USUI MEDICAL, DENTAL AND VISION

BENEFIT PROVISIONS OF THE

USUI INTERNATIONAL GROUP

HEALTH & WELFARE BENEFIT PLAN

Plan Document

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ARTICLE I – ESTABLISHMENT

1.1 THE PLAN. Usui International Corporation (the "Company") maintains the Usui International Group Health & Welfare Benefit Plan. This document sets forth group medical, dental and vision benefits available to its eligible employees under that plan. The Company wishes to amend and restate the Usui group medical, dental and vision benefits provided under the Usui International Group Health & Welfare Benefit Plan, effective April 15, 2019. The plan benefits as set forth in this document and any future amendments will be known as the Usui Medical, Dental and Vision Program under the Usui International Group Health & Welfare Benefit Plan. "Plan" for purposes of this document, means the Usui Medical, Dental and Vision Program, which is part of the Usui International Group Health & Welfare Benefit Plan

The Plan is maintained for the exclusive benefit of employees of the Plan Sponsor and related employers that adopt the Plan, if applicable.

The Plan is intended to satisfy the requirements of the Internal Revenue Code of 1986, as amended ("Code"), and the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

This document, along with the Administrative Services Contract ("ASC") and Benefits Booklet constitute the written plan document.

1.2 EFFECTIVE DATE. The effective date of the Plan (or the Plan as amended and restated pursuant to this document, if applicable) is April 15, 2019.

1.3 ADOPTING EMPLOYER. The Plan Sponsor may extend this Plan or portions of the Plan to Adopting Employers. The Adopting Employer must agree in writing to participate in the Plan and to be bound by its provisions. The term "Employer" as used herein will refer to the Plan Sponsor and Adopting Employers. The Adopting Employers, if any, are listed in Appendix A.

1.4 INCORPORATION. The Plan provides medical, dental and vision benefits, which are described in the underlying ASC and Benefits Booklets issued by the Third-Party Administrator with respect to this Plan. These documents are incorporated into and made a part of this Plan and are called the "incorporated documents" in this Plan. The incorporated documents may be amended at any time in accordance with Article VIII of this Plan.

ARTICLE II – DEFINITIONS AND CONSTRUCTION

2.1 DEFINITIONS. The following words or phrases, when used in this Plan, have the following meanings:

(a) Administrator or Plan Administrator: The person or entity appointed by the Plan Sponsor with authority and responsibility to manage and direct the operation of the Plan. If no such person or entity is appointed, the Plan Administrator will be the Company.

(b) Adopting Employer: Any corporation that is a member of a controlled group of corporations, as defined in Code § 414(b), of which the Company is a member; any trade or business, whether or not incorporated, under common control, as defined in Code § 414(c), with the Company; each member of an affiliated service group, as defined in Code § 414(m), of which the Company is a member; and any other entity required to be aggregated with the Company under Code § 414(o) that adopts the Plan pursuant to Section 1.3.

(c) ASC: The Administrative Services Contract entered into between the Company and the Third-Party Administrator.

(d) Benefit: A benefit provided to any Participant under the Plan.

(e) Benefits Booklet: The current applicable Summary of Benefits and Coverages ("SBC") and benefits-at-glance, member handbook and/or benefits addendum by the applicable Third Party Administrator.

(f) Children or Child: Provided they reside in the United States of America, an Employee's biological child, adopted child, child placed for adoption, child for whom the Employee has been granted legal guardianship, or a child for whom the Employee must provide coverage pursuant to a court order, or as otherwise set forth in the applicable ASC.

(g) COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(h) Code: The Internal Revenue Code of 1986, as amended from time to time.

(i) Company: Usui International Corporation.

(j) Effective Date: April 15, 2019.

(k) Eligible Dependent: Unless otherwise provided by the applicable ASC or applicable Benefits Booklet, an Eligible Employee's (i) legal Spouse; (ii) Child or Children until the day on which they attain age 26; and (iii) disabled Child or Children who is or are totally and permanently disabled prior to age 26 who are unable to earn a living as a result of his or her disability who depend upon the Eligible Employee for support and maintenance.

(l) Eligible Employee: An Employee who meets the eligibility requirements of Section 3.1.

Employee: Any person who is receiving compensation for personal services rendered to the Employer as a common law employee of the Employer, including any self-employed individuals as defined in Code Section 401(c)(1); or on layoff status or an authorized leave of absence from any position with the Employer, and including a Foreign National employee of the company who is currently on assignment in the United States of America if completed at least 30 days of active full-time employment with a related company.

Notwithstanding anything to the contrary, the following individuals are excluded from the definition of Employee for purposes of this Plan: (i) those individuals designated by the Employer as independent contractors as evidenced by the issuance of a Form 1099, regardless of any later recharacterization; (ii) non-resident aliens (within the meaning of Code Section 7701(b)(1)(B)), who receive no earned income (within

the meaning of Code Section 911(d)(2)), from the Employer which constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)), or receives earned income but it is all exempt from income tax in the United States; (iii) a leased employee within the meaning of Code Section 414(n); and (iv) collectively bargained employees unless specifically bargained to participate in this Plan.

(m) Employer: The Company and any Adopting Employer.

(n) ERISA: The Employee Retirement Income Security Act of 1974, as amended from time to time.

(o) HIPAA: The Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing regulations.

(p) Medicaid: A state plan for medical assistance approved under title XIX, Section 1912 of the Social Security Act.

(q) Participant: An employee who meets the participation requirements of Article III and in the case of elective benefits, elects to participate.

(r) Plan: For purposes of this document, the Usui Medical, Dental and Vision program, as set forth in this document and any later amendments, the Plan is part of the Usui International Group Health & Welfare Benefit Plan.

(s) Plan Sponsor: Usui International Corporation

(t) Plan Year: August 1 – July 31

(u) Third Party Administrator: Blue Cross Blue Shield of Michigan.

2.2 CONSTRUCTION. Plural pronouns are used throughout the Plan for purposes of simplicity and will be interpreted to include the singular. Where necessary or appropriate to the context, the masculine will include the feminine, the singular will include the plural and the plural will include the singular.

ARTICLE III– ELIGIBILITY, PARTICIPATION AND ENROLLMENT

3.1 ELIGIBILITY AND PARTICIPATION.

(a) Self-funded Benefits. All Employees regularly scheduled to work at least 30 hours per week will be eligible for, and begin to participate in, self-funded benefits in accordance with the applicable ASC and Benefits Booklet and this Section.

(b) Eligible Dependents. Each Eligible Dependent of an Eligible Employee will be eligible to participate in the benefits offered under the Plan on the date the Eligible Employee becomes eligible to participate in the Plan.

(c) Date of Participation. An Eligible Employee may begin to participate in the Benefits on the first day of the month following 30 days of employment, except for employees transferred from an affiliated company that is within the Plan Sponsor's controlled group or affiliated service group and who will begin to participate on their first day of employment.

3.2 ENROLLMENT.

(a) Open Enrollment. At such time as may be determined from time to time by the Employer in its sole discretion, there will be an annual Open Enrollment Period during which an Eligible Employee will have the opportunity to change his or her current elections or coverage under the Plan. Unless a Participant affirmatively and timely elects to be covered during the annual Open Enrollment Period for the following Plan Year, the Participant will not be enrolled in the medical, dental and vision Benefits offered under the Plan for the following Plan Year regardless of existing elections.

(b) Special Enrollment. Except as otherwise expressly provided for in the ASC, an Eligible Employee may enroll for Benefits under the Plan during a Special Enrollment Period if the Eligible Employee previously declined coverage under the Plan for himself or for an Eligible Dependent and if each of the following conditions is met:

(i) The Eligible Employee or Eligible Dependent(s) was covered under a group health plan or had health insurance coverage at the time the coverage under the Plan was previously offered to the Employee or Eligible Dependent(s);

(ii) The Eligible Employee's or any of his or her Eligible Dependent's coverage was under a COBRA continuation provision and the coverage under such provision was exhausted; or the coverage was not under a COBRA continuation provision and either the coverage was terminated as a result of loss of eligibility as a result of legal separation, divorce, death, Employee's termination of employment, or Employee's reduction in the number of hours of employment, (but excluding, for example, loss due to failure to timely pay premiums or due to termination for gross misconduct), employer contributions toward such coverage were terminated, or a benefit option under such coverage was terminated;

(iii) The Eligible Employee requests Special Enrollment for himself and/or for his Dependent(s) within 30 days after such COBRA continuation coverage is exhausted; within 30 days after coverage under the other insurance or coverage is terminated, if the termination is due to loss of eligibility; or within 30 days after Employer contributions to the other insurance ceased.

Coverage will be effective on the first day of the month following the date the enrollment form is received by the Plan Administrator.

In addition, except as otherwise limited by the applicable ASC, an Eligible Employee who is enrolled for a Benefit under the Plan or an un-enrolled Eligible Employee who is eligible to enroll for a Benefit under the Plan but who has not so enrolled, is entitled to a Special Enrollment Period if a person becomes an Eligible Dependent of the Eligible Employee through marriage, birth, adoption or placement for adoption. An Eligible Employee who is not enrolled for a Benefit under the Plan at the time a person becomes his Eligible Dependent may enroll himself alone, or himself and his Dependent(s) during this Special Enrollment Period. An Eligible Employee who requests a Special Enrollment for an Eligible Dependent due to birth, adoption of a child, or placement for adoption, may enroll a spouse and/or other dependents during this Special Enrollment Period, if otherwise eligible.

An eligible Employee must request Special Enrollment for himself, and/or for his or her Eligible Dependent(s), as applicable, for a Benefit under the Plan, under this Section, within 30 days of the date of the marriage, or within 30 days of the date of birth, adoption or placement for adoption. Notwithstanding anything to the contrary herein, if an Eligible Employee timely requests Special Enrollment for himself or for an Eligible Dependent(s) during the first 30 days, the enrollment date will become effective as of the date of birth, adoption or placement for adoption, or, in the event of marriage, on the first day of the month following the date in which the enrollment form is received by the Plan Administrator.

(c) Benefits Election Procedure. The Plan Administrator will provide one or more election forms to each Participant who is eligible to participate in the Plan. If a Participant timely elects coverage, the Participant's annual compensation will be reduced by the cost to the Participant of coverage elected the cost of which shall be determined by the Plan Administrator.

3.3 REDUCTION OF CERTAIN ELECTIONS TO PREVENT DISCRIMINATION. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any non-discrimination requirement imposed by the Code or any limitations on benefits provided to "key employees" (as defined in Code Section 416(i)(1)), the Plan Administrator will take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by highly compensated Employees and/or "key employees" with or without consent of such Employees.

3.4 TERMINATION OF PARTICIPATION. Except as otherwise provided in the ASC, and subject to any rights under COBRA or pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"), coverage under this Plan with respect to a Participant and his or her covered Dependent(s) will automatically terminate as of the dates described below.

(a) Coverage under the Plan with respect to a Participant will automatically terminate as of:

(i) The date the Plan is discontinued;

(ii) The date the Participant voluntarily stops his or her coverage under the Plan;

(iii) The date the Participant is no longer eligible for coverage under the Plan;

(iv) The date the Participant fails to make any required contributions;

(v) The date the Participant becomes covered under another group health plan sponsored by the Employer;

(vi) The date the Participant dies; or

(vii) The date the Participant's employment ends for any reason, including job elimination.

(b) Coverage under the Plan with respect to a covered Dependent will automatically terminate as of:

(i) The date the Participant is no longer eligible for Dependent coverage under the Plan;

(ii) The date the Participant does not make the required contribution towards the cost of Dependent coverage;

(iii) The date the Participant's coverage under the Plan ends due to any of the reasons listed is subsection (a), above;

(iv) The date the covered Dependent is no longer eligible for coverage (in this case, coverage ends on the day the covered Dependent no longer meets the Plan's definition of "Eligible Dependent");

(v) The date the covered Dependent becomes eligible for comparable benefits under any other group health plan sponsored by the Employer.

3.5 ABSENCE DUE TO FMLA. To the extent the Employer is subject to the Family and Medical Leave Act of 1993 ("FMLA"), if an Eligible Employee Participant is absent from work due to an approved medical or family leave of absence which is covered under the FMLA, and such Participant elects to continue coverage, the Participant's share of the cost of continued coverage under the Plan will be paid as follows:

(a) If the FMLA leave is a paid leave, the Participant's cost of coverage will be paid by payroll deduction unless he has a change in family status and elects to change his or her coverage.

(b) If the FMLA leave is unpaid, payment will be made by such Participant to the Employer, as elected by the Participant:

(i) On an after-tax basis at the same time as it would be made if by payroll deduction;

(ii) On a pre-payment basis from any taxable compensation payable to the Participant; provided, however, that no pre-payment may be made in a manner that will permit a pre-tax payment to be made in one taxable year of the Participant that will be applied to a subsequent taxable year of the Participant; or

(iii) In accordance with an alternate payment arrangement entered into between the Participant and the Employer.

(c) If such a Participant's required payment is more than 30 days late, coverage under the Plan during an FMLA leave will cease retroactively to the date the required payment was due, provided the Employer has given the Participant at least 15 days advance written notice that if payment is not received

by the 30th day, coverage will be dropped on that date retroactive to the date the required payment is due. If the notice is not timely sent, coverage will cease 15 days after the required notice is given or the date specified in the notice, if later, unless the payment has been received by that date.

(d) A Participant who returns from an FMLA leave within the same Plan Year the leave commenced will continue in the Plan with no change in elections, unless he or she has a change in election event as described in Section 3 and is entitled to make a new election. If there is no change in election, the applicable compensation reduction agreement will continue at the rate in effect on the day before the leave of absence commenced. A Participant whose FMLA spans two (2) Plan Years will be afforded the same opportunity as active employees to make changes during the applicable Open Enrollment Period and any change in elections will take effect at the start of the Plan Year commencing during the FMLA and will remain in effect for the duration of the Plan Year in accordance with Plan terms.

3.6 CONTINUATION OF HEALTH COVERAGE UNDER "COBRA". The Plan will provide Participants and Covered dependents with continuation coverage for health coverage on a self-pay basis, to the extent required by the COBRA.

3.7 USERRA. Notwithstanding anything to the contrary herein, any person absent from employment by reason of service in the uniformed services will be provided Benefits under the Plan in compliance with Uniformed Service Employment and Reemployment Rights Act of 1994, as amended ("USERRA").

3.8 ABSENCE DUE TO NON-FMLA LEAVE OF ABSENCE. If a Participant is absent from work on an unpaid non-FMLA leave of absence, coverage under the Plan will continue during any short-term disability period in the sole discretion of the Employer. The Participant will be responsible for any required employee contributions during the non-statutory leave of absence the same as required during actual employment unless the Participant has entered into an alternate payment agreement with the Employer prior to the start of such non-statutory leave of absence. At the expiration of the short-term disability period, the Participant will be offered COBRA is otherwise eligible.

ARTICLE IV – BENEFITS

4.1 SELF-FUNDED BENEFITS. The Employer self-funds the Benefits under the Plan and has contracted with the Third-Party Administrator to administer the Benefits. Except to the extent specifically provided in the Plan to the contrary, the terms and provisions of the ASC and Benefits Booklet, including eligibility provisions, Benefits provisions, and claims provisions will determine the Benefits to which Participants will be entitled under the Plan if coverage has been properly elected. A Participant will make application and submit such evidence of eligibility or coverage as may be required by the Employer or Third-Party Administrator. Each ASC and Benefits Booklet is incorporated by reference as a part of the Plan, and coverage will be provided thereunder if properly elected.

4.2 PRE-TAX PREMIUM PAYMENTS. If the Employer sponsors a corresponding Code Section 125 cafeteria plan, an Eligible Employee may elect to pay Benefits on a pre-tax basis pursuant to such plan. If applicable, the Employer shall notify Eligible Employees of ability to pay for Benefits on a pre-tax basis prior to or in conjunction with each annual Open Enrollment Periods.

ARTICLE V – FUNDING AND CONTRIBUTIONS

5.1 FUNDING. The Plan is funded by contributions made by the Employer and employees, where applicable, in such amount to be determined by the Employer. Benefits are funded from the general assets of the Employer. There is no trust or other separately maintained fund for accumulation of Plan assets or from which benefits are paid.

5.2 PARTICIPANT CONTRIBUTIONS. The Employer will establish the cost required of each Participant for each of the Benefits offered under the Plan which may take into account the number of dependents to be covered. The cost will be determined by the Employer from time to time and communicated to Participants in enrollment materials or through any other means reasonably expected to convey the Participant contribution information to the Plan Participant. The Employer may change the contributions required of Participants at any time by notifying the Participants of the change.

5.3 EMPLOYER CONTRIBUTIONS. The Employer will make the benefit payments and pay the administrative expenses of the Plan to the extent these payments and expenses exceed Participant contributions.

ARTICLE VI – ADMINISTRATION

6.1 PLAN SPONSOR AND PLAN ADMINISTRATOR. The Company is the Plan Sponsor and Plan Administrator.

6.2 PLAN ADMINISTRATION. The Plan Administrator has the sole and discretionary authority and responsibility to determine the status and rights of Participants, to construe and interpret Plan terms, and to make final and binding determinations as to eligibility and benefits. The Plan Administrator may allocate and delegate any of these administrative duties among one or more persons or entities, provided that such allocation or delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibilities.

The Plan Administrator (or such person or entity as it may designate) will have such powers and duties as may be necessary to discharge its functions under the Plan, including, but not limited to the following:

(a) Rules: to promulgate uniform rules and regulations whenever in the opinion of the Plan Administrator such rules and regulations are required by the terms of the Plan or would facilitate the effective operation of the Plan;

(b) Annual Reports: to prepare, furnish, and file such annual reports with respect to the administration of the Plan as are required by law or as are reasonable and appropriate;

(c) Appointments: to appoint any fiduciaries, and to fix their compensation, if any, and exercise general supervisory authority over them.

(d) Plan Benefits: to establish eligibility requirements for employees and dependents, to determine Employer and Participant contributions to the Plan, to establish benefits which will be payable to any Participant or other person in accordance with the terms of the Plan and the person to whom such

benefits will be paid, and any charges, deductibles, maximum benefits, and all other amounts payable under the Plan;

(e) Construction: to interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan, and to decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(f) Forms: to require Participants (i) to complete and file with it such forms as the Employer finds necessary or desirable for the administration of the Plan, and (ii) to furnish all pertinent information requested by the Employer;

(g) Procedures: to prescribe procedures to be followed by Participants in electing benefits and filing claims for benefits;

(h) Information: to prepare and distribute, in such manner as the Employer determines to be appropriate, information explaining the Plan, and to receive from Participants such information as will be necessary for the proper administration of the Plan;

(i) Third Party Administrators: to appoint and remove the Third Party Administrator to perform certain responsibilities of the Employer and to enter into or change any ASC or any related agreements with the Third Party Administrator; and

(j) Records: to prepare, receive, review, and keep on file (as it deems convenient and proper) records of benefit payments and disbursements for expenses.

Notwithstanding the foregoing, to the extent delegated pursuant to the ASC or any related agreement with the Third Party Administrator, the Third Party Administrator will be the administrator of the Benefits provided under the ASC.

6.3 FIDUCIARIES. The Plan Administrator will be a "named fiduciary" of this Plan. The Plan Administrator has only those duties, responsibilities, and obligations (referred to collectively as "fiduciary duties") as specifically are given it under the Plan, or as otherwise are imposed by applicable law. The Plan Administrator will be deemed to have properly exercised such fiduciary authority unless it has abused its authority by acting arbitrarily and capriciously. In the exercise of discretionary authority and discretionary responsibility in the administration of the Plan, the Plan Administrator will have the broadest possible discretion in the interpretation of the Plan, which interpretation will be binding on all persons. The Plan Administrator may delegate its fiduciary duties under the Plan to other Plan fiduciaries.

Certain benefits are provided under ASC between the Company and the Third Party Administrator. The Third Party Administrator is the Claims Administrator and is the named fiduciary with respect to the claims administration of Benefits under the Plan in accordance with the ASC. The Plan Administrator has delegated to the Third Party Administrator discretionary authority to determine eligibility for benefits and the amount of benefits due, to construe the terms of the ASC and Benefits Booklet and generally to do all other things needed to administer the ASC and Benefits Booklet.

6.4 DELEGATION TO OFFICERS OR EMPLOYEES. The Plan Administrator will have the power to delegate its fiduciary duties under the Plan or under any benefit available under the Plan to officers and/or employees of the Employer and to other persons, all of whom, if employees of the Employer, will serve without compensation other than their regular remuneration from the Employer.

6.5 INDEMNIFICATION. The Employer will indemnify any employees of the Employer who are deemed fiduciaries under ERISA and hold them harmless, against any and all liabilities, including legal fees and expenses, arising out of any act or omission made or suffered in good faith pursuant to the provisions of the Plan, or arising out of any failure to discharge a fiduciary duty imposed by ERISA other than a willful failure to discharge an obligation of which the person was aware.

6.6 EMPLOYMENT OF ADVISERS. The Plan Administrator will have the authority to employ such legal, accounting, and financial counsel and advisers as it will deem necessary in connection with the performance of its duties under the Plan, and to act in accordance with the advice of such counsel and advisers.

6.7 FEES AND EXPENSES. All expenses incurred in the operation and administration of the Plan, including the fees and expenses of counsel and other advisors and the compensation, if any, of the fiduciaries, agents, and administrators will be paid or reimbursed by the Employer unless the Plan Administrator determines that such fees and expenses will be paid in whole or in part by the Plan or by Participants.

6.8 STOP LOSS INSURANCE. The Plan Sponsor may enter into an excess or stop loss insurance contract to protect the general assets of the Employer from claims payments under this Plan at a level to be determined by the Plan Sponsor. The proceeds of any such Policy will be payable to the Plan Sponsor, not to the Plan, will not be security for payment of benefits under the Plan and will not be assets of the Plan.

6.9 RESPONSIBILITY FOR HEALTH CARE SERVICES AND DECISIONS. The Plan Administrator and the Employer disclaim any right or responsibility to make health care treatment decisions. These decisions may only be made by health care providers in consultation with the Participant. Health care providers and the Participant may elect to continue treatments despite the Plan Administrator's, Employer's or Third Party Administrator's denial of coverage for such treatments and the Participant will be responsible for the cost of such treatments. Participants may appeal any of the decisions of the Plan Administrator or Third Party Administrator's in accordance with the claim and appeal procedure.

6.10 RULES AND DECISIONS. The Plan Administrator may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Plan Administrator will be uniformly applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator will be entitled to rely upon its interpretation of the terms of the Plan and information furnished by a Participant or beneficiary and the legal counsel of the Plan Administrator.

6.11 EXAMINATION OF RECORDS. The Plan Administrator will make available to each Participant such of its records under the Plan as pertain to him or her, for examination at reasonable times during normal business hours.

6.12 FACILITY OF PAYMENT. Payment of Plan benefits may be made on behalf of any person, including payment to an organization that has made payment to the person, when deemed expedient by the plan administrator to satisfy the intent of the Plan, and payment so made will discharge the liability of the Plan.

ARTICLE VII – CLAIM AND APPEAL PROCEDURES

7.1 SELF-FUNDED BENEFITS. The procedures for submission of a claim with respect to a given self-funded benefit, including a rescission, and obtaining review of a denied claim under will be governed by the applicable ASC or Benefits Booklet issued by the Third Party Administrator and any other procedures implemented from time to time by the Third Party Administrator, as applicable. Notwithstanding anything to the contrary herein, all such procedures will be in accordance with all applicable laws, including the Patient Protection and Affordable Care Act

7.2 NON-BENEFIT CLAIMS.

(a) Non-Benefit Claims. The Plan Administrator will determine all non-benefit claims (i.e., eligibility, QMCSOs, etc.). An individual may submit a written non-benefit claim to the Plan Administrator, stating the individual's name, the specific basis for their non-benefit claim, and any other additional information they wish to submit.

The Plan Administrator, upon receipt of a non-benefit claim, will make a determination and will provide written notification of its determination to the individual within 30 days after receipt of the individual's 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 the claimant, 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 a failure of the claimant to submit the information necessary to decide the non-benefit claim, the notice of extension will specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide such information.

(b) Manner and Content of Notification of Non-Benefit Claim Determination. The Plan Administrator will provide a claimant with written notification of an adverse determination. The notification will set forth the (i) 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 the claimant to perfect his or her claim, if any, and an explanation of 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 the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review; and (v) any internal rules, guidelines, protocols or other similar criterion on which the Plan Administrator relied in making its determination.

(c) Appeal of Adverse Non-Benefit Claim Determination. A claimant may appeal an adverse determination. To do so, such claimant must submit, within 180 days following receipt of the Plan Administrator's adverse determination, a written request for review to the Plan Administrator stating the specific basis of such request, and any additional materials the claimant wishes to submit. In connection with the claimant's request for review, the claimant 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 will provide all such documents to the claimant free of charge.

The Plan Administrator will take into account all documents, records and other information submitted by the claimant, without regard to whether such information was submitted or considered in the initial determination.

(d) Timing and Notification of Non-Benefit Claim on Review. The Plan Administrator will notify a claimant of the Plan's non-benefit claim determination on review within 30 days after receipt by the Plan of the claimant's request for review.

(e) Manner and Content of Notification of Non-Benefit Claim Determination on Review. The Plan Administrator will provide a claimant with written notification of the Plan's determination on review. In the case of an adverse determination, such notification will 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 the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, documents and records and other information relevant to the claim; (iv) a statement that the claimant has a right to bring an action Section 502(a) of ERISA; and (v) a description of any internal rule, guideline, protocol, or other similar criterion, upon which the Plan Administrator relied in making its determination.

(f) The decision of the Plan Administrator will be final and binding.

7.3 CLAIMS FOR BENEFITS. All claims for Benefits under the Plan must be filed within the timeline specified in the applicable ASC or Benefits Booklet; if no such timeline is specified, within two years after the claim was incurred.

7.4 RESCISSION OF PLAN COVERAGE.

(a) Definition. A "rescission" is a cancellation or discontinuance of coverage that has retroactive effect; provided, however, a cancellation or discontinuation of coverage that (1) has only a prospective effect, or (2) is effective retroactively due to the failure to timely pay required premiums or contributions towards the cost of Benefit coverage under the Plan is not a rescission.

(b) Internal Review. An individual's claim with regard to a rescission of coverage under the Plan will be subject to the same provisions as set forth in the Non-Benefit Claims provisions above. In addition, for purposes of rescission claims, an adverse determination notice issued during the internal review process will include an explanation of the claimant's right to external appeal as described in Section 7.

(c) External Review. If an individual's rescission claim is denied at the internal review level described in Section 7, the individual may file for external review by having the claim denial reviewed by an independent review organization who has no association with the Plan. Such external review will be governed by the applicable federal external appeals process, as then in effect.

7.5 FINALITY OF DECISION. All determinations of the Plan Administrator and the Third Party Administrator to the extent authority has been delegated to it, will be final and binding.

ARTICLE VIII – AMENDMENT AND TERMINATION

8.1 AMENDMENT. The Plan Sponsor may at any time amend any or all of the provisions of the Plan in a written document that expressly provides that it is an amendment to the Plan. The amendment must be approved by the Plan Sponsor's Board of Directors, any committee or individual authorized by the Board of Directors to approve such amendments, or the Treasurer of the Plan Sponsor. The amendment may apply prospectively or retroactively as permitted by law and the effective date of the amendment will be stated in the document.

8.2 TERMINATION. The Plan Sponsor may terminate the Plan at any time. Benefits incurred prior to the date of termination will be paid as soon as administratively possible after the termination date.

8.3 ADOPTING EMPLOYER'S TERMINATION OF PARTICIPATION. An Adopting Employer may terminate its participation in the Plan at any time by thirty (30) days advance written notice to the Plan Sponsor. The Plan Sponsor may, in its absolute discretion, terminate any Employer's participation at any time.

ARTICLE IX – NONALIENATION OF BENEFITS AND MEDICAL CHILD SUPPORT ORDERS

9.1 NONALIENATION OF BENEFITS. No interest, right, or claim in or to any part of or all of any benefit payable from the Plan will be assignable, transferable, or subject to sale, assignment, hypothecation, anticipation, garnishment, attachment, execution, or levy of any kind and the Plan Administrator will not recognize any attempt to so transfer, assign, sell, hypothecate, or anticipate the same except to the extent required by law, and any attempt to do so in violation of this provision will be void. This provision will not apply to any "qualified medical child support order" or "national medical support notice" as defined in Section 9.2, below, and will not apply to a Medicaid assignment.

9.2 CONTENTS OF A QUALIFIED MEDICAL CHILD SUPPORT ORDER.

(a) A "medical child support order" is any judgment, decree, or order, including approval of a settlement agreement, issued by a court of competent jurisdiction or an administrative agency authorized to issue child support orders under State law that:

(i) Provides for child support or for health benefit coverage to a child of an employee, is made pursuant to state domestic relations law, including a community property law, and relates to benefits under this Plan; or

(ii) Enforces a Medicaid provision relating to medical child support with respect to this Plan.

(b) A medical child support order is "qualified" if:

(i) It satisfies all of the following:

(A) It creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which an employee or beneficiary is eligible under the Plan. An "alternate recipient" is any child of an employee who is recognized under a medical child support order as having a right to enrollment under the Plan with respect to the employee;

(B) It clearly specifies the name and last known mailing address (if any) of the employee and the name and mailing address of each alternate recipient covered by the order. The order may substitute the name and mailing address of a state or local official for the mailing address of an alternate recipient;

(C) It provides a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined;

(D) It specifies the period to which the order applies;

(E) It does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the Medicaid provisions relating to medical child support; or

(ii) It is a "National Medical Support Notice" as described in Section 609(a)(5)(C) of ERISA with respect to the employee and an alternate recipient (a "Notice").

9.3 PROCEDURE FOR MEDICAL CHILD SUPPORT ORDERS. Whenever the Plan Administrator is served with a child support order from a court of competent jurisdiction, the Plan Administrator will follow the procedures adopted by the Plan Administrator.

9.4 EFFECT OF ELIGIBILITY FOR MEDICAID BENEFITS. If any employee or dependent is also covered under Medicaid:

(a) Payment for benefits for the Participant or dependent will be made in accordance with an assignment of rights made by or on behalf of the Participant or dependent as required by Medicaid;

(b) The eligibility for benefits under Medicaid will not be taken into account in enrolling the individual as a Participant or beneficiary or in determining or making any payments of benefits for such Participant or beneficiary; and

(c) If Medicaid has paid for medical services for which the Plan would have otherwise been liable, the Plan will make payment in accordance with any state law that provides that the state has acquired the Participant's rights with respect to the payment for those medical services.

ARTICLE X – HIPAA PRIVACY AND SECURITY COMPLIANCE

10.1 OVERVIEW. The Plan shall comply with applicable provisions of HIPAA and the Standards for Privacy and Individual Identifiable Information (the "Privacy Rule") as well as the Standards of Electronic Protected Health Information (the "Security Rules") to the extent required by law.

10.2 DEFINITIONS.

(a) "Electronic protected health information" means protected health information that is transmitted or maintained in electronic media.

(b) "Individually identifiable health information" is information that is a subset of health information, including demographic information collected from an individual, and

(i) Is created or received by this Plan; and

(ii) Relates to the past, present, or future physical or mental health or conditions of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and

(A) That identifies the individual; or

(B) With respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

(c) "Protected health information" means individually identifiable health information that is transmitted or maintained in any form or medium but excluding individually identifiable health information in:

(i) Education records covered by the Family Educational Rights and Privacy Act as amended, 20 United States Code ("USC") Section 1232g;

(ii) Student records described at 20 USC Section 1232g (a)(4)(B)(iv); or

(iii) Employment records held by the Employer in its role as an employer.

(d) "Summary health information" means information that summarizes claims history, expenses, or types of claims by individuals for whom the Employer provides benefits under the Plan, and from which individual identifying information has been removed in the manner described in 45 CFR 164.514.

10.3 PRIVACY OFFICER. The Plan has appointed Mr. Timothy Sircy as the Privacy Officer for purposes of HIPAA compliance.

10.4 DISCLOSURE OF SUMMARY HEALTH INFORMATION. The Plan may disclose summary health information to the Employer if the Employer requests such information for the purpose of obtaining premium bids for obtaining health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

10.5 DISCLOSURE OF ENROLLMENT/DISENROLLMENT INFORMATION. The Plan may disclose to the Employer information on whether an individual is participating in the Plan or is enrolled in

or has disenrolled from a health program offered under the Plan. Enrollment and disenrollment functions performed by the Employer are performed on behalf of Plan Participants and beneficiaries and are not Plan administrative functions. Enrollment and disenrollment information held by the Employer is held in its capacity as an employer and is not protected health information.

10.6 ELECTRONIC PROTECTED HEALTH INFORMATION. The Employer further agrees that if it creates, receives, maintains or transmits any electronic protected health information (other than enrollment, disenrollment and summary health information, which are not subject to these restrictions) on behalf of the Plan, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information, and it will ensure that any agents (including subcontractors) to whom it provides such electronic protected health information agree to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Plan any security incident of which it becomes aware.

10.7 DISCLOSURES TO THE COMPANY FOR PLAN ADMINISTRATION PURPOSES. The Plan will disclose protected health information to the Employer only in accordance with 45 CFR Section 164.500 et. seq. and the provisions of this Article. Unless otherwise permitted by law, the Plan may disclose protected health information to the Employer for Plan administration purposes. Plan administration purposes include but are not limited to the following:

(a) Claims processing;

(b) Quality assurance;

(c) Auditing;

(d) Eligibility and coverage determinations;

(e) Coordination of benefits adjudication and subrogation of health claims;

(f) Obtaining payment under contracts for re-insurance;

(g) Management of payment and health care operations; and

(h) Assessment of plan payment and health care operations and evaluation of proposed changes to payment and health care operations.

10.8 CONDITIONS OF DISCLOSURE FOR PLAN ADMINISTRATION PURPOSES. Other than enrollment/disenrollment information, summary health information and information disclosed pursuant to a signed authorization, the Employer will:

(a) Not use or further disclose the protected health information other than as permitted or required by the Plan documents, or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(e) Make available protected health information in accordance with 45 CFR 164.524, detailing a Participant's right of access to protected health information; make available protected health information for amendment and incorporate any amendments to protected health information in accordance with 45 CFR 164.526, detailing Participant's rights to amend their protected health information; and make available the information required to provide an accounting of disclosures in accordance with 45 CFR 164.528;

(f) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with this 45 CFR Part 164;

(g) If feasible, return or destroy all protected health information received from the Plan that the Employer continues to maintain in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or disclosure is not feasible, the Employer will limit future use and disclosures for those purposes that make the return or destruction of the information infeasible;

(h) Ensure that adequate separation between the Plan and the Employer is maintained as follows:

(i) The Employer will limit disclosure of and access to protected health information to the individuals or classes of employees identified in the HIPAA Privacy Policies and Procedures adopted by the Employer and any other employee who needs access to protected health information in order to perform Plan administrative functions.

(ii) The Employer will restrict the access to and use by the persons described above, to the plan administration functions that the Employer performs for the Plan.

(iii) The Employer will ensure that the provisions of this subsection (h) are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic protected health information.

(iv) The Employer will provide an effective mechanism for resolving any issues of noncompliance with the provisions of this Article by persons described above.

(v) The Employer will review and where appropriate, discipline, all instances of alleged violation of the rules of this Article in accordance with the Employer's employee discipline and separation of employment policies.

10.9 CERTIFICATION. The Plan will disclose protected health information to the Employer only upon receipt of a certification by the Employer that the Plan documents have been amended to incorporate the requirements described in Section 10.8.

10.10 ORGANIZED HEALTH CARE ARRANGEMENT. A health insurance issuer or health maintenance organization providing benefits to Participants in the Plan may disclose protected health information to the Employer and the Plan as permitted in this Article if a Notice of Privacy Practices is maintained and provided as required by 45 CFR 164.520.

10.11 GENETIC INFORMATION. The Plan will not use or disclose protected health information that is genetic information, as defined in 45 CFR §160.103, for determining eligibility (including enrollment and continued eligibility), the computation of premium or contribution amounts, the application of any pre-existing condition exclusion or other activities related to the creation, renewal or replacement of a contract of health insurance or health benefits.

ARTICLE XI – SUBROGATION AND COORDINATION OF BENEFITS

11.1 COORDINATION OF BENEFITS. Benefits and the coordination of benefit rules with regard to such Benefits under this Plan and other plans, including coordination of benefits relating to motor vehicle insurance and Medicare, will be governed in accordance with the terms of the applicable ASC and Benefits Booklet.

11.2 OVERPAYMENT. In accordance with the terms of the applicable ASC and Benefits Booklet, an overpayment occurs if: (i) the Plan pays an amount not payable under the Plan; (ii) the Plan pays an expense more than once; or (iii) an expense or benefit is paid by both the Plan and a third party. An expense or benefit is considered paid if it is paid to the Participant or another party on the Participant's behalf. If an overpayment is made by the Plan, the Plan has the right to recover the overpayment from the Participant or the third party, if applicable. If the Plan is not recovered from the Participant or the third party, if applicable, the Plan will deduct the amount of overpayment from further Benefits with respect to the Participant or the Participants Eligible Dependents, or from the Participant's wages, if applicable. The Plan's right to recover an overpayment does not affect any other right of recovery the Plan may have with respect to such overpayment.

11.3 SUBROGATION/RIGHT OF RECOVERY. Except as otherwise set forth in the applicable ASC and/or Benefits Books, the Plan has the right of subrogation/right of recovery as follows:

(a) Definitions. As used throughout this provision, the following terms have the following definitions:

(i) "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term Responsible Party includes the liability insurer of such party or any Insurance Coverage.

(ii) "Insurance Coverage" refers to any coverage providing health expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile Insurance Coverage, or any first party Insurance Coverage.

(iii) "Covered Person" includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the eligible family member of any plan member or person entitled to receive any benefits from the Plan.

(b) Subrogation. Immediately upon paying or providing any benefit under the Plan, the Plan will be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness or condition to the full extent of benefits provided or to be provided by the Plan.

(c) Reimbursement. In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, from such payment, up to and including the full amount the Covered Person receives from any Responsible Party.

(d) Constructive Trust. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he/she receives any payment from any Responsible Party as a result of an injury, illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

(e) Lien Rights. Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition for which Responsible Party is liable. The lien will be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any Insurance Coverage, related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

(f) First-Priority Claim. By accepting Benefits (whether the payment of such Benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that the Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person's damages. The Plan will be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

To the extent not delegated to the Third-Party Administrator, the Plan Administrator reserves the right to negotiate a return of less than the full amount on a participant by participant basis based on the facts and circumstances.

(g) Applicability to All Settlements and Judgments. The terms of this entire subrogation and right of recovery provision will apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the

settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

(h) Cooperation. The Covered Person will fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the Covered Person. The Covered Person and his/her agents will provide all information requested by the Plan, the Third Party Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights, or failure to reimburse the Plan from any settlement or recovery obtained by the Covered Person, may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person will do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice. The Plan's ability to enforce the terms of the plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The Covered Person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify any Responsible Party. The Plan reserves the right to notify Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

(i) Interpretation. In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Third Party Administrator for the Plan will have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

(j) Jurisdiction. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

(k) Worker's Compensation. If benefits are paid under the Plan and the Third Party Administrator determines the Participant received Worker's Compensation benefits for the same incident, the Third Party Administrator has the right to recover as described under this Section 11.3. The Third Party Administrator, on behalf of the Plan, will exercise its right to recover against the Participant. The rights under this Section 11.3 will apply even though:

(i) The Worker's Compensation benefits are in dispute or are made by means of settlement or compromise;

(ii) No final determination is made that bodily injury or illness was sustained in the course of or resulted from your employment;

(iii) The amount of Worker's Compensation due to medical or health care is not agreed upon or defined by you or the Worker's Compensation carrier; or

(iv) The medical or health care benefits are specifically excluded from the Worker's Compensation settlement or compromise.

ARTICLE XII – MISCELLANEOUS

12.1 EXCLUSIVE BENEFIT. The assets of the Plan, if any, will not be diverted to or used by the Employer for purposes other than the exclusive benefit of Participants and beneficiaries, except to pay the administrative expenses of the Plan.

12.2 STATUS OF PARTICIPANTS. No Participant will have any right or claim to any benefits under the Plan except in accordance with the provisions of the Plan. The adoption of the Plan will not be construed as creating any contract of employment between the Employer and any Participant or to otherwise confer upon any Participant or other person any legal right to continuation of employment, or as limiting or qualifying the right of the Employer to discharge any Participant without regard to any effect the discharge might have upon the Participant's rights under the Plan. Except for the right to receive a benefit for claims incurred under the terms of the Plan, no Participant will have any right, title or interest to any benefits or to any of the assets of the Employer because of the Plan.

12.3 NO ENLARGEMENT OF BENEFITS. This plan document describes the benefit programs provided to Employees of the Employer. These benefit programs are described in detail in booklets prepared by Third Party Administrators administering claims for benefits and booklets. This plan document will not enlarge or modify any benefits described in these booklets. In the event there is a conflict between the terms of the applicable ASC and Benefits Booklet and the Plan, the terms of the applicable ASC and Benefits Booklet will govern.

12.4 NO INTEREST IN EMPLOYER AFFAIRS. Nothing contained in this Plan will be construed as giving any Participant, employee, or beneficiary an equity or other interest in the assets, business, or affairs of the Employer or the right to examine any of the books and records of the Employer. The rights of Participants are limited to the right to receive payment of benefits when due.

12.5 GOVERNING LAW. This Plan will be interpreted and enforced in accordance with ERISA, the Code, or other applicable federal law, and the laws of the State of Michigan to the extent that state law may be applicable.

It is intended that this Plan meet all applicable requirements of the Code and ERISA and of all regulations issued thereunder. This Plan will 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 and/or ERISA, the provisions of the Code and ERISA will be deemed controlling, and any conflicting part, clause or provision of this Plan will be deemed superseded to the extent of the conflict.

12.6 TAX EFFECTS. Neither the Plan nor the Employer makes any representations or warranties regarding Federal, State, local or other tax treatment of benefits provided pursuant to the Plan and a Participant will have no rights against the Employer or the Plan if any tax consequences contemplated by any Participant are not achieved.

12.7 SEVERABILITY OF PROVISIONS. If any provision of the Plan is declared void and unenforceable, the other provisions may be severed and will not be affected thereby, and to the extent that the Plan will ever be in conflict with, or silent with respect to, the requirements of any other law or regulation, the provisions of the law or regulation will govern. In the administration of the Plan, the Plan Administrator may avail itself of any permissive provisions of any applicable law or regulation that are not contrary to the provisions of this Plan.

12.8 CONSTRUCTION AND INTERPRETATION. The Plan will be interpreted to maintain the tax qualification and tax benefits for the Employer and Plan Participants and to be consistent with the express purpose and intention of the Plan.

12.9 ENTIRE AGREEMENT. The Plan document and the incorporated documents constitute the entire agreement constituting this Plan.

IN WITNESS WHEREOF, the Company has caused this Plan to be executed this 19th day of June, 2019.

Usui International Corporation

By: T. Suu

Its: Treasurer

APPENDIX A

ADOPTING EMPLOYERS

None