WALL STREET HOLDING GROUP, INC.

HEALTH AND WELFARE PLAN

Originally Effective **April 1, 2013**
Amended and Restated as of **April 1, 2021**

Wall Street Holding Group, Inc.
1940 West Corporate Way
Anaheim, CA 92801

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SECTION 1 – ESTABLISHMENT AND PURPOSE

1.1 Establishment and Purpose

Wall Street Holding Group, Inc. ("WSHG") has established the Wall Street Holding Group, Inc. Health and Welfare Plan (the "Plan") for the purpose of providing health and welfare benefits to its eligible employees and their eligible dependents and to the eligible employees and eligible dependents of its "Affiliated Organizations." This Plan is established in conformance with and is to be construed as an employer provided welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"), with the documentation requirements of the Health Insurance Portability and Accountability Act of 1996 and its regulations ("HIPAA") for purposes of the health plan components contained herein, and with the requirements imposed on health plans under the Patient Protection and Affordable Care Act ("ACA") and all other applicable law.

1.2 Original Effective Date

This Plan originally took effect on April 1, 2013.

1.3 Amendment and Restatement

This Restatement reflects all changes made to the Plan, including all changes required to achieve compliance with applicable federal regulations as of April 1, 2021.

1.4 Plan Year

The Plan Year of the Plan is April 1 through March 31 of the following calendar year.

1.5 The Plan

Certain details regarding the terms and conditions of the Plan are contained in the insurance policies purchased by WSHG on behalf of its employees and the self-insured plan documents that describe the benefit programs ("Component Plans") of the Plan. Each Component Plan's benefit booklets and certificates, plan documents, and other governing documents, including any exhibits, supplements, addendums, or amendments thereto (collectively the "Benefit Documents"), when taken with this Plan document constitute the entire Plan, which is intended to conform to the written plan requirements under Section 402 of ERISA. The Component Plans are listed in Appendix A.

1.6 Health Insurance Portability and Accountability Act

The Plan will reasonably and appropriately safeguard Protected Health Information ("PHI") created, received, maintained, or transmitted to or by WSHG on behalf of the Plan in accordance with the requirements of HIPAA. The HIPAA provisions described herein apply only to the health plan Component Plans as defined in 45 CFR Section 160.103. They do not apply to non-health component coverage contained in this Plan.

1.7 Affiliated Organizations

For purposes of this Plan, the entities listed in Appendix B are Affiliated Organizations of WSHG that are authorized by WSHG to participate in the Plan and that adopt the Plan with the consent of WSHG for the exclusive benefit of its employees. Such entities may include any member of a controlled group of corporations with WSHG, any entity under common control with WSHG, or any member of an affiliated service group with WSHG, as such terms are defined in Internal Revenue Code ("Code") Section 414.

SECTION 2 – ADMINISTRATION OF THE PLAN

2.1 In General

WSHG has designated itself as the Plan Administrator of the Plan, as the term is used in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). WSHG is a Named Fiduciary, also as such term is used in ERISA. WSHG is the Plan's agent for service of legal process.

WSHG shall have authority and responsibility to control and manage the operation and administration of this Plan. WSHG shall discharge its duties with respect to the Plan (i) solely in the interest of persons eligible to receive benefits under the Plan, (ii) for the exclusive purpose of providing benefits to persons eligible to receive benefits under the Plan and of defraying reasonable expenses of administering the Plan and (iii) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character with like aims.

WSHG, as Plan Administrator, shall retain the authority to delegate to officers and employees of WSHG such responsibilities as are imposed on WSHG by ERISA and by the terms of this instrument, together with the authority to control and manage the operation and administration of the Plan.

2.2 Plan Administrator Powers and Responsibilities

Administration of the Plan. Subject to Section 2.3, the Plan Administrator shall have all powers necessary to administer this Plan, including, in its sole discretion, the power to construe and interpret the Plan documents; to decide all questions relating to an employee's eligibility to participate in the Plan; to determine the amount, manner, and timing of any payment of benefits or change in accordance with the Plan; and to appoint or employ advisors, including legal counsel, to render advice with respect to any of the Plan Administrator's responsibilities under the Plan. Any construction, interpretation, or application of the Plan by the Plan Administrator shall be final, conclusive, and binding. All actions by the Plan Administrator shall be taken pursuant to uniform standards applied to all persons similarly situated.

Records and Reports. The Plan Administrator shall be responsible for maintaining sufficient records to reflect the compensation and benefits of each participant. The Plan Administrator shall be responsible for submitting all required reports and notifications relating to the Plan to participants or their beneficiaries, the Internal Revenue Service, and the Department of Labor.

Rules and Decisions. The Plan Administrator may adopt such rules as it deems necessary, desirable, or appropriate in the administration of the Plan. All rules and decisions of the Plan Administrator shall be applied uniformly and consistently to all employees and participants in similar circumstances. When making a determination or calculation, the Plan Administrator may rely upon all information furnished to the Plan Administrator, including the participant's, former participant's, or beneficiary's current mailing address.

2.3 Appointment of Fiduciaries

All persons or entities who exercise discretionary control or authority over Plan management or assets, and all persons or entities with discretionary authority or responsibility for the administration of the Plan will be considered fiduciaries of the Plan to the extent of such discretionary control or authority.

WSHG hereby appoints each group insurance policy Issuer ("Issuer") and each self-insured plan "Contract Administrator" listed in Appendix A (as amended from time to time) as a fiduciary with such powers as may be necessary to determine the benefits payable under such policy or plan, and to resolve all questions pertaining to the applicability of each policy's or plan's benefit provisions. The decision of a fiduciary on any matter arising under a Component Plan's Benefit Documents, including (but not limited to) questions of Plan construction, interpretation, and administration, and final determinations of eligibility for Plan benefits shall be final, conclusive, and binding on all persons having an interest in or under such Component Plan.

WSHG also hereby intends that each such fiduciary shall be deemed to have complied with the requirements of ERISA Section 503 (claims procedure) in its exercise of its authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

2.4 Refund of Premium

For purposes of fully-insured Component Plans and in accordance with Department of Labor ("DOL") guidance, where any refund of premium (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates) is determined to be Plan assets attributable to participant contributions, such assets will be: 1) distributed to current Plan participants within 90 days of receipt, 2) used to reduce participants' portion of future premiums under the Plan (e.g., premium holiday); or 3) used to enhance future benefits under the Plan; or 4) used to pay Plan administrative expenses. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the costs to the Plan and the competing interest of participants, provided such method is reasonable, fair, and objective.

2.5 Expenses

WSHG shall pay all expenses authorized and incurred by the Plan Administrator in the administration of the Plan, unless by agreement or common practice the Plan Administrator absorbs such expenses.

2.6 Right of Reimbursement from Third Parties

The Plan Administrator may, but is not required to, apply the provisions of this Section 2.6 to the Plan. If a conflict exists with the provisions in the Component Plan's Benefit Documents, the provisions of the Component Plan's Benefit Documents shall control.

The Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that a participant or covered dependent may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount, or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if the participant or covered dependent has not been paid or fully reimbursed for all of their damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring the Plan participant to assert a claim to any of the benefits to which the participant or a covered dependent may be entitled. The Plan will not pay attorneys' fees or costs associated with the claim or lawsuit without express written authorization from WSHG.

If the Plan should become aware that a Plan participant or covered dependent has received a third-party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to the participant and covered dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of the participant or covered dependents.

Participant Duties and Actions. By participating in the Plan, each Plan participant and covered dependent consents and agrees that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, each Plan participant and covered dependent agrees to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once a Plan participant or covered dependent has any reason to believe that the Plan may be entitled to recovery from any third party, the participant must notify the Plan and agree to sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses

arising from circumstances that entitle the Plan participant or covered dependent to any payment, amount or recovery from a third party.

Each Plan participant and covered dependent consents and agrees that they shall not assign their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

2.7 Amendment, Termination, or Merger of Plan

Except as provided in this Section, WSHG (or its duly authorized representative) expressly reserves the unlimited right to amend, terminate, or merge the Plan, in its sole discretion. Any such action shall be adopted by the duly authorized representative of WSHG acting in accordance with its regular duties for WSHG.

WSHG may amend Appendix A to the Plan to accurately reflect the Component Plans offered under the Plan. Any such modification shall not necessitate a formal amendment to this Plan document.

Any amendment, termination or merger of the Plan shall be effective at such date as WSHG shall determine, subject to applicable law. If the Plan is terminated, the rights of the participants and beneficiaries of the Plan are limited to covered charges incurred before the Plan's termination. In connection with the termination, WSHG may establish a deadline by which all claims must be submitted for consideration. Upon termination, any Plan assets, if any, will be used to pay outstanding claims and all expenses of Plan termination. To the extent that any Plan assets remain following such payments, they will be used for the benefit of covered individuals and employees in accordance with ERISA.

SECTION 3 – ELIGIBILITY AND PARTICIPATION

3.1 General Eligibility for Benefits

WSHG shall, to the extent permitted by law and by each Component Plan, determine the terms, conditions, or limitations affecting eligibility for Plan benefits. Each eligible employee of WSHG or an Affiliated Organization will become a participant in the Plan ("Covered Employee") on the first day after he or she satisfies a Component Plan's eligibility and participation requirements, provided that he or she makes a timely coverage election, properly complies with all applicable enrollment procedures, and makes all contributions required under the Plan at the time and in the manner specified by WSHG and the Component Plan.

If elected by the Covered Employee and permitted under each applicable Component Plan, dependent coverage for his or her eligible spouse or domestic partner and/or eligible child(ren) will begin on the date the Covered Employee's coverage begins, provided that the Covered Employee or the dependent makes a timely coverage election and makes all contributions required at the time and in the manner specified by WSHG and the Component Plan.

Refer to Appendix C of the Plan's Summary Plan Description ("SPD") to determine the Plan's eligibility and participation requirements for both employees and their dependents. The specific Benefit Documents for each Component Plan also may contain additional eligibility and participation requirements including the terms under which the Covered Employee and his or her dependents may participate in a Component Plan.

3.2 Enrollment Procedures

WSHG may from time to time prescribe enrollment procedures that are consistent with the terms of the Plan. Such enrollment procedures may require a Covered Employee's authorization of payroll deductions for all applicable contributions required under the Plan with respect to the Covered Employee and any dependents.

3.3 Special Enrollment and Coverage Rights

HIPAA Special Enrollment Rights. The Plan shall comply with all applicable provisions of HIPAA with regard to the extension of Special Enrollment Periods to an employee, spouse or dependent, as described in Code Section 9801(f), as amended.

Eligibility Rules for Variable Hour, Part-Time and Seasonal Employees. Certain employees who are hired into positions that are not initially benefit-eligible may become participants in the Plan by achieving "Full-Time Status" ("ACA-FT") under the ACA's special eligibility rules for variable hour, part-time, and seasonal employees. WSHG shall administer ACA-FT eligibility procedures in a manner that is consistent with the final regulations issued by the Department of Treasury related to the "shared responsibility" provisions of the ACA.

Medical Child Support Orders. In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA section 609(a)(2)(B)), the Plan Administrator shall notify the affected participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA section 609(a)(2)(A)). Within a reasonable period, the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the participant and alternate recipient of such determination. The Plan shall comply with all legal requirements related to any order the Plan Administrator has determined to be a qualified medical child support order.

Continuation Coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985. Notwithstanding anything in the Plan to the contrary, to the extent required by Code Section 4980B and IRS Regulations thereunder ("COBRA"), a qualified beneficiary who would lose coverage under a Component Plan that is considered a health care plan under COBRA upon the occurrence of a qualifying event (as defined in Code Section 4980B(f)(3)) shall be permitted to continue coverage under such Component Plan(s) by electing to make the applicable contributions, on an after-tax basis, in accordance with procedures established by the Plan Administrator that are consistent with

COBRA and any other applicable federal law. WSHG shall provide notice to each Covered Employee and his or her spouse of their rights under COBRA in accordance with applicable law.

For purposes of COBRA coverage, the health benefit options under each Component Plan shall be provided and operated as separate plans governed by separate Benefit Documents.

3.4 Coverage during a Leave of Absence

Subject to the leave policies and procedures adopted by WSHG and to the extent prescribed by law, a Covered Employee may be eligible to continue certain or all Plan benefits for a period of time during an approved leave of absence.

In general, if a Covered Employee goes on an unpaid FMLA, USERRA, or other approved unpaid leave of absence that does not affect eligibility, he or she may, at the Covered Employee's option, continue certain benefits under the Plan for a limited period of time, so long as he or she continues to make any required contribution payments in accordance with WSHG's leave policies and applicable laws.

During a paid leave of absence, a Covered Employee generally will continue coverage under the Plan on the same terms and conditions as required by the Plan Administrator prior to his or her leave of absence so long as the Covered Employee had benefit elections in place prior to the commencement of the leave of absence. The Covered Employee's regular contribution amounts shall continue to be deducted from his or her compensation during such paid leave of absence.

Family and Medical Leave Act ("FMLA")

Notwithstanding any provision to the contrary in this Plan, if a Covered Employee goes on a qualifying unpaid leave under FMLA, WSHG will, to the extent required by FMLA, continue to maintain the Covered Employee's group health plan benefits on the same terms and conditions as if the Covered Employee was still an active employee.

Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")

Notwithstanding any provision herein to the contrary in this Plan, if a Covered Employee goes on a qualifying leave of absence under USERRA, then, to the extent required by USERRA, WSHG will continue his or her Plan coverage on the same terms and conditions as if the Covered Employee was still an active employee.

Applicable State or Municipal Law

WSHG shall permit a participant to continue participation in the Plan as required under any applicable state or municipal law to the extent that such law is not pre-empted by federal law.

College Student Medical Leave ("Michelle's Law")

To the extent any Component Plan is a group health plan that requires certification of student status in order to maintain a dependent child's coverage, the Plan shall comply with Michelle's Law. A dependent child enrolled in an institution of higher education who loses his or her student status due to a medically necessary leave of absence shall be allowed to continue such Component Plan coverage for up to one year as measured from the first day of the leave of absence or from the date coverage would otherwise terminate due to the loss of student status, whichever is earlier.

3.5 Termination of Coverage

The coverage of a Plan participant will terminate in accordance with the terms and conditions set forth in the SPD and Benefit Documents for each applicable Component Plan.

SECTION 4 – BENEFITS

4.1 Benefits

For purposes of this Plan, the benefits included hereunder shall be the benefits provided by the Component Plans listed in Appendix A as amended from time to time. The Benefit Documents for each Component Plan contain a complete description of the benefits available and any limitations or exclusions applicable to those benefits.

4.2 Source of Benefits

Benefits under any Component Plan will be provided and paid solely by the Plan pursuant to the terms of the applicable insurance policy or service agreement or applicable self-insured plan document. WSHG neither guarantees nor has any responsibility for the quality of the health care or services provided or the level of benefits paid under any insurance policy or service agreement.

4.3 Coordination of Benefits

The applicable coordination of benefits provisions for the Component Plans are set forth in the benefits documents, contracts, certificate booklets and evidences of coverage for each such Component Plan.

4.4 Coverage Options

WSHG shall have the right to enter into a contract with one or more Issuers and Contract Administrators for the purposes of providing or administering any benefits under the Plan and shall have the right to amend, terminate or replace any such Component Plans. Deductibles, co-payments, co-insurance, and out-of-pocket limits may vary among the coverage options available under the Component Plans, among the different features of a single coverage option, among groups of Plan participants, or in any other manner determined in the discretion of WSHG. In selecting each coverage option, WSHG may rely on tables, appraisals, valuations, projections, opinions or reports furnished by individuals or service providers employed or engaged by WSHG, and may take into account the projected or anticipated costs and expenses relating to the Plan or Component Plan, including administrative costs. Notwithstanding the foregoing, in no event shall the out-of-pocket limit for non-grandfathered group health plans exceed amounts permissible under Public Health Service Act Section 2707(b), as applicable.

4.5 Change in Coverage

WSHG may from time to time prescribe the terms, conditions, and procedures under which a Plan participant may modify or terminate coverage under the Plan or under one or more Component Plans, in addition to those set forth in any applicable Code Section 125 plan describing permissible election changes due to one of the qualifying life events allowed under the Code and/or other federal laws or court orders.

4.6 Funding

The premiums required hereunder, and certain self-insured benefits will be paid solely from the general assets of WSHG. WSHG shall have no obligation, but shall have the right, to insure or self-insure a Component Plan and purchase stop-loss coverage with respect to any self-insured Component Plan. In the event WSHG purchases stop-loss insurance that reimburses WSHG for excess claims paid under a self-insured Component Plan, any participant contributions required for such self-insured coverage will not be used to pay the premium for the stop-loss insurance. The stop loss insurance premium will be paid from the general assets of WSHG.

Nothing herein shall be construed to require WSHG to contribute to or under any Component Plan, to continue to sponsor any Component Plan, or to establish a trust, maintain any fund, or segregate any amount for the benefit of any individual covered under the Plan except as specifically required under law or under the terms of a Component Plan.

No Plan participant or any other person shall have any claims against, right to, or security or other interest in, any fund, account or asset of WSHG from which any payment under the Plan may be made.

Notwithstanding anything to the contrary contained herein, participation in the Plan and payment of Plan benefits may be conditioned on Plan participant contributions to the Plan at such time and in such amounts as WSHG establishes. WSHG may require that contributions of an employee and his or her dependents participating in the Plan be made by payroll deduction if such employee is on WSHG's payroll. Payroll deductions may be pre-tax or after-tax as determined by WSHG in its sole discretion.

4.7 Claims and Appeal Procedures

The procedure for obtaining payment of benefits shall be set forth in the Component Plans' Benefit Documents. In the event that such procedures do not exist or fail to comply with ERISA Section 503, the ACA (where applicable), and/or their implementing regulations, the claims and appeal procedures set forth in the Plan's SPD shall apply.

4.8 Recovery of Overpayment

Any amount paid to any person in excess of the amount to which he or she is entitled under the Plan will be repaid to the Plan or, if applicable, the Issuer, promptly following receipt by the person of a notice of such excess payments. In the event such repayment is not made, such repayment may be made, at the discretion of WSHG or, if applicable, the Issuer, by reducing or suspending any further payments due or future benefits otherwise payable under the Plan to the person and by taking such other or additional actions as may be permitted by applicable law.

4.9 Participant Responsibilities and Unclaimed Benefits

Each Plan participant shall be responsible for providing the Administrator, Claims Administrator and/or WSHG with the current address of the Plan participant, dependents, or beneficiary. Any notices required or permitted to be given hereunder shall be deemed given if directed to such address and mailed by regular United States mail. The Administrator, Claims Administrator, or WSHG shall not have any obligation or duty to locate a person who is or may become entitled to benefits under the Plan except as required by applicable law.

In the event that such a person becomes entitled to a payment under this Plan and such payment is delayed or cannot be made:

- Because the current address according to WSHG's records is incorrect,
- Because the Plan participant, dependent or beneficiary fails to respond to the notice sent to the current address according to WSHG's records,
- Because of conflicting claims to such payments, or
- Because of any other reason,

the amount of such payment, if and when made, shall be that determined under the provisions of this Plan without payment of any interest or earnings.

If, after any amount becomes payable hereunder to a Participant, dependent or beneficiary, and the amount remains unclaimed or any check issued under the Plan remains uncashed after the time period specified and communicated to the claimant by the Plan Administrator (or after 12 months if the time period is not specified by the Plan Administrator) the amount thereof shall be forfeited and shall cease to be a liability of the Plan to the extent the Plan Administrator exercised reasonable care in its attempt to make such payment.

4.10 Additional Health Plan Provisions

The Plan, including the Component Plans, shall comply to the extent applicable with federal and state laws to which they are subject, including, but not limited to:

- Group health plan benefits shall be provided as required by and in conformance with the Patient Protection and Affordable Care Act ("ACA"), as amended from time to time;

- Mental health benefits shall be provided to the same extent as other medical benefits as required by the Mental Health Parity Act and the Mental Health Parity and Addiction Equity Act ("MHPAEA"). To the extent required by applicable law, and to the extent the Plan offers both medical/surgical benefits and mental health/substance abuse benefits and imposes non-quantitative treatment limitations ("NQTL") on such benefits, the Plan shall perform a comparative analyses of the design and application of NQTLs and make such analyses available to applicable state and/or federal authorities in accordance with MHPAEA and the guidance thereunder;
- Certain benefits received in connection with a mastectomy shall be provided as required by the Women's Health and Cancer Rights Act;
- Coverage for childbirth related benefits shall be provided as required by the Newborns' and Mothers' Health Protection Act of 1996;
- Americans with Disabilities Act of 1990 ("ADA");
- State Children's Health Insurance Program, as amended;
- Compliance with the requirements of the Genetic Information Nondiscrimination Act of 2008 ("GINA"); and,
- Compliance with the COVID-19 relief requirements of the DOL's and Treasury's Joint Notice dated May 4, 2020 and Disaster Relief Notice 2021-15 related to the extension of time for receipt of certain participant notices and payments.

4.11 Wellness Program

Notwithstanding anything in the Plan to the contrary, to the extent the Plan includes a voluntary wellness program designed to promote the health and wellbeing of covered individuals that includes incentives or rewards for participation, the wellness program shall be administered in accordance with all applicable federal laws, including the ADA, GINA, and HIPAA (as amended by the ACA).

SECTION 5 – THE USE AND DISCLOSURE OF PHI

To the extent that a Component Plan is a group health plan that uses, creates, or has access to protected health information ("PHI") as defined by HIPAA, the following provisions apply. WSHG's HIPAA Privacy and Security Procedures are incorporated by reference herein.

5.1 Health Plans

As permitted by HIPAA, the terms of this Section shall not apply to health information that is:

- Summary health information provided to WSHG for the purposes of obtaining premium bids or modifying the group health plan;
- Information provided to WSHG regarding whether an individual is participating or has enrolled or disenrolled from the plan; or,
- Information provided to WSHG pursuant to an authorization which meets the requirements of the HIPAA Privacy Rules described at 45 C.F.R. Section 164.508.

5.2 Business Associates

The Plan may disclose PHI to its Business Associates (as such term is defined under HIPAA) who have agreed in writing to comply with all applicable HIPAA regulations for purposes related to the administration of the Plan.

5.3 Third Parties with Authorization

With the exception of uses and disclosures of PHI for health care treatment, payment for health care and health care operations, the Plan will disclose PHI to third parties as permitted by HIPAA and upon authorization by the participant, and the information may be used only as described in the authorization. The Plan will not require any participant to complete an authorization as a condition of payment, enrollment, or eligibility for benefits.

5.4 Plan Sponsor

The Plan will disclose PHI to WSHG as plan sponsor of the Plan ("Plan Sponsor") only upon receipt of a certification from the Plan Sponsor that this Plan document contains the limitations and conditions required by HIPAA and contained in this Section.

The Plan Sponsor may use and disclose PHI for the purposes of administration functions that WSHG performs for or on behalf of a group health plan Component Plan to the extent and in accordance with the uses and disclosures permitted by HIPAA and contained in this Section.

5.5 Conditions and Limitations on Use and Disclosure by Plan Sponsor

The Plan Sponsor shall:

- Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree in writing to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment related actions and decisions unless authorized by an individual;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- Not use or disclose PHI that is genetic information for underwriting purposes;

- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures in accordance with HIPAA;
- Make internal practices, books and records relating to the use and disclosures of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;
- Report breaches of unsecured PHI as described in Section 5.10;
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- Ensure adequate separation between the Plan and WSHG as required by 45 C.F.R. Section 164.504(f)(2)(iii) and described in this Plan.

5.6 Organized Health Care Arrangement

The Plan Administrator may intend the Plan to form part of an Organized Health Care Arrangement along with any other benefit under a covered health plan (under 45 C.F.R. Section 160.103) provided by WSHG.

5.7 Access to PHI

In accordance with, and to the extent permitted under, HIPAA, only the following employees or classes of employees may be given access to PHI, including electronic PHI:

- the Privacy Officer;
- the Security Officer (electronic PHI); and,
- staff designated by the Privacy Officer or Security Officer.

The Plan shall ensure that any member of WSHG's workforce who may have access to PHI pursuant to this Section 5.7 is, in a timely manner, properly and routinely trained on WSHG's policies and procedures with respect to PHI, as necessary and appropriate under HIPAA.

5.8 Limitations of PHI Access and Disclosure

The persons described in Section 5.7 may only have access to and use and disclose PHI for Plan administration or operation functions that the Plan Sponsor performs for the Plan. Procedures shall be implemented to ensure that only these designated employees have access to PHI, and even then, that they have access only to the minimum necessary amount of PHI to perform their duties.

The persons described in Section 5.7 may only have access to and use and disclose PHI for Plan administration or operation functions that the Plan Sponsor performs for the Plan. Procedures shall be implemented to ensure that only these designated employees have access to PHI. As required by HIPAA, any access, use or disclosure of PHI shall be limited to the minimum necessary to accomplish the intended purpose of the permitted use or disclosure.

5.9 Security Rules

WSHG further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information, de-identified information or summary health information, which are not subject to these restrictions) on behalf of the Plan, it will:

- Implement administrative, physical, and technical safeguards and security measures that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI;

- Ensure that the adequate separation required by 45 CFR § § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- Ensure that any agent (including subcontractors) to whom it provides such electronic PHI shall agree in writing to implement reasonable and appropriate security measures to protect the PHI; and
- Report to the Plan any security incident of which it becomes aware.

5.10 Breach Notification Rules

In the event of a breach of unsecured PHI by the Plan, the Plan will notify affected individuals, the Department of Health and Human Services, and/or the media in the form and method described under HIPAA.

5.11 HITECH Rules

To the extent that WSHG transmits health information electronically in connection with a Covered Transaction as defined by the HIPAA Privacy Rules, it shall do so in a manner which meets the criteria established by the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH") and its regulations.

5.12 Nondisclosure of Genetic Information for Underwriting Purposes

The Plan shall not use or disclose PHI that is Genetic Information (as set forth in 45 CFR Section 160.103) for underwriting purposes, as defined in 45 CFR Section 164.502(a)(5)(i).

SECTION 6 – GENERAL PROVISIONS

6.1 Nonassignability

It is a condition of the Plan, and all rights of each person eligible to receive benefits under the Plan shall be subject thereto, that no right or interest of any such person in the Plan shall be assignable or transferable in whole or in part, either directly or indirectly, or by operation of law or otherwise, including, but not by way of limitation, execution, levy, garnishment, attachment, pledge, or bankruptcy, but excluding devolution by death or mental incompetence, and no right or interest of any such person in the Plan shall be liable from, or subject to, any obligation or liability of such person, including claims for alimony or the support of any spouse. Notwithstanding the foregoing, the Plan will recognize the assignment of rights of benefits to an alternate recipient as required by any qualified medical child support order within the meaning of ERISA Section 609(a).

6.2 Employment Noncontractual

The Plan confers no right upon any employee to continue in employment or affect or modify the terms of an employee's employment in any way.

6.3 No Guarantee of Tax Consequences

WSHG makes no commitment or guarantee that any amounts paid to or for the benefit of a participant under the Plan will be excludable from the participant's gross income for federal or state tax nor that any other favorable tax treatment will apply to or be available to any participant with respect to such amounts. 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 and state tax purposes, and to notify the Plan Administrator if the participant has reason to believe that any such payment is not so excludable.

6.4 Indemnification of WSHG by Participants

If any participant receives one or more payments or reimbursements under the Plan that are not for an allowable expense, such participant shall indemnify and reimburse WSHG for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursement. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that the participant would have owed if the payments or reimbursements that had been made to the participant as regular cash compensation, including the participant's share of any Social Security tax that would have been paid on such compensation, less any additional income and Social Security tax actually paid by the participant.

6.5 Misrepresentation or Fraud

In the event a participant obtains benefits wrongfully due to intentional misrepresentation or fraud, the Plan Administrator, claims administrators, and issuers/contract administrators reserve the right, to the extent permitted by law, to terminate a participant's benefits, deny future benefits, take legal action against such participant, and/or offset from any future benefits the value of benefits the Plan has paid relating to inaccurate information or misrepresentations provided to the Plan.

6.6 Notices

The Plan Administrator shall provide all notices to Plan participants in the manner and form required by federal or state law, including the use of electronic means in conformance with the federal rules governing this method, if permitted. It is the Plan participant's and beneficiary's responsibility to keep the Plan Administrator informed of current addresses.

6.7 Nondiscrimination Rules

This Plan is intended to be nondiscriminatory under applicable provisions of the Code and its regulations. If WSHG determines before or during any Plan Year that the Plan or one of its Component Plans may fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated or key employees, WSHG shall take such reasonable action as WSHG deems appropriate, under rules uniformly applicable to similarly situated covered employees, to ensure compliance with such requirements or limitation, or to avoid adverse tax consequences for highly compensated or key employees. Such action may include, without limitation or the employee's consent, a modification or revocation of the highly compensated or key employee's election or elections.

6.8 Separate Plans

To the extent required to satisfy applicable law, including, but not limited to, the nondiscrimination provisions of the Code, and any privacy and security laws, each coverage level, each group of employees covered by the Plan, and each class of benefits provided under the Plan, may constitute a separate "plan."

6.9 Severability

If any provision of the Plan is held invalid, unenforceable, or inconsistent with any law, regulation or requirement, its invalidity, unenforceability, or inconsistency shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

6.10 Governing Law

The Plan is intended to constitute a welfare benefit plan within the meaning of Section 3(1) of ERISA or any other federal law. To the extent not preempted by ERISA, this Plan shall be interpreted and construed in accordance with the laws of the State of California.

6.11 Time Limit and Venue for Legal Actions

The time limit for bringing any lawsuit that arises under or relates to this Plan or a Component Plan (other than claims for breach of fiduciary duty governed by Section 413 of ERISA) is as follows:

- Before bringing any lawsuit seeking benefits under a Component Plan, such claimant must complete the applicable claims procedure of the Plan or the Component Plan (and comply with all applicable deadlines established as part thereof). Failure to properly exhaust the claims procedure will extinguish the claimant's right to file a lawsuit with respect to the claim.
- In the case of a Component Plan that is self-insured by WSHG, any lawsuit seeking benefits must be brought within the shorter of (i) one year from the date of the final appeal denial under the Plan's claims and appeals procedures or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; claims against nonfiduciaries; and claims for breach of fiduciary duty that are not governed by Section 413 of ERISA) must be brought within one year of the act or omission giving rise to the claim.
- In the case of a fully-insured Component Plan, the time period for bringing any lawsuit against the Issuer or the Plan shall be determined by the terms of the applicable Component Plan. If the Component Plan does not set forth such a time period, any lawsuit seeking benefits must be brought within the shorter of (i) one year from the date of the final appeal denial under the Plan's claims and appeals procedures or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; claims against nonfiduciaries; and claims for breach of fiduciary duty that are not governed by Section 413 of ERISA) must be brought within one year of the act or omission giving rise to the claim.

Any legal action relating to, arising out of, or involving the Plan shall be litigated in the state or federal court of proper jurisdiction in the State of California.

6.12 Headings and Captions

The headings and captions herein are provided for reference and convenience only and shall not be considered part of the Plan nor be employed in the construction of the Plan.

6.13 Gender and Number

Whenever used in the Plan, words in the masculine gender shall include all gender distinctions, and unless the context otherwise requires, words in the singular shall include the plural, and words in the plural shall include the singular.

IN WITNESS WHEREOF, the undersigned authorized representative has executed this amended and restated Plan document effective as of April 1, 2021, on behalf of Wall Street Holding Group, Inc. to evidence the adoption of this amended and restated Plan as set forth herein.

For Wall Street Holding Group, Inc.:

Signature: _____

Name: _____

Title: _____

Date: _____

APPENDIX A

WALL STREET HOLDING GROUP, INC. HEALTH AND WELFARE PLAN

Insurance Policy Issuers and Contract Administrators of Component Plans

The Benefit Documents for each of the following Component Plans are incorporated by reference herein. This list is subject to modification from time to time in accordance with Section 2.7 of this Plan document.

Fully-Insured Component Plans	Policy/Group No.	Type of Benefit
Cigna Health 400 North Brand Boulevard, Suite 400 Glendale, CA 91203	3329318	Dental – PPO Dental – DHMO
ComPsych 455 North Cityfront Plaza Drive, 13th Floor Chicago, IL 60611-5322	COM589	Employee Assistance Program (EAP)
Vision Service Plan (VSP) 3333 Quality Drive Rancho Cordova, CA 95670	30082120	Vision

Self-Insured Component Plans	Contract No.	Type of Benefit
The Health Plan 1110 Main Street Wheeling, WV 26003	0180955703	Medical – PPO Prescription Drugs General-Purpose Health FSA

APPENDIX B

WALL STREET HOLDING GROUP, INC. HEALTH AND WELFARE PLAN

Affiliated Organizations

For purposes of the Plan, the following entities are Affiliated Organizations of WSHG that have adopted the Plan with the consent of WSHG.

Entity Name	FEIN
Arch Telecom	27-2875461

WALL STREET HOLDING GROUP, INC.

HEALTH AND WELFARE PLAN

Summary Plan Description

April 1, 2021

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PLAN INFORMATION

This document, when incorporated with the benefit booklets and certificates, and provider contracts, policies, and descriptions ("Benefit Documents"), constitutes this Plan's Summary Plan Description ("SPD") pursuant to the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

This SPD outlines your rights and responsibilities under the Plan and reflects the Plan's benefits under each benefit program ("Component Plans") as of April 1, 2021, which may change from time to time. You should keep this SPD with the Benefit Documents provided to you upon enrollment in each Component Plan. You also should share this SPD with any family members you have elected to cover under the Plan.

Plan Name:	Wall Street Holding Group, Inc. Health and Welfare Plan
Type of Plan:	Welfare Benefit Plan
Plan Year:	April 1 through March 31 of the following calendar year
Plan Number:	501
Effective Date of this SPD:	April 1, 2021
Original Effective Date of Plan:	April 1, 2013
Funding Method:	Funded through fully-insured contracts and self-insured arrangements
Source of Contributions:	From WSHG's general assets and employee contributions, when required by WSHG in its sole discretion
Plan Sponsor and Plan Administrator:	Wall Street Holding Group, Inc. 1940 West Corporate Way Anaheim, CA 92801 714-829-1627
Plan Sponsor's Employer Identification Number:	11-3141199
Agent for Service of Legal Process:	The agent for the service of legal process for the Plan is the Plan Sponsor at the address set forth above
Claims Administrators:	See Appendix B and the Benefit Documents associated with each Component Plan

For additional information regarding the Plan, contact WSHG's Human Resources at benefitshelp@arch-telecom.net, or refer to the Benefit Documents for each applicable Component Plan. Copies of the Benefit Documents are available free of charge from WSHG on request.

INTRODUCTION

Establishment and Purpose

Wall Street Holding Group, Inc. ("WSHG") maintains the Wall Street Holding Group, Inc. Health and Welfare Plan (the "Plan") for the exclusive benefit of, and to provide welfare benefits to, its (and its "Affiliated Organizations") eligible employees, their spouses and eligible dependents.

These benefits are provided under various insurance contracts entered into between WSHG and insurance companies or service providers ("Issuers"), as well as through self-insured plans funded by the general assets of WSHG. The Benefit Documents for each Component Plan are incorporated herein by reference only to the extent they provide detailed descriptions regarding each Component Plan's eligibility rules, benefit descriptions, claims and appeal procedures, or other substantive provisions. This Summary Plan Description ("SPD") is not intended to give any substantive rights to benefits that are not already provided for in the Plan and the applicable Benefit Documents. Accordingly, if the terms of this SPD conflict with the terms of the Plan-related Benefit Documents, the terms of the Plan-related Benefit Documents will control, unless superseded by applicable law. If there is a conflict between the Benefit Documents and this SPD with respect to the legal compliance requirements of ERISA and any other federal law, this SPD will control, unless superseded by applicable law.

Benefits

The Benefit Documents provided to you upon enrollment in the Component Plans listed in Appendix A will contain a complete description of the benefits available under this Plan and any limitations or exclusions applicable to those benefits.

For purposes of the Component Plans that qualify as group health plans, the applicable Benefit Documents describe the use of network providers, the composition of the network, and the circumstances, if any, under which coverages will be provided for out-of-network services. The directory of participating network providers is available free of charge by contacting the applicable Issuer at the website or member services phone number provided in the Issuer's Benefit Documents. The Issuer can also provide you with information on any conditions or limits on the selection of primary care providers or specialty medical providers that may apply under the Component Plan.

Flexible Spending Plan. WSHG maintains a flexible spending plan that allows you to set-aside pre-tax dollars to pay for qualified health care expenses ("Health FSA") and/or qualified dependent care expenses ("Dependent Care FSA"). Review the FSA's separate summary plan description or other Benefit Documents for additional details on your FSA benefits.

Eligibility Rules

Please refer to Appendix C of this SPD to determine your and your dependents' eligibility for participating in the Component Plans. The specific Benefit Documents for the Component Plans may contain additional requirements with regard to dependent eligibility for such Component Plans and the terms under which you and your dependents may participate.

Eligibility Not Based on Health-Related Factors. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") prohibits the Component Plans that are group health plans from discriminating with regard to eligibility, premiums, or contributions on the basis of specified health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

Eligibility Not Based on Pre-Existing Conditions. The Patient Protection and Affordable Care Act (often shortened to the Affordable Care Act) ("ACA") generally prohibits the Component Plans that are group health plans from denying coverage or excluding specific benefits from coverage due to an individual's pre-existing condition. A pre-existing condition includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.

Misrepresentation or Fraud. In the event a participant obtains benefits wrongfully due to intentional misrepresentation or fraud, the Plan Administrator, claims administrators, and Issuers/contract administrators reserve the right, to the extent permitted by law, to terminate a participant's benefits, deny future benefits, take legal action against such participant, and/or offset from any future benefits the value of benefits the Plan has paid relating to inaccurate information or misrepresentations provided to the Plan.

Employee Contributions

WSHG, at its discretion, may require employee contributions as a condition of participation in any Component Plan. Each year, WSHG will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. You will be notified of any required contribution amounts in your enrollment materials prior to each Plan Year. You also may request a copy of any required contribution amounts from the Plan Administrator.

Pre-Tax Contributions. WSHG may administer the Plan in accordance with Internal Revenue Code Section 125 and underlying regulations. This enables you to pay your share of premiums for certain Component Plans on a pre-tax basis, thereby lowering your cost to participate in the Plan. Note that you do not pay Social Security taxes on the pre-tax dollars used, which could result in a small reduction in your Social Security benefits at retirement.

Contributions for Non-Tax Dependents. If you elect coverage for your eligible domestic partner who is not your federal tax dependent you will be required to pay contributions for the domestic partner coverage on an after-tax basis and the amount WSHG contributes toward your domestic partner's coverage will be treated as imputed income. The amount of your imputed income will be added to your paychecks each payroll period and will be subject to income tax withholding. Before enrolling your domestic partner, you should talk to your tax advisor about the tax implications for you.

Recovery of Overpayment. You must immediately repay any excess payments or reimbursements paid to you by the Plan in error. You must reimburse WSHG for any liability WSHG may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may reduce or suspend any further payments due or future benefits otherwise payable to you under the Plan and may take any other actions as may be permitted by applicable law, including offsetting your salary or wages accordingly.

Enrollment and Elections

Initial Enrollment. If you are eligible to participate in the Plan, you can become a participant by properly and timely completing an enrollment form or enrolling online, if applicable. If you do not timely enroll when you are first eligible, you must wait until the next open enrollment period unless one of the events permitting a change in your benefit elections occurs first.

Annual Open Enrollment. You may change your benefit elections (or enroll in the Plan if you did not enroll when first eligible) during each annual open enrollment period. You should review the enrollment materials provided to you and follow the instructions for enrolling or re-enrolling, as applicable. If you do not properly complete enrollment on a timely basis, your elections for the prior Plan Year may cease or remain the same for the subsequent Plan Year depending on the policies adopted by WSHG.

Special Enrollment. You may change your elections under the group health Component Plan if you have a Special Enrollment Right and you timely notify WSHG. See the section called "Special Enrollment and Coverage Rights" below for more information.

Changing Elections. Federal law generally requires that an election made under the Plan remain in effect without modification for the entire Plan Year for which the election is made. You may, however, be able to revoke or change an election on account of, and consistent with, one of the "Qualifying Life Events" adopted by WSHG, as permitted by federal law. Any election made on an after-tax basis may be changed in accordance with WSHG's policy or any applicable Component Plan limitation.

See the "Permissible Election Changes" section of this SPD for a list of Qualifying Life Events. See the "Special Enrollment and Coverage Rights" section below for additional details on HIPAA special open enrollment rights.

Special Enrollment and Coverage Rights

HIPAA Special Enrollment Rights

Group health plans must provide special enrollment opportunities ("Special Enrollment Rights") to certain employees, dependents, and qualified beneficiaries under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Special enrollment is available in the following situations:

- The acquisition of a new spouse or dependent;
- A loss of other coverage in another group health plan, health insurance, Medicaid, or CHIP; or,
- Becoming eligible for a state premium assistance subsidy.

Special Enrollment Rights do not apply to "limited scope" dental or vision benefits or certain Health FSAs.

If you or your dependents become eligible for special enrollment and properly enroll in coverage during such special enrollment period, coverage generally will begin no later than the first day of the calendar month following a

timely enrollment request. However, if the special enrollment event is the birth of a newborn, or the adoption or placement for adoption of a dependent child, coverage will begin as of the date of birth, adoption, or placement for adoption. Any requests for special enrollment or to obtain more information should be directed to:

Wall Street Holding Group, Inc.
Attn: Human Resources
1940 West Corporate Way
Anaheim, CA 92801
benefitshelp@archtelecom.net

If you decline to enroll during the special enrollment period, you may be required to wait until the Plan's next annual open enrollment period to elect coverage.

Adding a New Spouse or Dependent. If your family grows as the 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.

Loss of Other Coverage in another Group Health Plan, Health Insurance, Medicaid, or CHIP. If you or your dependents were otherwise eligible to enroll in the Plan but declined coverage due to enrollment in another group health plan, health insurance, Medicaid, or Children's Health Insurance Plan ("CHIP"), you may be able to enroll yourself and your dependents in the Plan mid-Plan Year provided that you request coverage within the following timeframes:

- Within 30 days after your or your dependent's other group health/health insurance coverage ends due to a loss of eligibility (or if the other employer ceases to make contributions toward such coverage);
- If your or your dependent's other coverage is COBRA continuation benefits, within 30 days after the exhaustion of the entire applicable COBRA continuation period; or,
- Within 60 days after your or your dependent's Medicaid or CHIP coverage ends due to a loss of eligibility under the applicable program.

Becoming Eligible for a State Premium Assistance Subsidy. If you or your dependents are eligible to enroll in the Plan while simultaneously being eligible to enroll in Medicaid or CHIP, your state of residence may offer a premium assistance program ("PAP") that can help you pay for Plan coverage that would otherwise be unaffordable to you.

Once you or your dependents are accepted into your state's PAP, WSHG must allow you to enroll in the Plan mid-Plan Year provided that you request coverage within 60 days of being determined eligible by the PAP**.**

For more information on the PAP or PAPs that may be available to you and your dependents as of July 31, 2021, go to:

California:
Website: Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

The list of states that offer PAPs is updated bi-annually by the Department of Labor ("DOL"). To review the current list of states, go to https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. You also can contact the DOL at www.askebsa.dol.gov or call 1-866-444-EBSA (3272) for more information on Medicaid, CHIP, and PAPs.

Determine Your Medicaid/CHIP Eligibility. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible, contact your state's Medicaid or CHIP office or call 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply, including in the state's PAP (if available).

Coverage Options Available Through the Exchange. If you or your children are not eligible for Medicaid or CHIP, you won't be eligible for a PAP, but you may be able to buy affordable individual insurance coverage through a Health Insurance Marketplace ("Exchange"). For more information on the coverage options available to you through the Exchange, go to www.healthcare.gov.

Dependent Coverage under QMCSOs

The Plan may be required to cover your child(ren) due to a Qualified Medical Child Support Order ("QMCSO") even if you have not enrolled the child in the Plan. You may obtain a copy of WSHG's procedures governing QMCSO determinations, free of charge, by contacting WSHG's Human Resources at benefitshelp@archtelecom.net.

A QMCSO is any judgment, decree or order, including a court-approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that WSHG determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of

wedlock, those not claimed as dependents on your federal income tax return, and children who don't reside with you.

Continuation of Coverage Rights

See the "Continuation of Coverage Rights" section of this SPD for additional details on a participant's right to continue certain health care benefits under the Plan for a limited period of time following a loss of coverage due to a qualifying event such as voluntary or involuntary job loss, reduction in work hours, death, divorce, or other life events.

Cessation of Participation

Unless otherwise stated in the applicable Benefit Documents, your coverage will cease upon the earliest of the following:

- The date or end of the month (as applicable under each Component Plan) in which you cease to satisfy the eligibility requirements for a particular Plan benefit. This may result from your death, reduction in hours, or termination of active employment, or it may result because you average less than 130 hours of service per month during a Standard Measurement Period and are not eligible for benefits during the Standard Stability Period;
- The end of the period for which you paid your required contribution if the contribution for the next period is not paid when due;
- The date you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") as described in the "Employees on Military Leave" section; or,
- The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, termination of the contract or agreement, or by discontinuance of contributions by WSHG.

Coverage for your spouse and other dependents (including your domestic partner) terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the Benefit Documents for the Component Plan. In addition, their coverage will terminate:

- The date or end of the month on which your covered spouse, domestic partner or child is no longer considered an eligible dependent;
- The date, end of the month, or end of the Plan Year in which your dependent child attains a Component Plan's limiting age (unless the Component Plan allows for the continuation of coverage for a mentally or physically disabled child who is primarily dependent on you for support);
- The end of the pay period in which you stop making contributions required for dependent coverage; or,
- The date that a child is no longer covered under a QMCSO, if the child is not otherwise eligible to participate in the Plan.

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) may have the right to continue health coverage temporarily under COBRA. See the "Continuation Coverage Rights" Section of this SPD for additional details.

PERMISSIBLE ELECTION CHANGES

You generally cannot change your benefit elections under the Plan or vary the salary reduction amounts that you have selected during the Plan Year. However, you may revoke a benefit election (including, but not limited to, an election not to receive benefits under the Plan) after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year if both the revocation and new election are on account of and consistent with a Qualifying Life Event (as described below).

Election and salary reduction changes shall be effective on a prospective basis only (i.e., election changes will generally become effective no earlier than the first day of the next calendar month following the date that the election change request was filed), except that an election change on account of a HIPAA Special Enrollment Right, 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 back to the date of the qualifying event.

If you undergo a Qualifying Life Event, you must inform the Plan Administrator and complete the required change-in-coverage enrollment materials within 30 days after the occurrence of the Qualifying Life Event (or within 60 days in the case of a Special Enrollment Right due to loss of eligibility for Medicaid or Children's Health Insurance Program ("CHIP") coverage).

In the event of a conflict between the following provisions and the Internal Revenue Code ("IRC") Section 125 plan adopted by WSHG, the IRC Section 125 plan shall control. The Plan Administrator reserves the right to determine whether an Employee has experienced a Qualifying Life Event and whether the Employee's requested election is consistent with such event.

Change of Status

Qualifying Life Events include a change of status due to one of the following events permitted under the rules and regulations adopted by the Department of the Treasury, but only if the Qualifying Life Event changes the individual's eligibility for the applicable benefit. These change in status rules apply to elections for all qualified benefits (e.g., accident or health coverage, Health FSA, Dependent Care FSA), except that election changes are generally not permitted for Health FSA or Dependent Care FSA benefits if the Qualifying Life Event is a change in residence:

- **Legal Marital Status**. Events that change an employee's legal marital status, including marriage, death of employee's spouse, divorce, legal separation, and annulment.
- **Number of Dependents**. Events that change the number of employee's dependents, including following birth, death, adoption, placement for adoption.
- **Employment status**. Any of the following events that change the employment status of the employee, the employee's spouse, or the employee's dependent: termination or commencement of employment; strike or lockout; commencement of or return from an unpaid leave of absence; or a change in worksite. In addition, if the eligibility conditions of this Plan or other employer-sponsored plan of the employee, spouse, or dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection.
- **Dependent Satisfies or Ceases to Satisfy Eligibility Requirements**. Events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, change in student status, or any similar circumstance.
- **Residency Change**. A change in the place of residence of the employee, spouse, or dependent that results in a loss of coverage (e.g. relocates outside the current plan's service area).
- **Qualifying Dependent**. For the Dependent Care Assistance Plan only, a dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a Qualifying Life Event.

HIPAA Special Enrollment Rights

An employee may change an election for group health coverage during a Plan Year and make a new election that corresponds with HIPAA Special Enrollment Rights, including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP), as long as the employee meets the notice requirements. Special Enrollment Rights can occur when:

- You lose eligibility for coverage under a group health plan or other health insurance coverage (such as if you

and your dependents lose coverage under your spouse's plan) or if your employer terminates contributions toward health coverage.

- You gain a new dependent through marriage, birth, adoption, or being placed for adoption.
- You or your dependents lose coverage under a CHIP or Medicaid or become eligible to receive premium assistance under those programs for group health plan coverage.

ACA Marketplace/Exchange Enrollment

Qualifying Life Events include the opportunity to enroll in the ACA Marketplace/Exchange or other plans that offer minimum essential coverage under the ACA. These Qualifying Life Events apply to elections for group health plan coverage that is not Health FSA benefit coverage and that provides minimum essential coverage under the ACA:

- **ACA Marketplace/Exchange Election**. You may elect to cancel contributions for and payment of your portion of the group health plan premiums if (1) you are eligible for a special enrollment period to enroll in a "qualified health plan" through an ACA Marketplace or (2) you are seeking to enroll in a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period.
- **ACA Reduction in Hours**. You may elect to cancel contribution for and payment of the employee-paid portion of group health plan premiums if (1) you had been reasonably expected to average at least 30 hours of service per week and subsequently move to a position in which you are reasonably expected to average less than 30 hours of service per week, even if you continue to be eligible under your employer-sponsored group health plan; and (2) your revocation of the election of coverage under the group health plan corresponds to your (and any dependents') intended enrollment in another plan that provides ACA minimum essential coverage with the new coverage effective no later than the first day of the second month following the month in which the original coverage is revoked.

Change in Cost of Coverage

A change in cost or coverage, as follows, may allow an election change. The following Qualifying Life Events do not apply to the election of Health FSA benefits:

- **Change in Coverage under Another Employer's Plan**. You may make a new election if there is a change in coverage (for you, your spouse or your dependent) under a plan provided by another employer. Your new election must be on account of the change in the other employer's plan and correspond with that change. Among other things, this rule permits you to make election changes during another plan's open enrollment period.
- **Significant Coverage Decrease with or without Loss of Coverage**. If your coverage under a benefit is significantly curtailed or ceases during a Plan Year, you may revoke your election of such benefit and, in its place, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.
- **Significant Improvement or Addition of a New Benefit**. If, during the period of your coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then you may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, if you are not participating in the Plan when these options are added or changed, you may opt to become a participant and elect the new or newly improved benefit package option.
- **Significant Cost Increase**. If the cost of one of your benefit options increases significantly, you may either make corresponding changes in your payments or revoke your elections and, in lieu thereof, receive on a prospective basis coverage under another benefit option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.
- **Significant Cost Decrease**. If the cost of your benefit option decreases significantly, you may make corresponding changes in your payments. In addition, if you are not enrolled in the Plan and the cost of an option decreases significantly, you may elect coverage under the corresponding benefit package.
- In addition, if the expenses for a Component Plan increase or decrease during a Plan Year, the Plan may automatically increase or decrease accordingly your required periodic contribution for such health insurance benefits.

Other Situations

Other situations that may permit an election change:

- **Court Order**. A judgment, decree, or other order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical

Child Support Order) that requires accident or health coverage for an employee's child or for a foster child who is a dependent of the employee. The employee may change his or her election to provide coverage for the child if the order requires coverage for the child under the Plan and may cancel coverage under the Plan for the child if the order requires the employee's spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided.

- **Entitlement to Medicare or Medicaid**. If an employee or an employee's spouse or dependent who is enrolled in an employer-sponsored accident or health plan becomes enrolled under Part A or Part B of Medicare or under Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines), the employee may make an election change to cancel or reduce coverage of that employee, spouse, or dependent under the accident or health Component Plan. In addition, if an employee or an employee's spouse or dependent who has been enrolled in such coverage under Medicare or Medicaid loses eligibility for such coverage, the employee may make an election to commence or increase his or her coverage or the coverage of his or her spouse or dependent, as applicable, under WSHG's accident or health plan.
- **Loss of Coverage under Health Plan of a Governmental or Educational Institution**. If an employee or an employee's spouse or dependent is enrolled in a group health coverage sponsored by a governmental or educational institution and loses such coverage, the employee may make an election change to add coverage under a corresponding WSHG plan. Group health coverage sponsored by a governmental or educational institution includes (but is not limited to) coverage under: a state children's health insurance program (SCHIP); a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization; a state health benefits risk pool; and a foreign government group health plan.
- **FMLA Leaves of Absence**. A participant may revoke coverage or, if coverage is required, continue coverage but delay payment of his or her share of the cost for group health plan coverage during the period of a leave of absence under FMLA. An employee who revokes coverage shall be entitled to reinstate coverage upon returning from a leave of absence under FMLA.
- **COBRA Premiums**. If the employee or the employee's spouse or dependent becomes eligible for continuation coverage under an employer's group health plan as provided in Code section 4980B or any similar state law, the employee may elect to increase contributions under the Plan in order to pay for the continuation coverage.
- **Correcting Discrimination Issues under the Code**. If WSHG determines before or during a Plan Year that the Plan or one of its Component Plans will fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated or key employees, WSHG may decrease or revoke the elections of affected highly compensated or key employees to ensure compliance with such nondiscrimination requirements or benefit limitation.

COVERAGE DURING A LEAVE OF ABSENCE

You may be eligible to continue certain Plan benefits for yourself and your covered dependents for a period of time during an approved voluntary or involuntary leave of absence, subject to the leave policies and procedures adopted by WSHG and to the extent prescribed by law. The type of leave you take determines the cost of your benefits (i.e., whether you can continue to pay the same contribution amounts toward your coverage or will need to pay the full premium cost). If you elect not to continue your benefits during your approved leave of absence or if you fail to timely pay for your benefits, your benefits may terminate for the duration of your leave.

Please refer to WSHG's leave policies and procedures for a description of the different types of leaves of absence available, the maximum length and types of benefits available while on a leave of absence, employee contributions requirements, and the procedures for paying your share of premiums.

Family and Medical Leave Act

In the event WSHG employs 50 or more individuals within a 75-mile radius, WSHG will be subject to the Family and Medical Leave Act of 1993 ("FMLA"). FMLA generally allows eligible employees to take a specific amount of job-protected, unpaid leave for certain family and medical reasons.

If you take FMLA leave, you may continue your group health care coverage under the Plan (e.g. medical, dental, vision, Health FSA) for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave.

- If you are being paid directly by WSHG and you substitute accrued paid leave for some of your unpaid FMLA leave days (e.g. both types of leaves run concurrently), your share of premiums will continue to be deducted from your pay (on a pre-tax basis, if applicable).
- If you take an unpaid leave of absence that qualifies under FMLA, you may continue to maintain your health care benefits on the same terms and conditions as though you were still an active employee by paying any normally required contributions for your health care benefits in accordance with WSHG's FMLA policies and applicable law. If you do not make such payments, or do not make them in a timely manner, your health care coverage may cease.

  At least 15 days before cessation of your health care coverage, you will be provided with notice of the cancellation. Unless WSHG has adopted a longer grace period, you will have 15 days from the date of the notice to make the required payment.

Any coverages that are terminated during your FMLA leave will be reinstated upon your return from leave without any evidence of good health or newly imposed waiting period so long as you make the required contributions, including any catch-up payments attributable to the period prior to your return from leave, if applicable. If you experience a change in status event while you are on leave, or upon your return from leave, you may make appropriate changes to your elections.

If you do not return to work at the end of your FMLA leave you may be entitled to COBRA continuation coverage. You also may be required to reimburse WSHG for the cost of coverage provided to you while you were on unpaid FMLA leave (the cost equals the COBRA premium, without a 2% add-on), unless your failure to return to employment is due to a serious health condition, the need to care for a servicemember, or because of other circumstances beyond your control.

For additional information on FMLA leave, and for information on participant contributions to Plan coverage during FMLA leave, please contact the Plan Administrator.

Employees on Military Leave

Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you take a military leave under USERRA, whether for active duty or for training, you are entitled to extend your health care coverage (e.g. medical, dental, vision, Health FSA) for up to 24 months as long as you give WSHG advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). Your total leave, when added to any prior periods of military leave from WSHG, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit. Additionally, the maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the contributions required for active employees. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (and any amount for dependent coverage) who is not on military leave.

If you take a military leave, but your coverage under the Plan is terminated (e.g. you do not elect the extended coverage), when you return to work with WSHG you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to health care coverage under the Plan.

If you do not return to work at the end of your military leave you may be entitled to continue coverage under COBRA continuation coverage for the remainder of the COBRA continuation period, if any. Any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible.

These rights apply only to employees and their dependents covered under the Plan before leaving for military service.

Applicable State or Municipal Law

WSHG shall permit you to continue participation in the Plan as required under any applicable state or municipal law to the extent that such law is not pre-empted by federal law.

College Student Medical Leave ("Michelle's Law")

To the extent any Component Plan is a group health plan that requires certification of student status in order to maintain a dependent child's coverage, the Plan shall comply with Michelle's Law. A dependent child enrolled in an institution of higher education who loses his or her student status due to a medically necessary leave of absence shall be allowed to continue such Component Plan coverage for up to one year as measured from the first day of the leave of absence or from the date coverage would otherwise terminate due to the loss of student status, whichever is earlier.

The Plan must receive written certification from the child's physician confirming the serious illness or injury and the medical necessity of the leave or change in enrollment status (e.g. a switch from full-time to part-time student status).

CONTINUATION OF COVERAGE RIGHTS

In the event WSHG employs 20 or more employees in the preceding year, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") will apply to certain Component Plans that are group health plans (e.g., medical, dental, vision, Health FSA). Nothing in this section is intended to expand your rights beyond COBRA's requirements or the requirements of any other applicable federal or state law.

COBRA coverage is a continuation of the Plan's COBRA-eligible benefits when your coverage would otherwise end due to a life event known as a "qualifying event" (as described below). After a qualifying event, COBRA coverage must be offered to each person who is a "qualified beneficiary," which may include you, your spouse, and/or your dependent children. If elected, you must pay the full cost of the COBRA coverage (including both employer and employee contributions) as described in the "Cost of COBRA Coverage" section.

If you are interested in receiving more information about your COBRA rights and obligations under the Plan, contact WSHG's Human Resources at benefitshelp@archtelecom.net.

Other Coverage Options

Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family members through the Health Insurance Marketplace (ACA Exchange), Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as coverage under your spouse's plan) through a special enrollment period. Some of these options may cost less than COBRA coverage. You can learn more about many of these options at www.healthcare.gov.

Enrolling in Medicare instead of COBRA Coverage. 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 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.

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.

Qualifying Events for COBRA Coverage

Employee. If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events occurs:

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

Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA coverage.

Spouse. If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occurs:

- 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; or,
- You become divorced or legally separated from your spouse.

Dependent Children. Your dependent children will become qualified beneficiaries if they lose coverage under

the Plan because any of the following qualifying events occurs:

- 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 parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a dependent child.

Notifying the Plan of a Qualifying Event

The Plan will offer COBRA coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. However, when the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries without notification that such a qualifying event has occurred.

You Must Notify the Plan Administrator of Certain Qualifying Events. For the 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), a COBRA election will be available to you only if you notify WSHG in writing within 60 days after the later of (1) the date of the qualifying event; or (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. Your notice must provide the type of qualifying event, the date of the qualifying event, and the name and address of the employee, spouse or dependent who underwent the qualifying event. You must provide this notice to:

Wall Street Holding Group, Inc.
Attn: Human Resources
1940 West Corporate Way
Anaheim, CA 92801
benefitshelp@archtelecom.net

You may lose your right to elect COBRA continuation coverage if proper procedures are not followed within the time periods described.

COBRA Coverage Elections

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA coverage will be offered to each of the qualified beneficiaries who then will have an independent right to elect coverage. Covered employees may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.

If mailed, your election must be postmarked (or if hand delivered, your election must be received by the individual at the address specified on the election form) no later than 60 days after the date of the COBRA election notice provided to you at the time of the qualifying event (or, if later, 60 days after the date that Plan coverage is lost).

Length of COBRA Coverage

The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the "Early Termination of COBRA Coverage" section below.

Employee Coverage. Under COBRA, employees themselves are only eligible for either:

- 18 months of coverage, due to termination of employment or a reduction in hours; or,
- 29 months of coverage, if a qualified beneficiary covered under the Plan is eligible for a disability extension (which occurs when the individual is determined to be disabled by the Social Security Administration before the 60th day of COBRA coverage and remains disabled for the initial 18 months of coverage). The 11-month extension begins at the conclusion of the original 18 months of coverage.

COBRA coverage will be available to the employee and any covered family members. Additionally, under USERRA, covered employees who enlist in the military or are called to active duty may have COBRA-like coverage rights for themselves and their dependents that last for up to 24 months.

Dependent/Qualified Beneficiary Coverage. Dependents who are qualified beneficiaries are eligible for the same coverage durations above, but their coverage may extend even further in certain situations:

- 36 months of coverage, due to losing dependent-child status under the plan;
- Up to 36 months of coverage, when the qualifying event is the employee's termination of employment or a reduction in hours and the employee became entitled to Medicare less than 18 months before the qualifying event (where the 36 months is measured

from the date the employee became entitled to Medicare); or,

- Up to 36 months of coverage, when there is a second qualifying event during continuation coverage (the death of the covered employee; the divorce or separation of the employee and spouse; the covered employee becoming entitled to Medicare or loss of dependent-child status under the Plan), where the 36 months is measured from the original COBRA coverage start date.

  These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

Notification Requirement for Extensions. The extension of COBRA coverage due to a disability or a second qualifying event is available only if you notify WSHG in writing within 60 days after each qualifying event. You must provide this notice to:

Wall Street Holding Group, Inc.
Attn: Human Resources
1940 West Corporate Way
Anaheim, CA 92801
benefitshelp@archtelecom.net

For the disability extension, the notice must be provided within 60 days of the latest of (1) the date of the Social Security Administration's disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; and (3) 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. In addition, to be entitled to a disability extension, you must provide the notice within 18 months after the covered employee's termination of employment or reduction of hours.

You may lose your right to elect COBRA coverage if proper procedures are not followed within the time periods described.

Special COBRA Rule for Health FSAs. COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the Plan Year. Health FSA COBRA coverage will only last until the end of the Plan Year during which the qualifying event occurred. **The use-it-or-lose rule will continue to apply, so any unused funds (in excess of any carryover amount, if applicable) will be forfeited at the end of the Plan Year (and grace period if applicable) and the Health FSA COBRA coverage will be terminated**.

If applicable, any carryover funds remaining in a Health FSA account after the end of the Plan Year in which a qualifying event occurred will continue to be available to reimburse health care expenses until the qualified beneficiary's other COBRA coverage (e.g. medical, dental, vision) ends.

Early Termination of COBRA Coverage

COBRA coverage will automatically terminate before the end of the maximum coverage period if:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. Note that he or she must notify WSHG in writing within 30 days after a qualified beneficiary becomes entitled to Medicare benefits or becomes covered under other group health plan coverage;
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. Note that you must notify WSHG in writing within 30 days after the Social Security Administration determines that a qualified beneficiary is no longer disabled;
- WSHG ceases to provide any COBRA-eligible group health plan coverage for its employees; or,
- For any reason the Plan would otherwise terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as for fraud).

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage, including both employee and employer contributions. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health plan ("Applicable Premium") (including both employer and employee contributions) for coverage of a similarly situated

plan participant or beneficiary who is not receiving COBRA coverage.

For self-insured group health benefits, the amount the Plan may charge for COBRA coverage will depend on the amount of Applicable Premium for such coverage. Applicable Premium may be equal to either:

- A reasonable estimate of the cost of providing coverage determined on an actuarial basis; or,
- The cost of coverage for the immediately preceding Plan Year (including claims costs, administrative expenses, stop-loss premiums, and stop-loss reimbursements) as adjusted for cost of living.

The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of any COBRA premium changes.

Payment for COBRA Coverage. If you elect COBRA continuation coverage, you do not have to send any payment with the COBRA election form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election (this is the date the envelope containing the payment is post-marked, if mailed). **If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan**. You are responsible for making sure that the amount of your first payment is correct and paid in a timely manner.

After you make your first payment for COBRA coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments can be made monthly. Under the Plan, each of these periodic payments for COBRA coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without a break. **The Plan will not send periodic notices of payments due for these coverage periods, so it's important to keep track of the due dates**.

Although periodic payments are due on the first of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each payment. Your COBRA coverage will continue for each coverage period if payment for that period is made before the end of the grace period for that payment.

Temporary Provisions Related to COBRA Subsidy Availability

Under the American Rescue Act Plan of 2021, certain employees and their dependents who lost group health coverage during the COVID-19 pandemic due to the employee's involuntary termination (other than for gross misconduct) or reduction of hours are permitted to temporarily receive fully-subsidized COBRA coverage between April 1, 2021 and September 30, 2021. Such employees and dependents may also be allowed a special election right to elect such subsidized coverage.

Special Rules for Certain Qualified Beneficiaries under the American Rescue Plan of 2021. Notwithstanding any provisions to the contrary in the "Continuation of Coverage Rights" Section of this SPD, special rules for COBRA coverage will apply temporarily in accordance with the American Rescue Plan Act of 2021 ("ARPA"). ARPA provides temporary premium assistance for COBRA continuation coverage ("COBRA Premium Assistance"). The COBRA Premium Assistance is available to certain employees and their dependents who are eligible for COBRA continuation coverage due to a qualifying event that is a reduction in hours or an involuntary termination of employment (other than involuntary termination that was due to gross misconduct), and who elect COBRA continuation coverage. You will NOT be eligible for this COBRA Premium Assistance in the event you are eligible for Medicare or eligible for coverage under another group health plan, such as a plan sponsored by a new employer or a spouse's employer. Domestic Partners are not eligible for this COBRA Premium Assistance. In addition, the COBRA Premium Assistance and any special election rights will not be available for continuation coverage under the Health FSA Component Plan.

If you qualify for COBRA Premium Assistance, you do not need to pay any of the COBRA premium otherwise due to the Plan for the period from April 1, 2021 through September 30, 2021. If you continue your COBRA continuation coverage beyond that date, the COBRA Premium Assistance will cease, and you will have to pay the full amount due for your remaining COBRA continuation coverage.

- **Additional Election Opportunity**. If you were offered COBRA continuation coverage as a result of a reduction in hours or an involuntary termination of employment, and you declined to take COBRA continuation coverage at that time, or you elected COBRA continuation coverage and later discontinued it, you may have another opportunity to elect COBRA continuation coverage and receive the COBRA

Premium Assistance, if the maximum period you would have been eligible for COBRA continuation coverage has not yet expired (if COBRA continuation coverage had been elected or not discontinued). In such case, you will receive a notice of an extended COBRA election period informing you of this opportunity. You will have 60 days after the notice is provided to elect COBRA. However, this additional election period does not extend the period of COBRA continuation coverage beyond the original maximum period. COBRA continuation coverage with COBRA Premium Assistance elected in this additional election period begins with your first period of coverage beginning on or after April 1, 2021. You can begin your coverage prospectively from the date of your election, or, if you had a qualifying event on or before April 1st, you may choose to start your coverage as of April 1st, even if you receive an election notice and make such election at a later date. In either case, please note that the COBRA Premium Assistance is only available for periods of coverage from April 1, 2021 through September 30, 2021.

- **Cessation of COBRA Premium Assistance**. You will cease to be eligible for COBRA Premium Assistance for any month of coverage after the ***earlier*** of (1) the date you become eligible for Medicare or any other group health plan coverage (not including coverage that is only excepted benefits such as dental or vision coverage, a Qualified Small Employer Health Reimbursement Arrangement, or a health flexible spending arrangement); or (2) the last day of your maximum COBRA continuation coverage period, as determined by the date of your qualifying event. If you become eligible for Medicare or such other group health plan coverage during the period you are receiving COBRA Premium Assistance, you MUST notify the Plan Administrator in writing. If you fail to provide this notice, you may be subject to a financial penalty.

  If your COBRA continuation coverage period ends before September 30, 2021, this right to COBRA Premium Assistance will NOT extend your rights to COBRA continuation coverage. In addition, COBRA coverage may end before September 30, 2021 in certain circumstances, including for failure to pay premiums, for fraud, or, as mentioned above, if you become covered under another group health plan or entitled to Medicare.

- **Election Timing**. If you are eligible for this COBRA Premium Assistance, you must elect COBRA continuation coverage within 60 days of receipt of the relevant COBRA notice you will be sent by the Plan, or you will forfeit your right to elect COBRA continuation coverage with COBRA Premium Assistance. The temporary deadline extensions of COBRA election periods specified in the "Deadline Extensions for Participant Actions" subsection above do NOT apply to the 60-day election period related to this COBRA Premium Assistance.

Continuation Coverage for Domestic Partners

Unlike a spouse, a covered domestic partner of an employee does not have an independent statutory right to elect COBRA coverage. However, once a plan extends coverage to domestic partners or their children, certain COBRA rights and obligations may arise. For example, if an employee and covered domestic partner lose coverage due to the employee's termination of employment or reduction of hours, the employee may elect to continue the coverage in place prior to the qualifying event, which included coverage for the domestic partner. On the other hand, the death of the employee would not trigger any COBRA continuation coverage rights for a domestic partner, and no COBRA rights would be available upon the termination of a domestic partnership.

Contact WSHG's Human Resources for additional information on the Plan's extension of certain COBRA coverage rights to domestic partners.

Plan Contact Information

In order to protect your and your dependent's rights, you should keep WSHG informed of any changes in your address and the addresses of family members.

Wall Street Holding Group, Inc.
Health and Welfare Plan
Wall Street Holding Group, Inc.
1940 West Corporate Way
Anaheim, CA 92801
benefitshelp@archtelecom.net

ADDITIONAL HEALTH PLAN PROVISIONS

The following additional health plan provisions apply to Component Plans that are group health plans. Note that the definition of the health plans subject to each law may vary. If you have any questions about which law or laws apply to your benefits, contact the Plan Administrator.

Temporary Provisions Related to COVID-19

The following federal provisions were enacted in response to the 2019 Coronavirus ("COVID-19") National Emergency. These provisions shall sunset on the dates specified below, or as specified in any further COVID-19 legislation or regulatory guidance.

Deadline Extensions for Participant Actions

In accordance with federal guidance, when determining the deadline for any of the following participant actions, the Plan Administrator shall disregard the earlier of 1) one year from the date the deadline would have begun running for an individual; or 2) until 60 days after the announced end of the COVID-19 National Emergency or such other date announced by the Agencies in any future notice ("Outbreak Period"):

Special Enrollment: The 30-day period (or 60-day period, if applicable) to request HIPAA special enrollment.

COBRA Continuation Coverage:

- The 60-day election period for COBRA continuation coverage after receipt of the COBRA election notice;
- The date for making COBRA premium payments (e.g. 45-day initial payment deadline and/or 30 day grace period for subsequent payments); and,
- The 60-day period for individuals to notify the plan of a COBRA qualifying event (e.g. divorce/legal separation, child attaining age 26, or SSA disability determination).

Claims/Appeals:

- The deadline to file a claim under the Plan's claims procedures;
- The deadline to file a claim for a Health FSA during a runout period if the runout period ends any time during the Outbreak Period;
- The deadline to file an appeal of an adverse benefit determination; and,
- The deadline to file, if applicable, a request for external review of a final adverse benefit determination or, if a request for external review was not complete, to file information to perfect the request for an external review.

The above provisions shall be administered in accordance with Families First Coronavirus Response Act ("FFCRA"), the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") and any applicable guidance related to the COVID-19 National Emergency.

Expansion of Eligible Medical Expenses

The Coronavirus Aid, Relief, and Economic Security Act ("the CARES Act") expands IRS regulations to allow Health FSAs, and other account-based group health plans to pay for or reimburse expenses for menstrual care products and certain over-the-counter ("OTC") medicines and drugs *without a prescription*.

In addition, in accordance with IRS Announcement 2021-7, any personal protective equipment ("PPE") for the primary purpose of preventing the spread of COVID-19 (e.g. masks, hand sanitizer, sanitizing wipes) is a reimbursable expense under account-based group health plans.

Title VII of the Civil Rights Act of 1964

Generally, benefits provided under a group health plan must be provided without regard to the race, color, sex (including pregnancy), national origin, or religion of the eligible employee and his or her eligible dependents. A group health plan cannot discriminate on the basis of: eligibility to receive coverage under the Plan; the terms and conditions on which coverage is provided; or, what an employee is charged for coverage.

In addition, under the Pregnancy Discrimination Act of 1978, group health plans must provide coverage for pregnancy, childbirth, and related medical conditions on the same basis as coverage for nonpregnancy-related conditions.

Newborns' and Mothers' Health Protection Act of 1996 ("Newborns' Act")

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). However, in order to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to provide the Plan with advance notice of services or providers related to the hospital stay. For information on precertification, contact your Plan Administrator.

Women's Health and Cancer Rights Act

In the case of an employee or dependent who receives benefits under the medical plan in connection with a mastectomy and who elects breast reconstruction (in a manner determined in consultation with the attending physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which a mastectomy has been performed, including nipple and areola reconstruction and re-pigmentation to restore the physical appearance of the breast;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under the Plan.

Affordable Care Act

Certain group health plans are subject to provisions of the ACA. Notwithstanding anything in the Plan to the contrary, the Plan shall comply with the ACA and all applicable regulations, as may be amended from time to time. Nothing in this section is intended to expand your rights beyond ACA's requirements or the requirements of any other applicable federal or state law.

Patient Protections

Primary Care Provider Designation. If a non-grandfathered group health plan requires or allows participants to designate primary care providers, or if the Plan automatically designates a primary care provider for a participant, then the participant has the right to designate any primary care provider who participates in the Plan's network and who is available to accept the participant or participant's family members.

Access to Pediatric Care. If a non-grandfathered group health plan requires or provides for the designation of a participating primary care provider for a dependent child, the Plan shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics (including pediatric subspecialties) as the child's primary care provider if such provider participates in the network of the Plan or Issuer.

Access to Obstetrical or Gynecological Care. A participant, regardless of age, shall not need prior authorization from a non-grandfathered group health plan or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology.

Emergency Services. A non-grandfathered group health plan that provides emergency services may not require preauthorization for those services. Emergency services must be provided regardless of whether the provider is in- or out-of-network without any time limit within which treatment must be sought.

In addition, the plan generally cannot impose any copayment or coinsurance for out-of-network emergency services that is greater than what would be imposed if the services were provided in-network.

Mandated Coverage

Preventive Care Services. Non-grandfathered group health plans subject to the preventive services coverage mandate must provide coverage for certain recommended preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements. If the attending provider determines that the service is medically necessary, a plan must provide coverage regardless of sex assigned at birth, gender identity, or gender of the individual, as recorded by the plan. Updated lists of the preventive services covered under this provision are available at https://www.healthcare.gov/coverage/preventive-care-benefits/.

Coverage for Clinical Trials. Non-grandfathered group health plans must provide benefit coverage (including physician charges, labs, x-rays, professional fees, and other routine medical costs) for certain routine patient costs for qualified individuals who participate in an approved clinical trial. Approved clinical trials must be covered for the treatment of cancer and other life-threatening diseases or conditions. If a participant experiences complications as a result of the clinical trial, any treatment of those complications must be covered on the same basis that the treatment would be covered for individuals not in the clinical trial.

Mental Health Parity and Addiction Equity

All group health plans that provide both medical and surgical benefits, as well as mental health or substance use disorder benefits, shall provide such benefits subject to the following:

- The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Issuer's plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits;
- The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Issuer's plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits; and,
- The Plan Administrator or Issuer must make available to participants or beneficiaries, upon request, the criteria for medical necessity determinations for mental health and substance use disorder benefits and provide the reason for any denial of reimbursement or payment for services.

Under the ACA, group health plans are prohibited from imposing annual or lifetime dollar limits on Essential Health Benefits, including mental health and substance use disorder services and behavioral health treatment.

Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act of 2008 ("GINA") requires group health plans to not discriminate based on genetic information with respect to eligibility, premiums, and contributions. GINA generally prohibits employers with more than 15 employees from the collection or use of genetic information unless in an aggregate form that does not identify the individual. When GINA applies, genetic information is treated as Protected Health Information ("PHI") under HIPAA.

"Genetic information" includes any information about an individual's own genetic tests, the genetic tests of an individual's family members, and the manifestation of a disease or disorder in the individual's family members. For this purpose, a genetic test is any analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes (essentially, anything used to predict whether an individual has a predisposition to a disease, disorder, or pathological condition).

Wellness Program

WSHG may offer one or more voluntary wellness programs or disease management programs (each a "Program") under this Plan that are reasonably designed to promote the health and wellbeing of covered individuals. Such Programs offer certain incentives or rewards for participation in a Program or for satisfying certain health standards. If WSHG chooses to offer a Program or Programs, its terms and conditions will be communicated to you and it will be administered in compliance with all applicable laws.

CLAIMS AND APPEAL PROCEDURES

The following claims and appeal procedures must be followed by Plan participants ("Claimants") to obtain payment of benefits under the Plan, but only to the extent not otherwise provided in the applicable Component Plan's Benefit Documents. If the claims and appeal procedures in this section apply, they shall be construed and applied in a manner consistent with the ACA and the Department of Labor ("DOL") Regulation Section 2560.503-1 as in effect on the date the claim was received. To the extent that a conflict exists in the insurance contracts or administrative agreements, the provisions of the foregoing regulations will control.

For purposes of this Section, the term "Administrator" means the group insurance policy Issuer or self-insured plan contract administrator listed on Appendix A for the policy or Component Plan under which the claim has been filed.

Claims Procedures under Component Plans

The Benefit Documents provided by the Administrator for each Component Plan generally contain a detailed description of the Administrator's claims submission rules, claims and appeal procedures, and the member services contact information for any claims questions. Please refer to Appendix B for a listing of claims and claims appeal contacts, addresses, and phone numbers.

The Administrator will act as, or will designate, a claims administrator to decide your claim in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. The Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim.

If the Administrator denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial ("Adverse Determination"). You may request a review of a denied claim by appealing to the Administrator. The Administrator will decide your appeal in accordance with its reasonable claims and appeal procedures, as required by ERISA (if ERISA applies) and other applicable law. In addition, certain group health plans must provide for external review procedures upon the exhaustion of your internal appeal process (e.g. review of your claim outside of the Plan), but only if the claim is related to medical judgment, rescission of coverage, or a determination that a treatment is experimental or investigational.

Unless specifically provided otherwise in a Component Plan, you must make a claim for benefits under the Plan and any Component Plan within one year after the date you incurred the expense that gives rise to the claim. It is your responsibility to make sure this requirement is met.

Reasonable claims and appeal procedures may not preclude an authorized representative (who has been appointed using a form that is made available by the Plan Administrator) from acting on your behalf in pursuing or appealing a benefit claim. You are responsible for providing the Administrator, claims administrator and/or WSHG with your current address. The Plan Administrator, claims administrator and WSHG do not have any obligation or duty to locate a person who is or may become entitled to benefits under the Plan except as required by applicable law.

Types of Claims

Under ERISA, a claim is a request for benefits made in accordance with a Component Plan's claims-filing procedures, including any request for a service that must be pre-approved. Questions concerning Plan benefits, coverage and eligibility questions, and other casual inquiries are generally not considered claims for benefits.

Group Health Claims

For purposes of group health plans subject to ERISA (e.g. medical, dental, vision), there are four types of health claims: Urgent Care, Pre-Service, Post-Service, and Concurrent Care ("Health Claims").

- Urgent Care Claim**.** An "Urgent Care Claim" is a claim (other than a post-service claim) for which the application of a non-urgent care timeframe could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. The Component Plan must defer to an attending provider to determine if a claim for health benefits is urgent.
- Pre-Service Claim. A "Pre-Service Claim" is a non-urgent claim for a benefit under the Component Plan where the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

- Post-Service Claim. A "Post-Service Claim" is a claim for a benefit under the Component Plan after the services have been rendered.
- Concurrent Care Claim**.** A "Concurrent Care Claim" is a claim for which the Component Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and either the plan later reduces or terminates coverage for those treatments, or you request to extend coverage for those treatments. A concurrent care claim may be treated as an Urgent Care Claim, Pre-Service Claim, or Post-Service Claim, depending on when during the course of your care you file the claim.

Submission of Claims

Each Component Plan may place additional conditions on how and when a claim must be made, as well as require submission of specific information with claims, including medical information and coordination of benefits information. Each Component Plan's claims procedures shall contain a formalized system of administrative safeguards to ensure that claims are decided consistently with Plan documents and with past determinations in similar circumstances.

Special Notice for Incorrectly Filed Urgent Care or Pre-Service Claims. In the case of an incorrectly filed Urgent Care Claim or Pre-Service Claim, the Administrator will notify you as soon as possible but no later than 24 hours (Urgent Care) or five days (Pre-Service) following receipt by the Component Plan of the incorrectly filed claim. The notice may be written or oral unless you request a written notice and must include information regarding proper procedures to follow.

Notice of the Claim Determination

The Administrator must provide you with a notice of an Urgent Care or Pre-Service determination (whether adverse or not). If the Administrator decides in favor of the claim, the notice will include sufficient information to fully apprise you of the Component Plan's decision to approve the requested benefits.

For all initial claims, if the claims administrator of the Component Plan does not fully agree with your claim, you shall receive an adverse benefit determination ("Adverse Determination"), which is a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An Adverse Determination for a Health Claim related to a non-grandfathered group health plan may include a claim for benefits due to a rescission of coverage (generally a retroactive cancellation of coverage).

Timing of Initial Adverse Determinations

The time period for an initial Adverse Determination begins running when a claim is filed, even if the claim is incomplete. The original determination period for deciding certain claims (but generally not appeals) may be extended by the Administrator. However, there can be no extension unless an extension notice is provided to you *prior* to the end of the original determination period. The extension notice must indicate the matters beyond the control of the Component Plan that gave rise to the need for the extension and the date by which a determination is expected to be made.

The Administrator shall provide you with the Adverse Determination within the following timeframes:

Group Health Plan Claims:

- **Urgent Care Claim**: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Component Plan if all information was included with the claim. If the Urgent Care Claim is incomplete, the Administrator will notify you within 24 hours and you will have a reasonable period of time, but no less than 48 hours to complete the claim. The Administrator will then decide the claim as soon as possible but no later than 48 hours after the earlier of the receipt of the specified information, or the end of the period of time provided to submit the specified information.
- **Non-Urgent Pre-Service Claim**: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Component Plan. The Administrator may extend the original period for up to 15 days upon written notice to you. If the extension is due to an incomplete claim, you will have at least 45 days to provide the requested information.
- **Post-Service Claim**. Within a reasonable time, but no later than 30 days after receipt of the claim by the Component Plan. The Administrator may extend the original period for up to 15 days upon written notice to you. If the extension is due to an incomplete claim, you will have at least 45 days to provide the requested information.
- **Concurrent Care Claim Related to Termination or Reduction of Treatment**. Within enough advance time to provide the Claimant with an opportunity to appeal and obtain a decision before the benefit at issue is reduced or terminated.

- **Concurrent Care Claim Related to Request for Extension of Treatment**. In the case of an Urgent Care Claim, within 24 hours after receipt of the claim by the Component Plan provided your request is made at least 24 hours prior to the end of the approved treatment. All other non-urgent claims will be treated as a new Non-Urgent Pre-Service or Post-Service Claim as applicable.

Content of the Adverse Determination Notice

The Administrator must provide you with a written or electronic "Notice of Adverse Determination," except that the notice for an Urgent Care Claim may be provided orally (within the applicable timelines) so long as a written or electronic notice is provided to you within three days.

The Notice of Adverse Determination must be written in a manner calculated to be understood by you. In addition, the Notice for a Health Claim related to a non-grandfathered group health plan must be provided to you in a culturally and linguistically appropriate manner.

The Notice of Adverse Determination shall include the following information:

- The specific reason for the Adverse Determination;
- References to the specific Component Plan provisions on which the Adverse Determination is based;
- A description of any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the Component Plan's review procedures and the applicable time limits; and,
- A statement of your right to bring a civil action under ERISA Section 502(a) after an appeal.

The Notice of Adverse Determination for a Health Claim will include the following information:

- Specific references to the internal rules, guidelines, protocols, or other similar criteria on which the Adverse Determination is based. For Health Claims, such specific references may be made available to you by including a statement that the information is available free of charge upon your request.
- If the claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the determination, or a statement that such explanation will be provided free of charge upon your request; and,
- In the case of a Health Claim involving Urgent Care, a description of the expedited review process applicable to such claim.

The Notice of Adverse Determination for a Health Claim related to a non-grandfathered group health plan will include the following additional information:

- Information sufficient to identify the claim involved;
- A description of the Component Plan's standard, if any, used in denying the claim;
- A description of available internal appeals and external review procedures; and,
- Disclosure of the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman who can assist individuals with their claims.

Appealing a Denied Claim

If you disagree with an Adverse Determination after following the above steps, you or your appointed representative may formally request an appeal by following the Component Plan's appeal procedures as set forth in the Component Plan's Benefit Documents.

In the appeal, you may submit written comments, documents, records, and other information relating to the claim for benefits. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. In addition, for a Health Claim related to a non-grandfathered group health plan, you must be permitted to present evidence and testimony as part of the appeal process.

You may appeal any denial of a Health Claim within 180 days (within 60 days for Other Non-Health Claims) of receipt of such a denial by submitting a written request for review to the Administrator. If you do not appeal in a timely manner, you lose your right to later object to an adverse determination on review ("Appeal Decision").

If the appeal relates to a claim for payment, your request should include, at minimum:

- The patient's name and the identification number from the ID card,
- The date(s) of service(s),
- The provider's name,
- The reason you believe the claim should be paid, and,

- Any documentation or other written information to support your request for claim payment.

Full and Fair Review

The review of your claim shall take into account all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered in the initial Adverse Determination. The Component Plan will identify, upon request to the Administrator, any medical experts or vocational experts whose advice was obtained on behalf of the Component Plan in connection with your Adverse Determination, without regard to whether the advice was relied upon in making the benefit determination.

The review of your appeal shall be conducted by an appropriate fiduciary of the Component Plan who is neither the individual who made the Adverse Determination that is the subject of the appeal, nor the subordinate of such individual.

In the case of a Health Claim involving urgent care, you are entitled to an expedited review process pursuant to which you may submit a request for an expedited Appeal Decision orally or in writing and all necessary information shall be transmitted between you and the Component Plan by telephone, facsimile, or other available similarly expeditious method.

In deciding an appeal for a claim that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the Adverse Determination that is the subject of the appeal, nor the subordinate of any such individual.

The Component Plan must provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Component Plan (or at the direction of the Component Plan) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notification of Appeal Decision is required to be provided to give you a reasonable opportunity to respond prior to that date. In addition, before the Administrator can issue an Appeal Decision based on new or additional rationale for a Health Claim related to a non-grandfathered group health plan, you must be provided, free of charge, with the rationale, which must be provided to you as soon as possible and sufficiently in advance of the date on which the Appeal Decision is required to be provided to give you a reasonable opportunity to respond prior to that date.

Appeal Decision

If your claim on appeal is wholly or partially denied, the Administrator will provide you with a written notification of the Component Plan's Appeal Decision, within the required timeframes. In addition, the notice of the Appeal Decision for a Health Claim related to non-grandfathered group health plan, must be provided in a culturally and linguistically appropriate manner.

Any determination by the Administrator or any authorized delegate shall be binding and final in the absence of clear and convincing evidence that the Administrator or delegate acted arbitrarily and capriciously.

Timing of the Appeal Decision

For purposes of this section, the period of time within which the Appeal Decision is required to be made shall begin at the time your appeal is filed in accordance with the Component Plan's procedures without regard to whether all the information necessary to make an Appeal Decision accompanies the filing.

Group Health Plan Claim. The Administrator shall provide you with the Appeal Decision within the following timeframes:

- **Urgent Care Claim.** As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal by the Component Plan.
- **Pre-Service Claim**. Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal by the Component Plan.
- **Post-Service Claim**. Within a reasonable period of time, but not later than 60 days after receipt of the appeal by the Component Plan**.**
- **Concurrent Care Claim.** Before treatment ends or is reduced, where the Adverse Determination is the decision to reduce or terminate concurrent care early, or, if the Component Plan denies your request to extend treatment, within the appropriate time period based upon the type of claim.

Content of the Notice of Appeal Decision

The Administrator must provide you with a written or electronic notice of an Appeal Decision. The Notice of

Appeal Decision must be written in a manner calculated to be understood by you. In addition, the Notice for a Health Claim related to a non-grandfathered group health plan must be provided to you in a culturally and linguistically appropriate manner. The Notice of Appeal Decision shall include the following information:

- The specific reason for the Appeal Decision;
- References to the specific Component Plan provisions on which the Appeal Decision is based;
- A statement regarding your right, on request and free of charge, to access and receive copies of documents, records, and other information relevant to the claim;
- A statement describing any additional, voluntary appeal procedures offered by the Component Plan and your right to obtain information about such procedures; and,
- A statement of your right to bring a civil action under ERISA Section 502(a);

For an Appeal Decision related to a Health Claim the notice will include:

- Specific references to the internal rules, guidelines, protocols, or other similar criteria on which the Adverse Determination is based. For Health Claims, such specific references may be made available to you by including a statement that the information is available free of charge upon your request; and,
- If the claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the determination, or a statement that such explanation will be provided free of charge upon request.

The Notice of Appeals Decision for a Health Claim related to a non-grandfathered group health plan will include the following additional information:

- Information sufficient to identify the claim involved;
- A description of the Component Plan's standard, if any, used in in the Appeal Decision;
- A description of available internal appeals and external review procedures; and,
- Disclosure of the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman who can assist individuals with their claims.

Second Appeal

If specified in the Benefit Documents for each Component Plan or in documentation given to you by the claims administrator, you may be entitled to a second appeal following an adverse determination of your initial appeal. In such case, the second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal.

If a second appeal is provided by a Component Plan that is not a group health plan, the notification of the Appeal Decision with respect to the second appeal will be made in accordance with the same guidelines as those outlined above for the first appeal. If a second appeal is provided by a Component Plan that is a group health plan, the Appeal Decision with respect to any second appeal will be made according to the following schedule:

- **Urgent Care Claim**. As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- **Pre-Service Claim**. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- **Post-Service Claim**. Within a reasonable period of time, but not later than 30 days after receipt of the appeal.
- **Concurrent Claim**. The response will be made in the appropriate time period based upon the type of claim: Pre-Service Urgent, Pre-Service Non-urgent or Post-Service.

Failure to Follow Claims Procedures

Generally, you are required to complete or exhaust a Component Plan's claims and appeal procedures as a prerequisite to filing a lawsuit for benefits. If your claim is related to a Component Plan that is a non-grandfathered group health plan, and the Component Plan fails to establish or follow a procedure that is consistent with the federal regulations, the Claimant will be deemed to have exhausted administrative remedies and the Claimant then may seek an external review (if applicable) or file suit under ERISA §502(a).

However, this will not apply if the error was de minimis, if the error does not cause harm to you, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. You may request a written explanation of the violation from the Component Plan,

and the Component Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Component Plan to be deemed exhausted.

Group Health Plan External Review

If your internal appeal for a benefit provided by a Component Plan that is a non-grandfathered group health plan is denied, you may have the right to have the claim reviewed by an independent reviewer organization (IRO), not employed by the Component Plan, through an external review process. This applies to claims that involve medical judgment as determined by the external reviewer or a rescission of coverage. You will be allowed at least four months to file a request for external review after the receipt of the Adverse Determination or Appeal Decision. The external review decision is binding on you and the Component Plan, except to the extent other remedies are available under federal law.

Predispute Arbitration

In the event a Component Plan requires voluntary or mandatory predispute arbitration as the first step in a claims dispute for Plan benefits, DOL regulations (29 C.F.R. §2560.503-1) state that benefit claimants cannot be subjected to arbitration costs and any mandatory arbitration provision must not prevent claimants from exercising their statutory remedies or keep them from going to court to appeal an arbitrator's decision. Please review each Component Plan's Benefit Documents for any arbitration clause, if applicable.

Exhausting Administrative Remedies and Filing Suit

These claim and appeals procedures must be exhausted for all claims before you can bring any legal action. **If you do not make a claim or file an appeal in the manner and within the appropriate time period discussed in this SPD or, if applicable, the Benefit Documents of a Component Plan, you may lose the right to file suit in state or federal court.**

A lawsuit seeking benefits under this Plan must be brought within certain time limits as detailed in the "Legal Actions" section of this SPD and in accordance with all applicable laws.

PLAN ADMINISTRATION

In General

WSHG is the "Plan Administrator" of the Plan and a "Named Fiduciary" within the meaning of such terms under ERISA. WSHG is the Plan's agent for service of legal process.

WSHG has the duty and discretionary authority to interpret and construe the Plan in regard to all questions of eligibility, the status and rights of any Plan participant under the Plan, and the manner, time, and amount of payment of any benefits under the Plan. Each employee shall, from time to time, upon request of WSHG, furnish to WSHG such data and information as WSHG shall require in the performance of its duties under the Plan.

WSHG may designate any individual, partnership, or other organization to carry out its duties and responsibilities with respect to the administration of the Plan. Such designation shall be in writing and such writing shall be kept with the records of the Plan.

WSHG may adopt such rules and procedures as it deems desirable for the administration of the Plan, provided that any such rules and procedures shall be consistent with provisions of the Plan and ERISA.

WSHG will discharge its duties with respect to the Plan (i) solely in the interest of persons eligible to receive benefits under the Plan, (ii) for the exclusive purpose of providing benefits to persons eligible to receive benefits under the Plan and of defraying reasonable expenses of administering the Plan, and (iii) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims.

Refund of Premium

For purposes of fully-insured Component Plans, where any refund of premium (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates) is determined to be plan assets attributable to participant contributions, such assets will be:

- Distributed to current Plan participants within 90 days of receipt; or,
- Used to reduce participants' portion of future premiums under the Plan; or,
- Used to enhance future benefits under the Plan; or,
- Used to pay Plan administrative expenses.

Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the costs to the Plan and the competing interest of participants, provided such method is reasonable, fair, and objective.

Privacy and Security of Information

Certain Component Plans provided under this Plan are health plans subject to the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") including regulations affecting the maintenance, creation or use of Protected Health Information ("PHI") (as defined under HIPAA). Please refer to the Notice of Privacy Practices issued by the Plan for a description of how your medical information may be used and disclosed and how you can get access to this information.

Plan Amendment and Termination

WSHG reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time, in its sole discretion. For example, WSHG reserves the right to amend or terminate benefits, covered expenses, benefit copays, lifetime maximums, and reserves the right to amend the Plan to require or increase employee contributions. WSHG also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by WSHG will be done in accordance with WSHG's normal operating procedures.

STATEMENT OF ERISA RIGHTS

As a participant in the Wall Street Holding Group, Inc. Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and any collective bargaining agreements, and, if required by ERISA to be filed, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500) (if required by ERISA to be prepared) and updated SPD. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500 (Summary of Annual Report), if required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

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 SPD and the documents governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report 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 $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 which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. For more information about this statement or your rights under ERISA, including COBRA, ACA, HIPAA, and other laws affecting group health plans, or if you need assistance in obtaining documents from the Plan Administrator, 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 the EBSA website at 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.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. In addition, you may contact the Office of Outreach, Education, and Assistance, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

OTHER IMPORTANT INFORMATION

Legal Actions

Any legal action relating to, arising out of, or involving the Plan shall be litigated in the state or federal court of proper jurisdiction in the State of California.

Time limits exist for bringing lawsuits related to this Plan. The time limit for bringing any lawsuit that arises under or relates to this Plan or a Component Plan (other than claims for breach of fiduciary duty governed by Section 413 of ERISA) is as follows:

- Before bringing any lawsuit seeking benefits under a Component Plan, you must complete the applicable claims procedure set out in the Plan or the Component Plan (and you must comply with all applicable deadlines that are required by the Plan or Component Plan). **If you fail to properly exhaust the claims procedure, you will lose your right to file a lawsuit with respect to the claim.**
- In the case of a Component Plan that is self-insured by WSHG, you must bring any lawsuit seeking benefits within the shorter of (i) one year from the date of the final appeal denial under the Plan's claims and appeals procedures or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; claims against nonfiduciaries; and claims for breach of fiduciary duty that are not governed by Section 413 of ERISA) must be brought within one year of the act or omission giving rise to the claim.
- In the case of a fully-insured Component Plan, the time period for bringing any lawsuit against the insurance company issuing such Component Plan or the Plan will be determined by the terms of the applicable Component Plan. If the Component Plan does not set forth such a time period, you must bring any lawsuit seeking benefits within the shorter of (i) one year from the date of the final appeal denial under the Plan's claims and appeals procedures or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits must be brought within one year of the act or omission giving rise to the claim.

Right of Reimbursement from Third Parties

By participating in the Plan, you and your covered dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. Accordingly, you and your covered dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses. If you or your covered dependents have any reason to believe that the Plan may be entitled to recovery from any third party, you must notify the Plan and agree to sign a subrogation/reimbursement agreement that confirms your prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle you or your covered dependents to any payment, amount, or recovery from a third party.

You and your covered dependents consent and agree that you will not assign your rights to settlement or recovery against a third person or party to any other party, including your attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

Non-Assignment of Benefits

Except as otherwise specifically provided in the Plan or required by law, benefits payable to you or your dependents under the Plan may not be assigned, transferred or in any way made over to another party. If and to the extent any assignment of benefits is permitted under any Component Plan, the Plan Administrator or the responsible fiduciary reserves the discretionary authority to determine whether any purported assignment of Plan benefits to a provider is valid. In other words, the Plan does not guarantee that any purported assignment will be valid under the terms of the Plan or any insurance contract.

Controlling Documents

The information contained in this SPD is a general discussion of the relevant provisions of the Plan found in the official Plan document and Component Plan Benefit Documents. In all events, the provisions of the official Plan document shall control with regard to all matters concerning the administration and operation of the Plan.

APPENDIX A

WALL STREET HOLDING GROUP, INC. HEALTH AND WELFARE PLAN SUMMARY PLAN DESCRIPTION

Insurance Policy Issuers and Contract Administrators of Component Plans

This Appendix A reflects the Plan benefits as of April 1, 2021. The Benefit Documents for the following Component Plans are incorporated by reference herein. All subsequent updates to such Benefit Documents will supersede any earlier versions for the periods defined in the updated materials.

Fully-Insured Component Plans	Policy/Group No.	Type of Benefit
Cigna Health 400 North Brand Boulevard, Suite 400 Glendale, CA 91203	3329318	Dental – PPO Dental – DHMO
ComPsych 455 North Cityfront Plaza Drive, 13th Floor Chicago, IL 60611-5322	COM589	Employee Assistance Program (EAP)
Vision Service Plan (VSP) 3333 Quality Drive Rancho Cordova, CA 95670	30082120	Vision

Self-Insured Component Plans	Contract No.	Type of Benefit
The Health Plan 1110 Main Street Wheeling, WV 26003	0180955703	Medical – PPO Prescription Drugs General-Purpose Health FSA

Non-ERISA Benefits. In addition to the above Component Plans, eligible employees are offered non-ERISA welfare benefits. Such non-ERISA benefits are not governed by ERISA or the "Statement of ERISA Rights" section of this SPD, and include the following benefit plan(s):

- Dependent Care FSA administered by The Health Plan

APPENDIX B

WALL STREET HOLDING GROUP, INC. HEALTH AND WELFARE PLAN SUMMARY PLAN DESCRIPTION

Claims Administrator Contact Information

Use the address and phone number provided on your ID Card if different.

Benefit Type	Claims/Claims Appeals Contact Information		
	Mailing Address	**Phone No.**	**Online**
Medical Prescription Drugs	The Health Plan Attn: Claims Administration 1110 Main Street Wheeling, WV 26003	888-816-3096	www.healthplan.org
Dental	Cigna Attn: Dental Claims PO Box 188037 Chattanooga, TN 37422-8037	800-244-6224	www.mycigna.com
Vision	VSP Attn: Claims Department 3333 Quality Drive Rancho Cordova, CA 95670	800-877-7195	www.vsp.com
FSA	The Health Plan Attn: Claims Administration 1110 Main Street Wheeling, WV 26003	888-816-3096	www.healthplan.org

APPENDIX C

WALL STREET HOLDING GROUP, INC. HEALTH AND WELFARE PLAN
SUMMARY PLAN DESCRIPTION

Eligibility and Participation Requirements

Employee Eligibility

An employee who is determined to be benefit-eligible as of his or her start date shall be offered coverage as of the Effective Date of Eligibility specified below.

Employee Class	Working Hours Requirement	Benefits Offered	Effective Date of Eligibility (Waiting Period)
All Employees	30 hours per week	All benefits listed on Appendix A	First day of the month following 60 days of employment

Certain Component Plans may delay the effective date of your eligibility if you are not "actively-at-work" (e.g. at work performing all of the regular duties of your job). Any actively-at-work requirement imposed by a group health plan (as defined by HIPAA) will not apply if the reason you are not actively-at-work is due to a health condition.

Special Eligibility Rules for Variable Hour, Part-Time and Seasonal Employees

Certain employees who are hired into positions that are not initially benefit-eligible may become participants in the Plan by achieving Full-Time Status ("ACA-FT") under special eligibility rules for variable hour, part-time, and seasonal employees. In the event WSHG adopts such rules, it intends to administer them in a manner consistent with the final regulations issued by the Department of Treasury related to the "Shared Responsibility" provisions of the ACA.

For purposes of these special eligibility rules (known as either the "Look-Back Measurement Method" or "Monthly Measurement Method"), a variable hour, part-time or seasonal employee will achieve ACA-FT status after averaging 130 or more hours of service per month (or 30 or more hours of service per week) during a period of time spanning a specific number of consecutive months ("Measurement Period"). Eligibility or ineligibility for benefits will last for a future specific number of consecutive months referred to as the "Stability Period." The maximum length of any Measurement Period or Stability Period shall not exceed 12-consecutive months.

If applicable, details regarding the Look-Back Measurement Method and/or Monthly Measurement Method adopted by WSHG (e.g. the classes of employees it applies to, a description of each type of measurement period, breaks-in-services rules, and procedures used to count hours of service) are available upon request from WSHG's Human Resources.

Dependent Eligibility

Unless specified otherwise under the applicable Component Plan's Benefit Documents, coverage for dependents, if elected, begins on the date your coverage begins (provided you timely enroll them in coverage). If your family grows as the result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your new dependent(s) mid-Plan Year provided you enroll them in a timely manner after your corresponding Qualifying Life Event.

Dependent Definitions. For purposes of eligibility and participation in this Plan, dependent definitions shall have the same meaning set forth in each applicable Component Plan's Benefit Documents which are incorporated by reference herein. Unless otherwise defined in the Benefit Documents for a Component Plan, your eligible dependents include:

- Your lawful same- or opposite-sex spouse under applicable law, unless legally separated by court decree; or,

Your domestic partner with whom you have lawfully registered into a domestic partnership in a state or municipality that provides for such registration.

- Your child(ren) under age 26 (regardless of financial dependency, residency with you, marital status, or student status), or if older, your unmarried child who is principally supported by you and who you can certify (on a periodic basis) is not capable of self-support due to a physical or mental disability that either began while the child was covered under the Plan or occurred prior to attaining age 26. For purposes of the Plan, a child includes:
  - Your (or your spouse's/domestic partner's) biological child, stepchild, legally adopted child (including any child lawfully placed for adoption with you by a court of competent jurisdiction);
  - A foster child who has been placed with you by an authorized placement agency or by judgment, decree, or other court order of any court of competent jurisdiction;
- Your court-appointed legal ward under a Component Plan's limiting age associated with legal guardianships (generally under age 26 or under the state-defined age of majority), provided he or she legally resides with you in a parent-child relationship and qualifies as your dependent for tax purposes.
- An eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order or a National Medical Support Notice, including a judgment, decree, or order issued by a court of competent jurisdiction, or an order issued through an administrative process that has the force and effect of law under applicable state law.

Proof of Dependent Status. WSHG reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. Documents requested may include (but are not limited to) copies of birth certificates, court orders, domestic partnership affidavits/registration certificates, divorce decrees or marriage certificates as needed to establish dependent status. Dependent eligibility determinations made by WSHG shall be final, binding and conclusive on all parties claiming an interest in the Plan.

Dual Coverage Prohibited. Except as specifically provided otherwise in an applicable Component Plan's Benefit Documents, in no event will an employee be covered under a Component Plan as both a participant and a dependent, or a dependent be covered under a Component Plan as a dependent of more than one participant.

Rehire Rule

An employee who is rehired prior to the end of a certain period of time after date of termination may be credited with hours of service met towards the eligibility waiting period during his or her preceding period of employment. If applicable, the Benefit Documents for each Component Plan will set forth the specifics for such rehire rules. Otherwise, a terminated employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and participation requirements for his or her employment class.

Summary of Material Modifications

To: **Participants**

From: **Human Resources**

Re: **Amendment to the Wall Street Holding Group, Inc. Health and Welfare Plan**

Effective Date: **January 1, 2024**

This Summary of Material Modifications (SMM) describes changes to the Wall Street Holding Group, Inc. Health and Welfare Plan (Plan) and supplements or modifies the information presented in your Summary Plan Description (SPD) with respect to the Plan. You should keep this SMM with the Plan's SPD and associated benefits documents provided to you upon enrollment in each benefit plan.

Changes to the Plan Provisions

Notwithstanding any provision contained in the Plan to the contrary, the Plan is amended as follows.

1. **Plan Year Change.** The Plan's Plan Year has been changed. There shall be a short Plan year from April 1, 2023, to December 31, 2023; thereafter, the Plan Year shall be from January 1 to December 31 of the same calendar year.

2. **Revised Eligibility and Participation Requirements**. The table set forth in your SPD's Appendix C, "Eligibility and Participation Requirements," is amended by replacing it in its entirety with the following:

Employee Class	Line(s) of Coverage	Effective Date of Eligibility (Waiting Period)	Working Hours Requirement
Full-Time Employees	All benefits listed on Appendix A	First day of the month following 60 days of employment	30 hours per week

Certain Component Plans may delay the effective date of your eligibility if you are not "actively-at-work" (e.g. at work performing all of the regular duties of your job). Any actively-at-work requirement imposed by a group health plan (as defined by HIPAA) will not apply if the reason you are not actively-at-work is due to a health condition.

All other Plan provisions remain unchanged so long as they are consistent with these material modifications.

For additional information regarding the Plan or to request a copy of the Plan's SPD contact:

Wall Street Holding Group, Inc.
220 Commerce, Suite 250, Irvine, CA 92602
Attn: Human Resources
714-829-1627 or benefitshelp@archtelecom.net

If this SMM was delivered to you by electronic means, you have the right to receive a paper copy of the SMM upon request.

Plan Information:

Plan Name: Wall Street Holding Group, Inc. Health and Welfare Plan
Plan Number: 501
Plan Year: April 1, 2023 to December 31, 2023; thereafter, January 1 to December 31 of the same calendar year