Voluntary Life Insurance	Employees performing the normal duties of his/her regular job on a regular and continuous basis of 30 or more hours each week

For Plan purposes, the term Employee excludes those individuals designated by the Employer as independent contractors, as evidenced by issuance of Form 1099, regardless of any later recharacterization as an Employee for the period in question, and also excludes employees working on a seasonal or temporary basis. In addition, the term "Employee" excludes those non-union employees with insurance coverage provided by Usui Japan.

An employee who is working on a temporary assignment outside the United States for a period of 12 months or less will be deemed to be working within the United States.

If eligible, you will become a Participant on the date listed below:

Benefit	Date Eligible to Participate
Group Term Life and AD&D Insurance	The day following 30 days of continuous employment
Group Long Term Disability Insurance	The day following 30 days of continuous employment
Group Short Term Disability Insurance	The day following 30 days of continuous employment
Group Voluntary Life Insurance	The day following 30 days of continuous employment

If your employment terminates or you are no longer an eligible Employee, or you fail to pay the Employee required portion of a premium, if any (and as determined from time to time by the Employer) you will cease to be a Participant. Also, you should contact the applicable Insurer directly to determine if there are conversion rights that allow you to continue coverage.

You will no longer be eligible to be a Participant in the Plan on the date on which the Plan terminates.

ARE DEPENDENTS ELIGIBLE FOR COVERAGE?

Eligible dependents who may elect coverage, subject to applicable Policy terms, are referenced in the table below:

Benefit	Eligible to Participate
Group Voluntary Life Insurance	Legal spouse; An Employee's natural-born, legally adopted and foster children (and stepchildren or any other child who lives with the employee in a regular parent/child relationship and who qualifies as the employee's "dependent" as defined in the Code) are eligible from age 14 days old to age 26 years old; Excluded is any dependent who is also an Employee or who is a member of the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary duty of 31 days or less). The Policy may contain additional exclusions.

WHAT IF YOU TERMINATE EMPLOYMENT AND ARE LATER REHIRED BY THE EMPLOYER?

If you are a Participant in the Plan, terminate employment with the Employer and are later rehired, your participation in the Plan upon your rehire is determined as follows:

Benefit	Rehire Policy
Group Term Life and AD&D Insurance	If a previously terminated employee is rehired within six months of a leave of absence or termination, benefits will become effective upon their date of rehire. All others will need to fulfill the required new hire waiting period.
Group Long Term Disability Insurance	If a previously terminated employee is rehired within six months of a leave of absence or termination, benefits will become effective upon their date of rehire. All others will need to fulfill the required new hire waiting period.
Group Short Term Disability Insurance	If a previously terminated employee is rehired within six months of a leave of absence or termination, benefits will become effective upon their date of rehire. All others will need to fulfill the required new hire waiting period.
Group Voluntary Life Insurance	If a previously terminated employee is rehired within six months of a leave of absence or termination, benefits will become effective upon their date of rehire. All others will need to fulfill the required new hire waiting period.

WHAT HAPPENS IF YOU TAKE A LEAVE OF ABSENCE?

Coverage for a particular benefit during a leave of absence is outlined in the respective benefit's Booklet or certificate, or the Employer's leave of absence policy.

If coverage for a particular benefit is provided by reason of your pre-tax deferrals pursuant to a Code Section 125 Cafeteria Plan and the Employer is subject to the Family and Medical Leave Act of 1993, as amended ("FMLA"), and you are absent from work due to an approved leave of absence which is then covered under the FMLA while you are a Participant and while the Employer is subject to the FMLA, you will continue to be a Participant in the Plan during the leave to the extent provided by the Code Section 125 Cafeteria Plan.

WHAT ARE THE SOURCES OF CONTRIBUTIONS AND COSTS OF BENEFITS?

The Employer, in connection with the Plan, on behalf of the Employees who participate in the Plan, purchases insurance coverage. Employees may be required to contribute to the cost of

coverage. If Employees are required to contribute to the cost of coverage, the Employer will notify Employees of the required premiums.

ARE THE BENEFITS PROVIDED THROUGH INSURANCE?

The benefits offered under the Plan are currently provided through the following insurance contract(s) as follows:

Benefit	Insurer	Insurer Address & Telephone Number
Group Term Life and AD&D Insurance	United of Omaha Life Insurance Company (Mutual of Omaha)	Mutual of Omaha Plaza Omaha, Nebraska 68175 1-800-775-8805
Group Long Term Disability Insurance	United of Omaha Life Insurance Company (Mutual of Omaha)	Mutual of Omaha Plaza Omaha, Nebraska 68175 1-800-775-8805
Group Short Term Disability Insurance	United of Omaha Life Insurance Company (Mutual of Omaha)	Mutual of Omaha Plaza Omaha, Nebraska 68175 1-800-775-8805
Group Voluntary Life Insurance	United of Omaha Life Insurance Company (Mutual of Omaha)	Mutual of Omaha Plaza Omaha, Nebraska 68175 1-800-775-8805

WHAT IS THE PLAN'S ANNUAL OPEN ENROLLMENT PERIOD?

The Plan's annual Open Enrollment Period is held prior to the start of the benefit contract year, which is the calendar year. The Employer will let you know ahead of time when the Open Enrollment Period will begin and end for a particular year. During this period the Employer will provide you with information on your benefit choices for the upcoming year and the applicable procedure for making your elections.

CAN I CHANGE MY BENEFIT ELECTIONS OUTSIDE OF THE OPEN ENROLLMENT PERIOD?

If you obtain Plan benefits pursuant to a Cafeteria Plan election governed by Section 125 of the Internal Revenue Code ("Code"), you cannot change your benefit elections during the Plan Year outside an Open Enrollment Period, unless you experience a "Change in Status Event" and the change you want to make is consistent with the Change in Status Event. Such a change must be allowed by the Cafeteria Plan and the Code Section 125 regulations.

PART II – Your Rights Under the Plan

IF YOU DISAGREE WITH ANY DETERMINATION OF YOUR BENEFITS, WHAT SHOULD YOU DO?

Benefit Claims

The Insurer(s) of the Plan benefits for which the determination was made has full responsibility for policy claims and claims review procedures, and the Insurer is responsible for the resolution of benefit claims in accordance with all applicable laws, including the Patient Protection and Affordable Care Act, as amended ("PPACA"). Claims procedures are described in the applicable Benefit Booklet(s) or other writing provided by the applicable Insurer. If you do not have a copy of the applicable claims procedures or the Benefit Booklet(s) you should contact the Plan Administrator to obtain a copy.

Non-Benefit Claims

With regard to non-benefit claims (e.g., eligibility, QMCSO, etc.), the Plan Administrator has adopted the following Claims Review Procedure.

If you have a non-benefit claim, your initial non-benefit claim should be written and personally delivered or mailed, certified mail, return receipt requested, to the Plan Administrator. Your non-benefit claim should state your name and address, the specific basis for your claim, and any additional material which you desire to present to the Plan Administrator for consideration.

The Plan Administrator, upon receipt of an initial non-benefit claim, shall make a determination and provide written notification of its determination to you within 30 days after its receipt of your non-benefit claim. This period may be extended one time by the Plan Administrator, provided the Plan Administrator both (i) determines that such an extension is necessary due to matters beyond the control of the Plan, and (ii) notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide such non-benefit claim, the notice of extension shall specifically describe the required information, and you shall be afforded at least 45 days from the receipt of the notice within which to provide such information.

The Plan Administrator shall provide you with written notification of an adverse determination. The notification shall set forth: (i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a description of any additional material or information necessary for you to perfect your non-benefit claim, if any, and an explanation as to why such material or information is necessary; (iv) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review; (v) any internal rules, guidelines, protocols or similar criterion on which the Plan Administrator relied in making its determination; (vi) any new or additional evidence or rationale that is considered, relied on or generated by (or at the direction of) the Plan in connection with the non-benefit claim and your right to respond to such new or additional evidence or rationale before the final claim determination is made; and (vii) the availability of, and contract information for, the applicable office of health insurance ombudsman.

You may appeal an adverse determination. To do so, you must submit, within 180 days following the receipt of the Plan Administrator's adverse determination, a written request for review to the Plan Administrator stating the specific basis for such request, and any additional materials you wish to submit. In connection with your request for review, you may request, in writing, copies of all documents, records, and other information upon which the Plan Administrator relied in making its determination. The Plan Administrator shall provide all such documents to you free of charge.

The Plan Administrator shall take into account all documents, records and other information submitted by you, without regard to whether such information as submitted or considered in the initial determination. Upon review of your request for review, if the claim involves a concurrent claim for benefits, the Plan Administrator shall not take into account or afford deference to its initial determination and shall see to it that a determination is made by the appropriate individual(s).

The Plan Administrator shall notify you of the Plan's determination on review within 30 days after receipt by the Plan of your request for review. If additional time is required by the Plan Administrator in order to make a determination, the Plan Administrator may extend this period by 30 days by notifying you in writing before the expiration of the initial 30 days.

The Plan Administrator shall provide you with written notification of the Plan's determination on review. In the case of an adverse determination, such notification shall set forth: (i) the specific reasons for the adverse determination; (ii) the specific Plan provisions on which the benefit determination is based; (iii) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records and other information relevant to a non-benefit claim, including any new or additional evidence or rationale that is considered, relied on or generated by (or at the direction of) the Plan in connection with the non-benefit claim and your right to respond to such new or additional evidence or rationale before the final non-benefit claim determination is made; (iv) a statement that you have a right to bring an action under ERISA Section 502(a); and (v) a description of any internal rule, guideline, protocol or other similar criterion, upon which the Plan Administrator relied in making its determination.

The decision of the Plan Administrator shall be final and binding.

WHAT OTHER RIGHTS AND PROTECTIONS ARE YOU ENTITLED TO UNDER THE PLAN?

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

a) Examine without charge, at the Plan Administrator's office and other locations, such as worksites, all Plan documents and copies of all documents filed by the Plan with the United States Department of Labor, such as Annual Reports and Plan Descriptions.

b) Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

c) 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.

You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claims. Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $147 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, you may file suit in a state or federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any question about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory of the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

WHAT ELSE SHOULD YOU KNOW ABOUT THE PLAN?

Plan Identification Numbers: The Internal Revenue Service has assigned the Employer, the Employer Identification Number 38-2726508. The Employer has assigned the Plan the number 501.

Plan Sponsor: Usui International Corporation, 44780 Helm Street, Plymouth, MI 48170; Phone: 1-734-354-3626

Plan Administrator: Employer; 44780 Helm Street, Plymouth, MI 48170; Phone: 1-734-354-3626

Plan Year: For recordkeeping purposes, the Plan Year begins on August 1 and ends on the following July 31

Legal Service: Service of process can be made upon the Plan Administrator.

Amendment and Termination: The Employer has the right to amend, modify or terminate the Plan at any time.

Further Information: If there is anything in this booklet which you do not understand, contact the Plan Administrator.