U.S. Employee Benefit Guide

January 2026

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Segal

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Section 1:
The Segal Company Staff Insurance Plan Summary Plan Description

This document, together with each of the benefits booklets and insurance contracts of coverage, constitutes the Summary Plan Description for the plan in accordance with the Employee Retirement Income Security Act of 1974.

Introduction

This SPD summarizes the major features of the benefits program for U.S. eligible employees of the Segal Group, Inc. (the "Company") and its subsidiaries as of January 1, 2023, with certain updates effective January 1, 2026. You should not rely on this information exclusively, as the terms of The Segal Company Staff Insurance Plan (the "Plan") are summarized in this document plus the applicable benefit booklets or insurance policies for each benefit under the Plan.

This SPD applies only to regular employees (it does not apply to a Special Project Worker (SPW) or Intern) of Segal within the continental United States who are scheduled to work at least 60% of their office's standard work hours. See "Eligibility" section of this SPD for more detailed information about who is an eligible employee.

This SPD is based on legal documents (such as Plan documents, benefit booklets and insurance contracts) currently in effect. As such, your rights are governed by the terms of this document and those legal documents. Any questions concerning the Plan shall be determined in accordance with the terms of the Plan document.

While every effort has been made to give you correct and complete information about your benefits, in the event of any conflict or inconsistency between this SPD and the Plan, the terms of the Plan will control. Where a conflict exists between this document and an insurance policy, the insurance policy will control, except to the extent the provisions of the insurance policy do not comply with applicable law, in which case this document will control.

This SPD contains a summary in English of your Plan rights and benefits under the Plan.

In addition, no person has the authority to make any oral or written statement or representation of any kind which is legally binding upon the Company that alters the Plan document or any legal document maintained in conjunction with the Plan.

The Company intends to continue the benefit programs as described in this SPD indefinitely but reserves the right, at its discretion, to change or even terminate all or any part of the benefits offered at any time and in any manner to the extent permitted by law. As a result, this SPD is not a contract, nor is it a guarantee of your benefits.

If the Company does modify or terminate any of the benefit programs offered, a subsequent SPD or Summaries of Material Modifications will be provided to advise you of any such modifications or termination, as required by ERISA.

Health Care/Flexible Benefits Programs

The Company offers a Flexible Benefits Program that lets you choose benefits based on your current needs. Using Company-provided Benefit Dollars (flex credits), plus your own contributions, you can purchase coverage from among a variety of health care and other benefit options. Benefit Dollars are provided to individual employees only; combining dollars for married employees is not allowed.

- **Medical coverage:** Aetna Preferred Provider Organization (PPO) Plan, High Deductible Health Plan (HDHP) with Health Savings Account (HSA), or in certain areas of the country an Exclusive Provider Organization (EPO) or Health Maintenance Organization (HMO). Both the Aetna PPO and HDHP with HSA plans use the Aetna Choice POS II Open Access network.
- **Dental coverage:** Preferred Provider Organization (PPO) Dental Plan through Guardian
- **Vision coverage:** Voluntary vision plan through VSP
- **Health Care Flexible Spending Account (HCFSA):** Employees contribute on a pre-tax basis to a designated account used to pay for out-of-pocket qualified medical expenses.
- **Dependent Care Flexible Spending Account (DCFSA):** Employees contribute on a pre-tax basis to a designated account used to pay for out-of-pocket qualified dependent day care expenses.
- **Life insurance coverage:** Basic Group Life, Supplemental Life, and Accidental Death and Dismemberment (AD&D).
- **Long-Term Disability (LTD) coverage:** Basic LTD, Additional Low Option LTD, and Additional High Option LTD.

What follows in this document is a brief description of our Flexible Benefit Program. Further details outlining the key aspects of the Plans along with additional information is provided in the individual booklet certificates issued by the insurance carriers, and posted on their websites as well as on SegalNet. Those booklets and/or certificates plus this document constitute the legal Summary Plan Description. The operation of the plans is legally governed by the official plan documents.

The Flexible Benefits Program is subject to change. This description does not create a contract between Segal and any employee. In order to meet its needs under changing conditions, the Company may, at its discretion at any time, terminate or modify the plans and the statements made in this summary.

Eligibility

Who is Eligible for Coverage under Segal Flexible Benefits Program?

If you are a regular employee (other than a Special Project Worker (SPW) or Intern) of Segal within the United States and you are scheduled to work at least 60% of your office's standard work hours, you are eligible for coverage under the Segal Flexible Benefits Program.

When Does Your Eligibility Begin?

You become eligible for coverage on the first of the month coinciding with or following your date of employment.

Example: Bob started working in our Boston office on June 14. Bob is eligible for Flexible Benefits Program benefits as of July 1 — the first of the month following his date of employment.

Are Your Dependents Eligible under the Flexible Benefits Program?

If you request coverage for your eligible dependents and, where applicable, authorize a before-tax payroll deduction for the required contribution, provide any required documents, and complete the process within the applicable enrollment window, your eligible dependents are eligible to be covered under the Flexible Benefit Program. Important: Please be sure to add your dependents as contacts in HRConnect so that later on in the enrollment process, you will be able to attach the applicable dependents to the applicable plan.

Under most plans, your "eligible dependents" include:

- Your spouse to whom you are legally married;
- Your Adult Children until the end of the month in which they turn age 26;
- Your unmarried Dependent Children over age 19 who are unable to support themselves because of physical, mental, or developmental disability; and
- Your spousal equivalent (see page 15).

"Dependent Children" are your own biological or adopted children, children placed with you for adoption, or any other child for whom you have legal guardianship.

Dependent eligibility under HMOs/EPOs may vary. Consult your HMO/EPO summary plan description for specific requirements.

When Are Your Dependents Eligible for Coverage?

Your dependents become eligible for coverage on the same date that you do.

Medical Coverage

Aetna PPO Plan

The Aetna PPO Plan (also known as Aetna Choice POS II or the "Plan") provides comprehensive medical coverage through in-network providers who are affiliated with the Plan

or through out-of-network providers who do not participate in the Plan's network. The Aetna PPO uses the Aetna Choice® POS II (Open Access) provider network. In-network preventive care is paid at 100%, with no coinsurance, no deductible and no copayment. Most other services are subject to the deductible first then 20% coinsurance or copay. It is important to note that the deductible applies to prescription drugs as well. There is a $1,000 employee only and $2,000 employee plus dependent(s) in-network deductible that must be satisfied for any coinsurance related procedures. The annual out-of- pocket expense limit for in-network services is $8,700 for employee only and $17,400 for employee plus dependent(s). Out-of-network services are subject to a $3,000 calendar-year deductible for employee only and a $6,000 calendar-year deductible for employee plus dependent(s). After you have met your deductible, you are subject to 40% coinsurance for covered expenses. The annual out-of-pocket expense limit for out-of-network services is $9,500 for employee only and $19,000 for employee plus dependent(s). Network doctors contract with Aetna to offer rates that are often much lower than their regular fees. This helps you save money on your healthcare expenses. The coinsurance, deductible, and out-of-pocket maximum amounts are higher for out-of-network services.

A complete description of benefits under the Aetna PPO Plan is available on Segal's benefits website, including the Aetna Medical Plan Booklet and Summary of Benefits and Coverage. The terms of the benefits and coverage will change from year to year.

With the Aetna PPO Plan, you can visit any doctor you choose, and you don't need a referral to see a specialist. Nor do you have to choose a primary care physician (PCP).

The Plan also features a prescription drug program through OptumRx, our pharmacy benefit manager "PBM". Please see the next section for details.

The choice of Aetna as Plan vendor is reviewed annually and is subject to change at any time.

Employee contributions are required and are based on salary and coverage tier. Cost-sharing is subject to change at any time.

Aetna High Deductible Health Plan (HDHP) with Health Savings Account (HSA)

The High Deductible Health Plan (HDHP) with Health Savings Account (HSA) is a high deductible plan. The HDHP allows you to contribute to an HSA (see HSA section of this Handbook). In-network preventive care is paid at 100%, with no coinsurance, no deductible and no copayment. All other services, including prescription drugs, are subject to the deductible, coinsurance, and/or copays. Your in-network provider will charge you the in-network contracted rate for non-routine/preventive services.

Then, after you pay an annual deductible of $1,850 for employee only or $3,700 for employee and dependent(s), covered expenses are subject to 10% coinsurance. The in-network maximum out-of-pocket limit is $4,750 for employee only and $9,500 for employee and dependent(s).

The HDHP also covers out-of-network expenses. The HSA may be used for out of network expenses as well. Out-of-network deductibles are higher, $4,750 for employee only or $9,500 for employee and dependent(s). Coverage for most out-of-network routine/preventive medical care and other covered medical services is subject to 40% coinsurance after the deductible. The

out-of-network out-of-pocket limit is $8,750 for employee only and $17,500 for employee and dependent(s).

The tax-advantaged HSA is what really sets the HDHP apart from other traditional medical plans. The HSA allows you to contribute money from your paycheck, tax-free, into your HSA to help cover your deductible and other qualified healthcare expenses. Segal also makes contributions to your HSA. With an HSA, you'll have the potential to build more savings for healthcare expenses or additional retirement savings through self-directed investment options. You will also have the ability to use your HSA funds to assist with paying providers until you meet your deductible and for the coinsurance and/or copays.

The Aetna HDHP with HSA uses the Aetna Choice® POS II (Open Access) provider network.

A complete description of benefits under the Aetna HDHP is available on Segal's benefits website, including the Aetna HDHP Medical Plan Booklet and Summary of Benefits and Coverage. The terms of the benefits and coverage will change from year to year.

The Plan also features a prescription drug program through OptumRx, our pharmacy benefit manager "PBM". Please see the next section for details.

The choice of Aetna as Plan vendor is reviewed annually and is subject to change at any time.

Employee contributions are required and are based on salary and coverage tier. Cost sharing is subject to change at any time.

Prescription Drug Coverage for Aetna PPO or HDHP Plan Participants

If you are participating in either the Aetna PPO or HDHP Plan, your prescription drug "Rx" coverage is NOT provided by Aetna, but rather by OptumRx, our Pharmacy Benefit Manager (PBM). Eligibility for the Rx program is the same as that for the medical program. As soon as you enroll for either of the Aetna medical plans noted above, you will also be enrolled in the OptumRx prescription drug program. **NOTE:** you will receive separate ID cards. Do not use your Aetna ID card for prescription drugs, rather, always use your OptumRx ID card for prescriptions.

A complete description of benefits under the OptumRx Prescription Drug Benefit is available on Segal's benefits website, including the Summary of Benefits and Coverage. The terms of the benefits and coverage will change from year to year.

Employee contributions are included in the medical plan contributions.

Prescription Plan Features

Network: OptumRx has a well-established national network of pharmacies through which you may fill prescriptions. If you use one of OptumRx's participating pharmacies, your out-of-pocket costs may be lower than if you use a non-participating pharmacy. You can obtain an up-to-date listing of participating pharmacies by visiting the OptumRx web site at www.optumrx.com. You can also call OptumRx at 866-837-9242. Be sure to register at the OptumRx website so that you have access to your medication information easily online, order renewals, print out ID cards, etc.

Claims and Appeals: Claims and appeals should be submitted to OptumRx at the address available through the website, telephone, or on your OptumRx prescription drug card.

See section 2 of this guide for further details on the OptumRx prescription plan.

The choice of OptumRx as PBM vendor is reviewed annually and is subject to change at any time.

Additional Health Plan Options

You may join an HMO or EPO if you live in the geographic service area of an HMO or EPO offered by the Company and complete the necessary enrollment. Managed care is provided through a primary care physician affiliated with the HMO or EPO. You must follow the HMO or EPO rules and, in most cases, use physicians and facilities affiliated with the HMO or EPO.

In general, all treatments recommended by your primary care physician, including preventive measures, are covered; however, there may be a copayment for each visit to a physician or for a particular service rendered. The HMOs and/or EPOs offered are reviewed annually and are subject to change at any time. HMO and EPO terms and conditions are governed by each individual HMO's or EPO's coverage booklet, available from your local HMO or EPO.

Employee contributions are required and are based on salary and coverage tier. Cost-sharing is subject to change at any time.

The choice of HMO and EPO vendors is reviewed annually and is subject to change at any time.

Dental Coverage

Under the Guardian Dental PPO Plan, comprehensive dental coverage can be obtained through in-network participating providers (offering discounted fees) or through out-of-network providers who do not participate in the Dental PPO's network.

The Dental PPO is self-insured and administered by Guardian. The Summary of Benefits is on SegalNet.

The choice of Dental PPO vendor is reviewed annually and is subject to change at any time.

Employee contributions are required and are based on salary and coverage tier. Cost sharing is subject to change at any time.

If you waive dental coverage and then elect dental coverage in a subsequent year, you will be enrolled automatically in the Transition Dental Plan. The Transition Dental Plan costs the same as the Dental PPO and you have the option to visit a participating or non-participating dentist. However, during the first year, the Transition Dental Plan only covers diagnostic, preventive and basic restorative services; major restorative services and child orthodontia are not covered. During open enrollment the following year, you will be automatically transferred to the full coverage Dental PPO.

Vision Coverage

The Company offers a voluntary Vision Plan that provides eye care and eyewear benefits. Employee contributions are pre-tax, and you can purchase a base plan or a buy-up plan through VSP Vision Care.

Employee contributions are subject to change at any time.

The choice of Vision Plan vendor is reviewed annually and is subject to change at any time.

See section 4 of this guide for further details on the Vision Plan.

Spousal Equivalent Coverage

Benefits coverage is available to same-sex and opposite-sex spousal equivalents of employees who meet criteria under the Segal Flexible Benefits Program. Qualified dependent children of your eligible spousal equivalent are also eligible for coverage.

Spousal Equivalent means an individual who meets the following criteria and completes an Affidavit of Spousal Equivalency as required by the Plan:

1. Provides the dates of the spousal equivalency;
2. Are each other's sole spousal equivalent and intend to remain so indefinitely;
3. Is not married to or legally separated from anyone else;
4. Is at least eighteen (18) years of age and mentally competent to consent to contract;
5. Is not related by blood closer than that which would otherwise prohibit legal marriage in the state in which they legally reside;
6. Resides together in the same residence and intend to do so indefinitely;
7. Is committed to the Eligible Employee's common welfare and, along with the Eligible Employee, is responsible for basic living expenses, demonstrated by providing at least three of the following:
    a. Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property;
    b. Common ownership of a motor vehicle;
    c. Driver's license listing a common address;
    d. Proof of joint bank accounts or credit accounts;
    e. Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under a partner's will;
    f. Assignment of a durable property power of attorney or health care power of attorney.

To enroll a spousal equivalent, you must first complete an Affidavit of Spousal Equivalency certifying certain criteria. To enroll a dependent child, you must certify that the child is claimed as an exemption on the most recent income tax return of either the employee or spousal equivalent and that a parent-child relationship exists between the employee and child.

Spousal equivalent medical coverage is available only under the Aetna PPO and HDHP plans and a limited number of HMOs and/or EPOs as well as the Dental and Vision plans.

The cost for enrolling a spousal equivalent and dependent children who do not qualify as IRS tax dependents is the same as it would be to cover any dependent under the medical, dental and vision plans, except that the cost must be paid on an after-tax basis and you will be taxed on imputed income for the dependent coverage premium paid by the Company. If, however,

your spousal equivalent or spousal equivalent's children qualify as your dependents for federal tax purposes, both your and the Company contributions can be made on a pre-tax basis and you are not subject to imputed income.

Employee Contributions to Medical, Dental, and Vision

When you elect coverage and authorize salary reductions, the Company will deduct your contribution for coverage from each paycheck before income taxes are withheld. Also, if you earn below the Social Security wage base, your contribution will be made before Social Security taxes (FICA) are withheld. This before-tax feature lowers your taxable income so that you save money on these payroll taxes.

Waiving Coverage

If you waive medical and/or dental coverage, you will not receive flex credits for the coverage.

If you waive medical coverage, you must certify in writing that you have coverage under another plan and meet any other standards required by the Company.

Enrollment

To become covered under any of the Flexible Benefits Program plans, you must complete the online enrollment process or required enrollment forms and provide any required documentation when you are first eligible and at annual enrollment.

Annual Enrollment

Once each year, usually for two weeks, in the October/November timeframe, the Company has an annual enrollment period. At that time, you may:

- Enroll, modify, or drop coverage;
- Add or drop dependents from coverage;
- Waive health coverage (the waiver must be re-certified annually); or
- Enroll in the Flexible Spending Accounts (enrollment does not carry over from year to year).

Benefit changes made during annual enrollment will become effective January 1 of the following calendar year. However, if EOI is still pending for life, AD&D or LTD insurance as of January 1, that coverage will take effect upon the approval of EOI rather than on January 1.

Your enrollment elections and any required documentation must be finalized by the date indicated in the annual enrollment materials. If elections are not made by that date, your current elections will remain in force for the following calendar year, except that you will not be able to contribute to the Health Care and Dependent Care Flexible Spending Accounts.

Special Enrollment

Under federal law, if you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in health plan coverage if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your

dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

In addition to the federal special enrollment rights, you may change your flexible benefit elections during the year only if you have a qualifying life event, and you must complete the change (including providing any necessary documentation) within 31 days of the qualifying life event.

Qualifying life events include:

- Marriage, divorce or legal separation;
- Birth, adoption or placement for adoption of a child;
- A court order to provide coverage for a dependent;
- A change in dependent eligibility;
- A change in your spouse's or your dependent's employment status, or the beginning or end of an unpaid leave of absence including under the Family and Medical Leave Act (FMLA);
- A change of residence or worksite that changes your eligibility for a health plan;
- Death of a spouse or dependent;
- Reduction in the number of hours of employment which changes your eligibility for coverage; or
- Loss of other health coverage due to any of the above events, termination of employer contribution, or cessation of COBRA Continuation Coverage.

Any changes you make to your benefits must be necessary, appropriate to and consistent with the change in status.

You may change your benefit elections under the following additional circumstances:

- Entitlement to Medicare;
- Gain or loss of coverage under Medicaid or CHIP; or
- Significant change in the cost of coverage.

To request special enrollment or obtain more information, visit https://segalco.sharepoint.com/sites/segalnet-human-resources-benefits/SitePages/Life-Events.aspx

Termination of Coverage

Your eligibility for coverage under the Flexible Benefits Program will end on the last day of the month in which one of the following events occur:

- You are no longer eligible for coverage;
- Your employment terminates;

- You cease to make any contribution required for your coverage; or
- The program or benefit plan terminates.

Coverage under the Flexible Benefits Program for your dependents will end if:

- Your coverage ends;
- During annual enrollment or a special enrollment you drop dependent coverage;
- Your dependent no longer qualifies as an eligible dependent;
- The program or benefit plans no longer provide coverage for dependents;
- Your dependent becomes covered as an employee;
- You cease to make any contributions required for this coverage;
- You die; or
- The program or benefit plans terminate.

Under certain circumstances when coverage for you and for your dependents would otherwise end, you or they may be eligible to continue coverage under certain plans.

What happens to your medical and dental coverage when you reach age 65?

If you remain an employee of Segal when you reach age 65, your medical and dental benefits will remain the same as they were before you reached age 65. If you retire, your benefits may change as outlined on page 27.

Health Care Flexible Spending Account (HCFSA)

A Health Care Flexible Spending Account (HCFSA) allows employees to contribute pre-tax for certain unreimbursed qualified health expenses for you and eligible dependents. Eligible expenses may include plan deductibles and copayments and certain unreimbursed health care expenses, as well as other items that are qualified medical expenses as referenced in IRS Publication 969.

Your contribution to the HCFSA is deducted from your pay before Social Security, federal and in most cases; state and local income taxes are calculated.

There are two HCFSAs offered: a full HCFSA and a limited-purpose HCFSA. You may elect coverage in the full HCFSA if you participate in any medical plan offered by the Company or elsewhere other than an HDHP, or if you waive medical coverage. You may elect coverage in the limited-purpose HCFSA if you participate in an HDHP offered by the Company.

Subject to non-discrimination testing rules, you can choose to contribute each calendar year on a before-tax basis from $120 to $3,300 in 2026 (subject to change each year).

Only expenses incurred in the calendar year can be reimbursed. Unused balances over 20% of the annual maximum will be forfeited; balances up to 20% of the annual maximum will roll over to the next calendar year. Claims must be submitted no later than March 31 of the following year.

Once you establish a HCFSA, you cannot stop contributions during the year unless you experience certain qualifying life events. (See Special Enrollment for more information).

Dependent Care Flexible Spending Account (DCFSA)

A Dependent Care Flexible Spending Account (DCFSA) allows employees to contribute pre-tax for certain qualified dependent day care expenses, for example, the cost of caring for your eligible child or elder dependents so that you (and your spouse, if married) can work. Eligible expenses are located in IRS Publication 503.

Your contribution to the DCFSA is deducted from your pay before Social Security, federal and in most cases; state and local income taxes are calculated.

You can establish a DCFSA each calendar year to pay for eligible expenses you have during that year. Subject to nondiscrimination testing rules, you can choose to contribute up to $7,500 each calendar year for expenses incurred during the calendar year. Unused balances are forfeited three months after the end of the calendar year. If your spouse also contributes to a DCFSA, your combined contributions to both your and your spouse's DCFSA cannot exceed $7,500 for the calendar year.

You should consult with a tax advisor to determine if your tax savings would be greater from a DCFSA or the dependent care tax credit.

Once you establish a DCFSA, you cannot stop contributions during the year unless you experience certain qualifying life events. (See Special Enrollment for more information).

WEX

WEX is the administrator of our HCFSAs and DCFSA. The choice of HCFSAs and DCFSA Plan vendor is reviewed annually and is subject to change at any time.

Health Savings Account (HSA)

If you are enrolled in the Company's HDHP, you may set up an HSA. An HSA is a tax-exempt account to pay or reimburse certain medical expenses you incur, for example, the deductible under the HDHP. If you are enrolled in Medicare or a health plan that is not an HDHP, you are not eligible to contribute to an HSA.

The Company contributes to the HSA for you; $750 annually for employee only or $1,500 annually for employee and dependent(s), on a per-pay-period basis. The Company contribution is pro-rated if you are enrolled in the HDHP for less than the full year. You may also make contributions to the HSA while you are covered under the HDHP. The total Company and employee contributions are limited to a maximum amount established and subject to change each year.

You own your HSA account and any unused HSA funds roll over and accumulate from year to year and remain in your account even if you terminate employment with the Company.

WEX is the administrator of the HSA. The choice of HSA administrator is reviewed annually and is subject to change at any time.

Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance

Segal offers two life insurance options: Basic Group Term Life Insurance and Supplemental Life Insurance. Segal also offers an Accidental Death and Dismemberment (AD&D) Insurance option.

Basic Group Term Life Insurance

Basic Group Term Life Insurance is provided by the Company at no cost to you. You may elect coverage equal to one times annual salary rounded to the next higher $500 up to a maximum of $50,000, or coverage equal to a flat $5,000. Your earnings used to determine your basic life coverage amount is your annual salary rate as of October 1 of the prior calendar year and bonuses paid from the Annual Incentive Plan (AIP) as of October 1 of the prior year as follows:

- Up to $40,000 of the bonus paid
- Plus 50 percent of bonuses over the first $40,000

If you elect coverage of one times salary, your insurance will, where applicable, automatically increase each January 1, to reflect salary increases to a maximum covered salary of $50,000.

On the January 1 following your 65th birthday, the amount of your Basic Term Life Insurance coverage will be reduced as follows:

At Age…	Coverage Reduces To…
65	65% of the amount then in effect
70	40% of the amount then in effect
75	25% of the amount then in effect

Coverage, however, will be reduced to no lower than $10,000.

Supplemental Group Life Insurance

If you elect Basic Group Term Life Insurance of one times salary (to a maximum of $50,000), you may purchase supplemental life insurance for you and your spouse or spousal equivalent and/or children. This plan is administered by The Hartford and The Hartford requires that you enroll for supplemental life insurance coverage at https://thehartford.com/benefits/enroll.

Supplemental life allows you to purchase large amounts of insurance protection at economical group rates and provides you with portability if you leave the Company. Rates are established according to age and whether you are a smoker or a non-smoker.

The Company will provide you with flex credits which you can use towards the purchase of the first one times your salary of non-smoker Supplemental life coverage. Supplemental life may only be purchased on an after-tax basis.

Your earnings used to determine your supplemental life and AD&D coverage amount is your annual salary rate as of October 1 of the prior calendar year and bonuses paid from the Annual Incentive Plan (AIP) as of October 1 of the prior year as follows:

- Up to $40,000 of the bonus paid

- Plus 50 percent of bonuses over the first $40,000

You can purchase Supplemental life coverage for you, your spouse or spousal equivalent and/or your dependent children. Coverage remains in effect as long as premiums are paid and, if you leave the Company, you can elect to continue coverage.

For You: You may purchase Supplemental life coverage in increments of $10,000 to a maximum of the lesser of four times your earnings or $1,000,000 in coverage. Coverage up to $400,000 is guaranteed without medical evidence of insurability for employees enrolling under the Flexible Benefits Program when first eligible. Current participants in the Flexible Benefits Program who wish to increase their coverage or who previously waived Supplemental life coverage and now want to elect coverage are subject to evidence of insurability.

For Your Spouse/Spousal Equivalent: You may purchase life insurance coverage of up to the lesser of 50% of your coverage or $50,000, in $10,000 increments for spouse or spousal equivalent Supplemental life coverage. Coverage of $10,000 is guaranteed without evidence of insurability if you are electing spouse or spousal equivalent Supplemental life under the Flexible Benefits Program when first eligible for the coverage. If both the employee and spouse or spousal equivalent are employed by Segal, they may elect coverage as an employee or spouse, but not as both.

For Your Dependent Children: If you elect Supplemental life for yourself and/or your spouse or spousal equivalent, you may purchase children's life insurance coverage of $10,000 for each dependent child. Children must be live birth to age 26 to be eligible.

At age 65, your basic and any supplemental life coverage will be reduced to 65% of the amount then in effect, to 40% at age 70 and to 25% at age 75. Any spouse life coverage is subject to the same reductions based on age. Life insurance coverage ends at termination of employment, and you will have the opportunity to convert to an individual plan.

Accelerated Benefit

If you become terminally ill with a life expectancy of 12 months or less and are under age 60 you can request an accelerated benefit amount of 25% of the amount of insurance or $50,000 if less and a maximum of $500,00 not to exceed 80% of your amount of life insurance. The money is paid out in a lump sum. You must request in writing that a portion of your life insurance be paid as an accelerated benefit and submit satisfactory proof of the terminal illness to The Hartford.

Electing a Beneficiary

Your life insurance will be paid after your death to the beneficiary you name.

You may change your beneficiary at any time and, if you choose, you may name different beneficiaries for the basic life and Supplemental life policies. To name a beneficiary for basic life, you must complete and return the appropriate beneficiary designation form available from SegalNet. To name a beneficiary for the Supplemental life, you do so at https://thehartford.com/benefits/enroll.

Continuation of Your Life Insurance Coverage During Disability

Waiver of premium is a provision which allows you to continue your and your dependents' life Insurance coverage without paying premium if you become disabled. If you qualify for waiver of premium, your basic life, supplemental life and dependent life insurance coverage may continue under certain conditions, subject to waiver of premium acceptance by the insurance company. To qualify for waiver of premium you must:

- be covered under the policy and be under age 60;
- be disabled and provide proof of loss that you have been:
  - disabled for 9 consecutive months, starting on the date you were last actively at work; or
  - diagnosed with a life expectancy of 12 months or less; and

provide such proof within one year of your last day of work as an active employee.

Coverage for Retirees and Those Who Terminate From the Company

If you leave the Company due to termination of employment or retirement, or if you go on a personal leave of absence, your medical, dental, and/or vision coverage will stop at the end of the month in which you leave the Company. If you are on an approved Family and Medical Leave, you may elect to continue coverage throughout the leave. You may be eligible to convert or port your basic group term life insurance coverage directly with the insurance company.

Application and payment of the first premium must be made within 31 days of the date your group insurance ends. Forms for continuing life insurance will be mailed to you directly by the insurance company.

Accidental Death and Dismemberment (AD&D)

You can purchase Supplemental AD&D coverage for you, your spouse or spousal equivalent and/or your dependent children. Coverage remains in effect as long as premiums are paid and, if you leave the Company, you can elect to continue coverage.

For You: You may purchase Supplemental AD&D coverage in increments of $10,000 subject to 1, 2, 3 or 4 times your earnings, to a maximum of $1,000,000 coverage. Coverage up to the lesser of three times salary or $400,000 coverage is guaranteed without medical evidence of insurability for employees enrolling under the Flexible Benefits Program when first eligible. Current participants in the Flexible Benefits Program who wish to increase their coverage as a multiple of salary or who previously waived Supplemental AD&D coverage and now want to elect coverage are subject to evidence of insurability.

For Your Spouse/Spousal Equivalent: You may purchase supplemental AD&D coverage of up to the lesser of 50% of your coverage or $50,000, in $10,000 increments for spouse or spousal equivalent coverage. Coverage of $10,000 is guaranteed without evidence of insurability if you are electing spouse or spousal equivalent supplemental AD&D under the Flexible Benefits Program when first eligible. If both the employee and spouse or spousal equivalent are employed by Segal, they may elect coverage as an employee or spouse, but not as both.

For Your Dependent Children: If you elect Supplemental AD&D for yourself and/or your spouse or spousal equivalent, you may purchase children's AD&D coverage of $10,000 for each dependent child. Children must be live birth to age 26 to be eligible.

At age 65, any AD&D coverage will be reduced to 65% of the amount then in effect, to 40% at age 70 and to 25% at age 75. Any spouse AD&D coverage is subject to the same reductions based on age. AD&D coverage ends at termination of employment, and you will have the opportunity to convert to an individual plan.

Long-Term Disability Benefits (LTD)

Eligibility

If you are a regular full-time or part-time employee (other than a Special Project Worker (SPW) or Intern) working at least 60% of your office's standard work hours, you are eligible for coverage under the Company's long-term disability plan. Benefits are paid after you have been totally disabled for 180 days.

The following LTD coverage options are available:

- Basic LTD;
- Basic LTD & Additional Low Option Coverage; or
- Basic LTD & Additional High Option Coverage.

Basic LTD Coverage

The Company considers the income protection offered by the LTD coverage too important to allow employees to waive coverage unless adequate LTD coverage is provided through another source. For that reason, Basic LTD coverage is provided by the Company at no cost to you.

Basic LTD coverage replaces 50% of your annual covered salary to a maximum covered salary of $60,000 (a maximum monthly gross benefit of $2,500).

LTD Coverage Alternatives

Since the Basic LTD level may not be right for everyone, the Company's Flexible Benefits Program provides you with higher LTD coverage levels from which you may choose. Your cost for this additional coverage depends on your age each January 1 and is indicated online in your personalized enrollment worksheet.

Additional Low Option Plan

The Additional Low Option Plan replaces 50% of your annual covered salary above $60,000 up to a maximum covered salary of $180,000. The incremental cost difference between the Basic LTD Plan and the Additional Low Option Plan will be deducted from your paycheck throughout the year.

Additional High Option Plan

The Additional High Option Plan replaces 60% of your annual covered salary up to a maximum covered salary of $200,000. The incremental cost difference between the Basic LTD Plan and the Additional High Option Plan will be deducted from your paycheck throughout the year.

Before-Tax and After-Tax Purchase Option

Benefits received under Basic LTD are generally **taxable** if coverage is purchased on a *before-tax basis* and **non-taxable** if purchased on an *after-tax basis*. Your coverage contributions will be before-tax unless you elect for them to be after-tax. Under the Additional Low and High Option Plans, you pay for coverage on an after-tax basis.

Annual Covered Earnings

Your benefits under the LTD Plan are based on your annual covered earnings. Your earnings used to determine your LTD and supplemental LTD coverage amount is your annual salary rate as of October 1 of the prior calendar year and bonuses paid from the Annual Incentive Plan (AIP) as of October 1 of the prior year as follows:

- Up to $40,000 of the bonus paid
- Plus 50 percent of bonuses over the first $40,000

Please see the Leaves of Absence section of the Employee Handbook for more information about LTD benefits.

Wellness Programs

Lyra Health

With Lyra Health, you and your eligible family members can enjoy up to **eight free short-term therapy or coaching sessions each year**. Clinical services include therapy treatment of psychological and psychiatric disorders, individual psychotherapy, marital and couples counseling, family therapy, group therapy, and psychiatric medication evaluation and management. The Lyra Care Navigation Team will help triage your issues, matching you with the right behavioral health or counseling provider, scheduling appointments, answering your questions, and assisting you with accessing educational materials. Lyra's Concierge Advanced Care will help search for the most appropriate higher level of behavioral health care (ex. facilities or intensive outpatient care).

Lyra Learn is an e-learning platform with evidence-based interactive mental health courses. There are on-demand courses about mental health topics such as curing burnout and managing stress. Lyra also offers a library of self-care resources including meditations, videos and tactics, and a mobile app to access Lyra.

Lyra Gather is a group discussion safe space led by mental health experts.

Work-life services are also available, such as:

- Legal Consultations
  - 30 minute free consultation per issue with an attorney or mediator and a 25% discount on ongoing services
  - 24/7 emergency services
  - Easy-to-use legal forms, documentation preparation and online legal library
- Identity Theft Support
  - 60 min free consultation with a Fraud Resolution Specialist
  - Assists members with restoring their identity and good credit
  - Free ID theft emergency response kit
- Work, Family and Everyday Life
  - Child, elder and pet care consultations, resources, and referrals
  - 24/7 access to services online or by phone
  - Online library of educational resources
- Financial Consultations
  - 30 minute free consultation with experienced financial counselor per issue
  - 30 minute free consultation on income tax planning, and a 25% discount on the CPA's normal fee for document preparation
  - Online financial library
- New in 2026:
  - Housing options and home ownership support
  - Financial assistance and budgeting help
  - Moving and relocation resources
  - Event planning
  - Retirement adjustment guidance
  - Distance caregiving support
  - Elementary, middle, and high school search
  - College search and financing guidance
  - GED and vocational school resources
  - Tutors and test preparation
  - Recreational activities and leisure travel planning

International employees have variations in work-life services:

- Unlimited access to legal and financial information and services (subject to availability, whereas these services are limited in the U.S.)
- Family/Childcare referral services (but not pet care referral services) are available.

Sign up or log in to Lyra Health at segal.lyrahealth.com or call Lyra Health at 833-511-0845.

Canadian employees can call Lyra Health at 1-800-874-3817.

Everyday Well-Being Program

The Everyday Well-being program consists of general everyday well-being, student loan repayments, and home purchase reimbursements.

As a regular employee who is regularly scheduled to work at least a 60% schedule of your office's standard work hours, you are eligible for the everyday well-being program after **90 days of benefits-eligible service.** You have until March 31 of the following year to file a request for reimbursement for a home purchase in the prior year. The amount reimbursed is considered taxable income to you at the time of reimbursement and will be reduced by the necessary taxes before payment is made to you.

General Everyday Well-being

The Everyday Well-being program provides reimbursements for up to $600 per year for eligible full-time employees and $360 for eligible part-time employees for any combination of eligible expenses related to:

- Healthy living
- Childcare or eldercare
- Adoption
- Financial planning
- Legal assistance
- Funeral services for an immediate family member

Submit claims directly to WEX using the instructions found in the Everyday well-being program description link above.

If you are an international employee, use the Everyday Well-being claim form to request reimbursement.

Student Loan Repayment

If you are a full-time employee, Segal will reimburse you up to $500 per year—up to $2,500 total—to help pay back your student loans. Part-time employees may be reimbursed up to $300 per year for a total of $1,500.

The reimbursement may not be used for parent loans or for parents who cosigned on a student loan.

Submit claims directly to WEX using the instructions found in the Everyday well-being program description.

If you are an international employee, use the Student loan repayment claim form to request reimbursement.

Home Purchase Reimbursement

Buying a home can be an exciting time, and it almost always comes with a long list of expenses, from closing costs and transaction fees to paying for movers and new housewares. If you are a full-time employee, Segal will celebrate your new home with a reimbursement of $1,000 toward the purchase of your primary residence. Part-time employees may receive $600.

You may receive the home purchase reimbursement once during your time at Segal.

Submit claims directly to WEX using the instructions found in the Everyday well-being program description.

If you are an international employee, use the home purchase reimbursement claim form to request reimbursement.

The Resolutions Program

The Resolutions Program provides a reward for completion of a health assessment. Health assessments provide both you and your health care plan with important information about your health. More importantly, the assessment is about you and for you—giving insight into your current state of health, what you're doing right, and what you can do to improve your health. All information is kept confidential by the health plan, and is not disclosed to Segal.

- Complete the health assessment offered by your health plan and receive up to $100 per calendar year
- Have your spouse/spousal equivalent complete one, too, and receive up to $50 per calendar year

Payments are considered taxable income to eligible employees.

Segal U.S. regular employees (excluding temporary Special Project Workers and Interns) regularly scheduled to work at least 60% of their office's standard work hours and with at least 90 days of benefits-eligible service are eligible for the Resolutions Program.

The maximum reward for any eligible employee under the Resolutions Program in a single calendar year is $150 if full-time or $90 if part-time, comprised of a maximum $100 for your completion of a health assessment if you're full-time or $60 if you're part-time and $50 for your spouse/spousal equivalent completion of a health assessment if you're full-time or $30 if you're part-time.

Complete the Resolutions Program Reward Application and submit it along with the required supporting documentation by email to Janet Arce and Winnie Tang in HR – Benefits. The deadline for submission of an application for a reward for health assessment completed in any calendar year is December 31 of that calendar year.

Burnalong

Register for Burnalong to access thousands of live and on demand classes and wellness programs spanning physical, mental and financial wellness. Get motivation from friends and family members you invite to join in. Receive AI-powered guidance plus access anytime,

anywhere. To activate your free Burnalong account complements of Segal, go to https://join.burnalong.com/segal.

Burnalong+

You can also upgrade your membership and gain access to participating fitness locations for a flat monthly rate, currently $29. You could visit multiple gym locations with one subscription and try any participating gym.

Health and Dental Coverage after Retirement

What happens to your medical and dental benefits when you retire?

Your medical and dental coverage under the Company's Active Plan will continue until the end of the month in which you terminate (retire from) employment. At retirement, if you meet the age and service criteria, you will be eligible for coverage under the Company's Retiree Health Plan. The Retiree Health Plan is a retiree-only plan and is separate from the Active Plan. The following is a general description of the Retiree Health Plan, but for complete details consult the Retiree Health Plan Document.

The eligibility criteria is:

- You retire from active service from the Company on or after your 55th birthday and are eligible to receive either an Early Retirement Pension or a Normal Retirement Pension from The Pension Plan of The Segal Company, and
- You were eligible to participate in the health plan under the Segal Flexible Benefits Plan prior to your retirement from the Company.

The Retiree Health plan provides eligible retirees with benefit credits that may be used either:

1. To offset the cost of health coverage purchased through the Company, or
2. Solely as a Medical Expense Reimbursement Account (MERA) to reimburse you for qualified medical expenses related to your health care.

Benefit credits are calculated at $100 for each full year of service, up to a maximum of 25 years or $2,500. No benefit credits are provided for partial years of service. Benefit credits are pro-rated in the 1st year of retirement if you retire other than on January 1. Only eligible spouses and dependents covered at the time of your retirement are eligible for coverage under this plan. At the time of retirement, you must elect to receive either benefit credits which offset the cost of coverage purchased through the Company or the MERA. Further information concerning the retiree health plan, including what happens when the retiree dies, is available in the Retiree Health Plan document.

The Retiree Health Plan of Segal, any of the health and dental coverage options offered, and the statements made in this information are subject to change or termination at any time for any reason. This information does not create a contract between Segal, Inc., and any retiree, surviving spouse or dependent.

Important Legal Notices

Women's Health and Cancer Rights Act of 1998 Annual Notification

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy.

If WHCRA applies to you and you are receiving benefits in connection with a mastectomy and you elect breast reconstruction, coverage must be provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.

Such coverage may be subject to annual deductibles, copays and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

Newborns' and Mothers' Health Protection Act Statement of Rights

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Your group health plan cannot require you to get permission (sometimes called prior authorization or precertification based upon medical necessity) for a 48-hour or 96-hour hospital stay because the plan claims that you, or your attending provider, have failed to show that the 48-hour stay (or 96-hour stay) is medically necessary. However, plans generally can require you to notify the plan of the pregnancy in advance of an admission in order to use certain providers or facilities or to reduce your out-of-pocket costs.

Your group health plan may impose deductibles or other cost-sharing provisions for hospital stays in connection with childbirth if the deductible, coinsurance, or other cost-sharing for the latter part of a 48-hour (or 96-hour) stay is not greater than that imposed for the earlier part of

the stay. For example, with respect to a 48-hour stay, a group health plan is permitted to cover only 80% of the cost of the hospital stay. However, a plan covering 80% of the cost of the first 24 hours could not reduce coverage to 50% for the second 24 hours.

For information on pre-certification, please refer to your medical plan Summary Plan Description (SPD).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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 for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in certain states, you may be eligible for assistance paying your employer health plan premiums. Contact your State for more information on eligibility.

For more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)
Menu Option 4, Ext. 61565

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323

COBRA–Continuation of Healthcare Coverage

In compliance with a federal law commonly called COBRA, the Flexible Benefits Program provides that you can elect temporary continuation of health care coverage for yourself and your eligible dependents under certain circumstances, which would normally cause coverage to end. Your eligible dependents include your dependents who were covered under the plan when a qualifying event occurs and a child who becomes a dependent by birth, adoption or placement for adoption during a period of COBRA continuation of coverage. You or your eligible dependents may choose to continue medical, dental, vision and health care flexible spending account coverage under COBRA if a COBRA qualifying event occurs. COBRA continuation benefits are identical to the medical, dental, and vision coverage currently provided for you and your family by Segal. You or your dependents will be required to pay 102% of the premiums for this coverage, or 150% of the premium during an extension after a Social Security determination of disability.

You do not have to show evidence of good health in order to continue coverage under COBRA. However, you must pay all of the premiums from the date of the qualifying event. Premiums are payable in advance by the 1st of each month. See discussion below, “Paying for COBRA coverage.”

COBRA Qualifying Events

You and/or your eligible dependents have the right to extend coverage for up to 18 months if coverage ends because:

- Your employment ends for any reason other than gross misconduct; or
- You do not work the required number of hours to maintain participation in the Company health insurance benefits program.

In no case are you entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or if you have a reduction in hours (unless you are entitled to an additional COBRA Continuation Coverage period on account of Social Security disability or due to state regulation). As a result, if you experience a reduction of hours then have a termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the date of the initial qualifying event.

Your spouse has the right to this extended coverage for up to 36 months if his or her coverage would otherwise end because:

- You are legally divorced or separated;
- You die; or
- You become entitled to Medicare.

Your dependent children have the right to this extended coverage for up to 36 months if their coverage would otherwise end because:

- They are no longer considered dependents because they reach age 26;
- You and your spouse become legally divorced or separated;
- You die; or

- You become entitled to Medicare.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Company, and the bankruptcy results in the substantial loss of coverage of any retired employee covered under the Plan, the retired employee will become eligible to elect COBRA. A spouse, surviving spouse or dependent child will also be eligible to elect COBRA if they also have a substantial loss of coverage. If elected, your COBRA coverage will extend until your death. Your dependents COBRA coverage will extend until 36 months after your death.

Procedure for Notifying Segal and the COBRA Administrator of Certain Events

It is your responsibility to inform the Company and the COBRA Administrator when certain qualifying events occur.

You must provide the Human Resources–Benefits Department and the COBRA Administrator notice of the following qualifying events:

- Your divorce or legal separation.
- If a child loses or ages out of coverage under the plan as a dependent.
- The occurrence of a second qualifying event after you have become entitled to COBRA with a maximum of 18 (or 29) months. This second qualifying event could include your death, divorce or legal separation or child losing dependent status.

In addition to these qualifying events, there are two other situations where you are responsible for providing the COBRA Administrator with notice:

- When you or your eligible dependents entitled to receive COBRA coverage with a maximum of 18 months, have been determined by the Social Security Administration to be disabled. This determination could extend COBRA coverage an additional 11 months.
- When the Social Security Administration determines that you or your eligible dependents are no longer disabled.

If you are providing notice due to a divorce or legal separation, a dependent losing eligibility for coverage or a second qualifying event, you must send the notice no later than **60 days** after the event.

If you are providing notice of a Social Security Administration determination of disability, notice must be sent no later than **60 days** after the later of (1) the date of the disability determination by the Social Security Administration; (2) the date of the qualifying event; or (3) the date on which the qualified beneficiary would lose coverage under the plan due to the qualifying event.

If you are providing notice of a Social Security Administration determination that you are no longer disabled, Notice must be sent no later than 30 days after the date of the determination by the Social Security Administration that you are no longer disabled

You must make sure that the Human Resources–Benefits Department and the COBRA Administrator are notified of any of these occurrences listed above. Failure to provide this notice

within the form and timeframes described will prevent you and/or your dependents from obtaining or extending COBRA coverage.

Notice of any of the situations listed above must be provided in writing. You may send the COBRA Administrator the following information: your name, which of the events listed above you are providing notice, and the date of the event. Written notice may be provided by either you or any of your eligible dependents.

Notice should be sent to the following address:

COBRA Participant Services:
Email: cobraadmin@discoverybenefits.com
Fax: 888-408-7224

Payment Processing Center address:
Wex Benefits Inc.
Post Office Box 2079
Omaha, NE 68103-2079

While other Company officials will ordinarily notify the Human Resources–Benefits Department of your death, termination of employment, reduction in hours, or entitlement to Medicare, you or your dependents also need to alert the Human Resources–Benefits Department and the COBRA Administrator promptly, to avoid confusion over the status of your health coverage.

How to Elect COBRA

Once the Company and the COBRA Administrator are properly notified of a qualifying event, you will be notified in writing whether you have an approved right to choose continuation coverage. If you are eligible for COBRA coverage, this notice will be in the form of an Election Notice. This Election Notice will include the date on which your coverage ends and the information and form needed to elect COBRA continuation coverage. Where you or your dependents have provided notice to the Human Resources–Benefits Department and the COBRA Administrator of a divorce or legal separation, beneficiary ceasing to be covered under the plan as a dependent, or a second qualifying event but are not entitled to COBRA, instead of an Election Notice, the COBRA Administrator will send you a written notice stating that COBRA coverage is not available, with the reason why you are not eligible for COBRA.

Under the law, you and/or your covered dependents will then have only **60 days** from the date you or they receive the Election Notice to apply for COBRA Continuation Coverage.

If you and/or any of your covered dependents do not choose COBRA continuation coverage within 60 days after receiving that notice, you and/or they will not have any group health coverage from this plan after coverage initially ended.

Each eligible dependent has an independent right to elect COBRA. COBRA Continuation Coverage may be elected for some members of the family and not others. In addition, one or more covered dependents may elect COBRA even if you do not elect it.

The COBRA Continuation Coverage That Will Be Provided

If you choose COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will be made in your COBRA Continuation Coverage.

COBRA Coverage in Cases of Social Security Disability

If you, your spouse, or any of your covered dependent child(ren) are entitled to COBRA coverage for an 18-month period, that period can be extended for the Covered Person who is determined to be entitled to Social Security Disability Income benefits, and for any other covered family members, for up to 11 additional months (for a total of 29 months) if all of the following conditions are satisfied:

- The disability occurred on or before the start of COBRA coverage, or within the first 60 days of COBRA coverage;
- The disabled Covered Person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration; and
- The COBRA Administrator must be notified by you or by the disabled Covered Person or another family member that the determination was received. See section “Procedure for Notifying Segal and the COBRA Administrator of Certain Qualifying Events” for the information on providing this notice.

This extended period of COBRA coverage will end at the **earlier** of:

- The last day of the month, 30 days after Social Security has determined that you and/or your eligible dependent(s) are no longer disabled;
- The end of 29 months from the date loss of coverage due to the COBRA qualifying event; or
- The date the disabled individual becomes entitled to Medicare.

You must also notify the COBRA Administrator in writing if you or your dependents receive extended coverage due to a Social Security determination of disability, and the Social Security Administration later determines that you are no longer disabled. See section “Procedure for Notifying Segal and the COBRA Administrator of Certain Qualifying Events” for information on providing this notice.

Paying for COBRA Coverage

Individuals who continue full coverage under COBRA pay 102% of the Plan’s cost, on an after-tax basis, except in cases of extended COBRA coverage due to Social Security disability. If the 18-month period of COBRA Continuation Coverage is extended because of Social Security disability, the Plan will charge members and their families up to 150% of the cost of coverage for the COBRA family unit that includes the disabled person for the 11-month Social Security

disability extension period. Any family units that do not include the disabled person will be charged 102% of the cost of coverage.

The COBRA Administrator will notify you of the cost of the coverage at the time you receive your Election Notice, and of any monthly COBRA premium amount changes. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

If you elect COBRA, you do not have to send any payment with the Election Form. There will be an initial grace period of 45 days to pay the first amount due starting with the date COBRA coverage was elected. This is the date the Election Notice is post-marked, if mailed. If this payment is not made when due, COBRA Continuation Coverage will not take effect.

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. Each of these periodic payments are due on the 1st day of each month. The COBRA Administrator will not send you periodic notices of payments due for these coverage periods. Although periodic payments are due on the dates shown above, there will then be a grace period of 10 days after the first day of the coverage period to pay these monthly payments. If payment of the amount due is not made by the end of this grace period, your COBRA coverage will terminate.

Payment is considered made when postmarked.

Confirmation of Coverage to Health Care Providers

Under certain circumstances, federal rules require the COBRA Administrator to inform your health care providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule is applicable under the following two circumstances.

- If a health care provider requests confirmation of coverage during the COBRA election period, and you, your spouse or your dependent child(ren) have not yet elected COBRA continuation coverage, then the COBRA Administrator will give a complete response to the health care provider about you and your dependents' COBRA continuation rights during the election period.

  For example, the Plan cancels your and your dependents' coverage as of the date coverage ends under the Plan. However, the Plan retroactively reinstates your coverage once COBRA continuation coverage is elected. If you have not yet elected COBRA, the COBRA Administrator will inform the health care provider that you do not currently have coverage, but that you and your dependents would have coverage retroactively to the date coverage was lost if you elect COBRA continuation coverage.

- If, after you have elected COBRA continuation coverage, a health care provider requests confirmation of coverage for a period for which the Company has not yet received payment; then the COBRA Administrator will give a complete response to the health care provider about you and your dependents' COBRA continuation rights during that period.

  For example, the COBRA Administrator cancels your and your dependents' coverage as of the first day of a period of coverage if it has not received your or your dependents' COBRA payment. However, the COBRA Administrator retroactively reinstates your coverage once the COBRA payment is made. If you and/or your dependents have not paid the applicable COBRA payment, the COBRA Administrator will inform the health care provider that you do

not currently have coverage, but that you and your dependents would have coverage retroactively to the first day of the period of coverage if timely payment is made.

Acquiring a New Dependent(s) While Covered by COBRA

If you, your spouse, or your dependent child elects COBRA and acquires a new dependent through marriage, birth, adoption or placement for adoption while enrolled in COBRA Continuation Coverage, that person may add the dependent to COBRA coverage for the balance of the COBRA coverage period. For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for five months of COBRA coverage.

To enroll your new dependent for COBRA coverage, notify the COBRA Administrator as soon as possible after acquiring the new dependent. There may be a change in your COBRA premium amount in order to cover the new dependent.

If COBRA coverage ceases for you, your spouse or your dependent child before the end of the maximum 18, 29, or 36-month COBRA coverage period, COBRA coverage also will end for the newly added dependent. However, COBRA coverage can continue for the former member's newly added newborn child, adopted child or child placed with the former member for adoption until the end of the maximum COBRA coverage period if the required premiums are paid on time. Check with the COBRA Administrator for more details on how long COBRA coverage can last.

Loss of Other Group Health Plan Coverage or other Health Insurance Coverage

If, while you are enrolled in COBRA Continuation Coverage, your spouse or dependent child loses coverage under another group health plan, you may enroll the spouse or dependent child for coverage for the balance of the period of COBRA Continuation Coverage.

The spouse or dependent must have been eligible but not enrolled for coverage under the terms of the plan. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Subsequent Events Affecting Dependents COBRA Coverage

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, divorce or legally separate, or if a covered child ceases to be a dependent child under the Plan, the maximum COBRA Continuation period for the affected spouse and/or child is extended to up to 36 months from the occurrence of your termination of employment or reduction of hours.

For example, assume you lose your job (the first COBRA-qualifying event), and you enroll yourself and your eligible dependents for COBRA coverage. Three months after your COBRA coverage begins, you divorce and your former spouse is no longer eligible for Plan coverage. Your former spouse can continue COBRA coverage for 33 months, for a total of 36 months of COBRA coverage.

This extended period of COBRA Continuation Coverage is **not** available to anyone who became your spouse after your termination of employment or reduction of hours. However, this extended

period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by, or placed for adoption with you (the active member) during the 18-month period of COBRA Continuation Coverage, as well as children who were dependents at the time of the first qualifying event.

Note that Medicare entitlement is not a second qualifying event under the active plan. As a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for dependents eligible for COBRA continuation coverage.

Also not, if a qualifying event that is a termination of employment or reduction in hours occurs less than 18 months after the date you become entitled to Medicare, the period of coverage for your covered dependents will last until 36 months after the date of your Medicare entitlement.

When COBRA Continuation Coverage May End Sooner than 18 or 26 Months

The time periods during which coverage is extended may be shortened if:

- The Company no longer provides group health coverage for any employees;
- The person electing coverage does not pay the required premium, or does not pay the amount due on time;
- After electing COBRA, the person becomes covered by another group health plan (If the other plan has a preexisting condition limitation that applies to you, you may continue your COBRA coverage.),
- After electing COBRA, you become entitled to Medicare;
- If you and/or your family members have the 11-month extension for Social Security disability and the person is no longer deemed disabled by the Social Security Administration; or
- If you take actions that would result in termination of active employee coverage (for example, if you submit false claims).

Other Coverage Options besides COBRA Continuation Coverage

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or

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

- 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.

Conversion Privilege

If your eligibility for group medical or long-term disability coverage ends because you terminate employment with the Company or because you no longer qualify as eligible, you or your dependents may be able to convert to an individual, non-group medical or long-term disability policy, if that right is offered by the plan under the coverage option that you have chosen. (You cannot convert to a non-group dental policy, you cannot convert coverage under the non-EPO Aetna medical plans, and long-term disability coverage conversion is not available if you terminate employment due to retirement). Benefits under these non-group policies may be different from your coverage under this Plan. You must apply for medical conversion coverage within 45 days of the date your coverage ends and within 30 days for long-term disability coverage. The carrier will bill you or your dependents directly at the rates in effect at the time you convert. Contact the Human Resources–Benefits Department for information about the availability of conversion rights.

Keep the COBRA Administrator Informed of Address Changes

In order to protect your family's rights, you should keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator. Contact the COBRA Administrator for any questions that you have about COBRA continuation coverage.

COBRA Participant Services:
Email: customerservice@wexhealth.com

Phone: 866-451-3399
Fax: 888-408-7224
Hours: Monday-Friday, 6:00am–9:00pm CST

Participant COBRA Web Portal:
www.wexinc.com

Payment Processing Center address:
WEX
Post Office Box 2079
Omaha, NE 68103-2079

COBRA Administrator:

WEX is the COBRA Administrator. The choice of the COBRA Administrator is reviewed annually and is subject to change at any time.

Your Privacy Rights Under HIPAA

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans like Segal's Flexible Benefits Plan protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment and is available from Human Resources–Benefits in the New York Office. This statement is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

This Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health Plan operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities, called "Business Associates" to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that company.

Under federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services, if you believe your rights have been violated.

This Plan maintains a Notice of Privacy Practices, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the Notice, go to SegalNet, our Company's Intranet. If you have questions about the privacy of your health information or, if you wish to file a complaint about a privacy issue, please contact Human Resources–Benefits in the New York office.

Travel Insurance

In addition to the survivor benefits already described, you are also covered for accidental death while traveling at the Company's request to conduct Company business and while commuting to

and from work. This coverage is available at no cost to you. If you die while covered under this plan, your beneficiary will receive $150,000.

Coverage begins when you leave your home or office on your way to work or any Company business requiring travel inside or outside the city where you work. Your coverage is in effect until you return to your home or office.

Leaves of Absence

This is a summary of key aspects of our Leave of Absence Policies and Plans.

Family and Medical Leave (FMLA)

If you have worked for the Company for at least one year and have completed at least 1,250 hours of work during the 12-month period prior to the commencement of such a leave, you are eligible to apply for a leave of absence under the Family and Medical Leave Act of 1993 (FMLA).

Your participation in the Flexible Benefit Program benefit plans in which you are enrolled will continue while you are on leave, as will any contribution requirements. If you fail to pay required contributions to the Company within 30 days after they are due, your coverage may be terminated. You will be required to reimburse the Company for the full cost of coverage during your leave (not just the employee's share) if you do not return to work following an FMLA leave or you return for less than 30 days unless you cannot return to work because of a serious health condition (or serious illness or injury of a covered service member) or other circumstances beyond your control.

Military Leave

Military leaves of absence are granted to employees in compliance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and all applicable state laws.

Eligibility

You are eligible for benefits and re-employment when you leave for and return from any type of uniformed service in the United States armed forces, the National Guard, or the commissioned corps of the Public Health Service, whether voluntary or involuntary.

If you are on active duty for a period of 31 days or less, you will continue to receive health care coverage for up to 31 days. If you are on active duty for a period of more than 31 days, you will be permitted to continue coverage for you and your Eligible Dependents at your own expense for up to 24 months. This continuation right operates in the same way as COBRA. See the section on COBRA Continuation Coverage for a full explanation of the COBRA coverage provisions. In addition, your Eligible Dependent(s) may be eligible for health care coverage under the TRICARE. This plan will coordinate coverage with TRICARE.

If you have any questions about taking a leave of absence or about how a leave of absence affects your coverage, please consult with the Human Resources–Benefits office**.** Your

USERRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

Short-Term Disability (STD) Benefits

Eligibility

As a regular full-time or part-time employee (other than a Special Project Worker (SPW) or Intern) working at least 60% of your office's standard work hours, you are eligible for short-term disability benefits from the first day of work.

How Short-Term Disability Works

If your absence from work because of a medical illness is expected to exceed five days, you may be eligible for short-term disability benefits. Therefore, it is important that you notify your manager, the STD insurer, currently The Hartford, and Human Resources-Benefits in the New York office the earlier of 1) the date you know you will be out of the office for a medical illness expected to exceed five days or two) on the fifth day of your absence from work due to a medical illness. Timely notification provides your manager with the information s/he will need to know to make adjustments in the department's business schedule. For Human Resources, timely notification allows us to prepare the necessary documents. In jurisdictions that mandate disability/medical benefits, you must apply for benefits both with The Hartford and with the appropriate entity for your jurisdiction. Please see the employee handbook for the jurisdictions that mandate these benefits. In California, the procedure is the same except that you must file for State Disability Insurance (SDI) benefits with California Employment Development Department (EDD)[2] rather than with The Hartford.

Based upon the information obtained, the Company may grant a disability leave for a period of medical disability. During your disability, you may be required on one or more occasions to submit proof of continued disability to the Company or its insurance carrier.

With the necessary approvals, you may be eligible to receive a portion of your salary for up to a maximum of 26 weeks. The salary replacement comes from a combination of weekly disability benefits paid from an insured plan, state mandated disability/medical benefits or state disability benefits in California) and supplemental salary continuation paid directly by the Company for qualified disabilities. The Company will not issue or continue to provide salary continuation without The Hartford's, state mandated disability/medical approval, or EDD's initial and continued approval of your disability claim. The amount to which you may be entitled depends upon your years of service with the Company.

Time spent by an employee on disability leave, for job-related and non-job-related-illnesses and injuries, is also chargeable against an employee's entitlement to Family and Medical Leave under applicable federal and state laws (provided, of course, that the condition qualifies as a serious health condition).

Short-term Disability and Salary Continuation Table

[2] For California short-term disability claims, click on Claims (ca.gov)

Completed Years of Service	Weeks at Full Salary	Weeks at Half Salary	Weeks at $170 Maximum[3]
0	4	0	22
1–2	6	2	18
3–4	8	5	13
5–6	10	8	8
7	14	10	2
8	18	8	0
9	22	4	0
10+	26	0	0

Your approved benefit payments under short-term disability and salary continuation are effective as of the eighth calendar day of absence due to disability. Time during the initial waiting period for short-term disability and salary continuation may be paid using your available sick time as applicable.

If a short-term disability due to the same or related causes recurs within 30 calendar days after you return to work, it will be considered the same period of short-term disability as your previous absence. However, a separate period of short-term disability will begin if at least 30 calendar days have passed since you returned to work on a full-time basis. Where applicable state laws indicate a shorter waiting period, the state law will govern.

In no event will more than 26 weeks of salary continuation for short-term disability be granted within a rolling 12-month period.

Except in certain jurisdictions with mandated coverage, the cost of this coverage is fully paid by the Company and any benefits you receive are fully taxable. In California, the benefits paid through the state disability program are funded by employee contributions and generally are not taxable (you should consult with your own tax professional as the Company is not providing any tax advice).

Benefits Coverage During Short-Term Disability

Health benefits remain in force during your disability leave and end as of the last day of the month through which you received salary, disability income, or vacation pay from the Company. Life insurance and long-term disability coverage remain in force during disability leave and end as of the last date through which you received salary, disability income, or vacation pay from the Company.

While you are on disability leave, salary reduction for any benefit coverage that requires employee contributions will continue while you are receiving salary supplement or vacation pay. If you are disabled and no longer receiving salary supplement, you are still required to pay your monthly contribution amount for all coverage. Arrangements regarding method of payment should be discussed with the Human Resources–Benefits department in the New York office.

[3] The maximum amount differs in certain jurisdictions with mandated coverage, and is subject to change annually.

Limitations

If your disability is related to work, you are covered by Workers' Compensation instead of the benefits described in this section.

Long-Term Disability (LTD) Benefits

Eligibility

As a regular full-time or part-time employee (other than a Special Project Worker (SPW) or Intern) working at least 60% of your office's standard work hours, you are eligible for LTD benefits.

How Long-Term Disability Works

You are considered totally disabled when you are deemed to be unable to work because of disease or injury. During the first 24 months of your total disability, you are considered unable to work if you are not able to perform, the material duties of your own occupation, and solely due to injury or sickness you are unable to earn more than 80% of your covered earnings. After the first 24 months of your total disability, you are considered unable to work if you are unable to perform the material duties of any occupation for which you may reasonably become qualified based on education, training or experience, and solely due to injury or sickness you are unable to earn more than 80% of your covered earnings.

Basic LTD coverage replaces 50% of your annual covered salary to a maximum covered salary of $60,000 (a maximum monthly gross benefit of $2,500).

Additional Low Option Plan

The Additional Low Option Plan replaces 50% of your annual covered salary above $60,000 up to a maximum covered salary of $180,000.

Additional High Option Plan

The Additional High Option Plan replaces 60% of your annual covered salary up to a maximum covered salary of $200,000.

Benefits are paid after you have been totally disabled for 180 consecutive calendar days and have been approved for payment.

The maximum benefit period is the later of your Social Security Normal Retirement Age or the maximum benefit period listed below:

Age When Disability Begins	Maximum Benefits Period
Age 62 or under	Your 65th birthday or the date the 42nd monthly benefit is payable, if later
63	The date the 36th monthly benefit is payable
64	The date the 30th monthly benefit is payable
65	The date the 24th monthly benefit is payable

Age When Disability Begins	Maximum Benefits Period
66	The date the 21st monthly benefit is payable
67	The date the 18th monthly benefit is payable
68	The date the 15th monthly benefit is payable
69 or older	The date the 12th monthly benefit is payable

When you are no longer deemed totally disabled, or if you should die, payments will stop immediately.

Life Insurance During Long-Term Disability[4]

Basic and Supplemental Life Insurance may be continued by the insurance carrier under a premium waiver provision. If you have additional life insurance coverage (e.g., spousal/child Supplemental Life Insurance), you must convert to an individual direct-pay policy with the insurance carrier. If applicable, you will receive the necessary forms directly from the carrier.

Before-Tax and After-Tax Purchase Option

If you elected additional LTD on a before-tax basis and become totally disabled, any LTD income that you receive will be taxable. Coverage elected on an after-tax basis would generally result in incremental LTD income that is not subject to taxes.

Integration with Other Income

Plan benefits will be reduced by the amount of Other Income benefits payable due to the same disability. Other Income Benefits include other disability benefits, government and Segal retirement benefits, Social Security benefits, workers' compensation benefits.

Limitations

You are not insured for any long-term disability that results directly or indirectly from:

1) that is caused or contributed to by war or act of war, whether declared or not;
2) caused by your commission of or attempt to commit a felony;
3) caused or contributed to by your being engaged in an illegal occupation; or
4) caused or contributed to by an intentionally self-inflicted injury.

There are also limitations for pre-existing conditions.

When Does Your LTD Coverage End?

Your coverage ends if:

- You leave active employment with the Company for any reason other than sickness or injury; or

[4] These provisions are subject to change. This description does not create a contract between the Company and any inactive employee receiving long-term disability benefits. In order to meet its needs under changing conditions, the Company at its discretion may, at any time, terminate or modify the Flexible Benefits Plan and the statements made in this description.

- The group policy is discontinued or replaced.

If your coverage ends because your employment ends, you may be eligible for conversion insurance.

The operation of the LTD Plan is legally governed by the official Plan document. You may obtain a copy of the LTD Plan document by contacting the Human Resources Department in New York.

If you have any questions about your disability benefits or if you need additional information, please contact the human resources representative in your office or Human Resources - Benefits in the New York office.

Personal Leave

We recognize that sometimes employees may need additional periods of time off of work.

During a personal leave, certain benefits end on your last day of active employment. These benefits include short and long-term disability and travel accident insurance. Other benefits, such as life insurance, medical, dental and vision, end at the end of the month following 30 days leave. At that time, you will receive a COBRA notice, which gives you the option of continuing benefits with Segal on a direct-pay basis.

Claims Procedures

Even though it does not happen often, occasionally disagreements about benefit eligibility or amounts arise. In most cases, they are resolved quickly. However, if you are unable to resolve the disagreement, formal appeals processes are in place to help you (or your authorized representative acting on your behalf) file a claim and appeal a denied claim.

In this section you will find the timeframes for responding to initial claims, as well as the appeals process. The timeframes for responding to claims depend on the type of claim (eligibility claim or claim for benefits, described below).

In no event can you (or any other person) challenge a decision in court until the applicable claims procedures have been complied with and exhausted. The decision of the Plan Administrator or the designated “Claims Administrator,” as applicable, on the final level of mandatory appeal will be final and binding on you, your dependents and any other interested party.

To the extent that the Plan Administrator properly delegates its claims authority to a Claims Administrator, the Claims Administrator may apply alternative timeframes than those set forth below, as described in the applicable certificate or booklet. To the extent that an insurer (or other Claims Administrator) administers claims under a Benefit Program, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company. Insurers will determine claims related to eligibility only to the extent eligibility depends on an insurance requirement, such as evidence of insurability.

The Claims Administrators for the various benefits provided by the Plan are listed at the end of this SPD. The Claims Administrators do not guarantee the payment of benefits under the Plan.

Procedures Regarding Eligibility

These procedures apply to claims for eligibility for coverage or enrollment in the Plan, to the extent those determinations have not been delegated to a Claims Administrator.

Filing a Claim

If you believe that you or your dependent is eligible for coverage under the Plan, you may file a claim in writing with the Plan Administrator at the following address:

Segal
66 Hudson Boulevard East, 20th Floor
New York, NY 10001

Initial Claim Decision

When an eligibility or enrollment claim is received, the Plan Administrator must notify you of its benefit determination within 90 days of the receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. You will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.

The Plan Administrator will send you a written notice of an adverse benefit determination. A denial of a claim will include:

- The reason(s) for the denial;
- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the Plan's appeal procedures and the time limits applicable to the appeal process; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

Appealing an Eligibility or Enrollment Claim Denial

If you (or your duly authorized representative) believe that a denial is incorrect, you may request a full review by the Plan Administrator (at the address above) within 60 days after your receipt of the denial of your claim. In connection with your appeal, you or your representative may submit written comments, documents, records and other information relating to the claim. You also have the right to request copies of all relevant documents (free of charge).

The Plan Administrator will furnish you with a written decision providing the final determination of the appeal. The Plan Administrator's decision on appeal usually will be made within 60 days

after receiving your appeal, unless special circumstances require an extension of an additional 60 days. If the period is extended, the Plan Administrator will notify you in writing of the extension within 60 days of receiving your appeal. The Plan Administrator's decision on review will be final and binding on you, your dependents and any other interested party. Your appeal notice will include:

- The specific reason or reasons for the appeal decision;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that you have the right to request access to and copies of all relevant Plan documents free of charge; and
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

Procedures Regarding Adverse Benefit Determinations

How Claims for Benefits Are Processed

How a claim for benefits is processed depends on the type of claim it is. There are several categories of claims:

- *Concurrent Care Claim* -- A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim. When possible, this type of claim should be filed at least 24 hours before the expiration of the course of treatment for which an extension is being sought.
- *Pre-Service Claim* -- A Pre-Service Claim is a claim for a benefit with respect to which the terms of Health Coverage require approval of the benefit in advance of obtaining medical care.
- *Post-Service Claim* -- A Post-Service Claim is a claim for a benefit that is not a Pre-Service Claim. Most claims are Post-Service Claims.
- *Urgent Care Claim* -- An Urgent Care Claim is any Pre-Service Claim for medical care or treatment with respect to which the failure to process the claim immediately could seriously jeopardize the life or health of you or your Dependent or subject you or your Dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.

Submitting a Benefit Claim

You must report claims to the address appearing at the end of this SPD promptly but no later than one year after the date of the service. If you do not provide this information to us within one year of the date of service, benefits for that health service will be denied or reduced, at the Claim Administrator's discretion. This time limit does not apply if you are legally incapacitated.

Required Information

When you request payment of benefits, you may be required to provide all of the following information:

- Employee's name and address;
- The patient's name, age and relationship to the employee;
- The member number stated on your ID card;
- An itemized bill from your provider that includes the following:
  - Patient diagnosis;
  - Date(s) of service;
  - Procedure code(s) and descriptions of service(s) rendered;
  - Charge for each service rendered;
  - Provider of service name, address and Tax Identification Number;
  - The date the injury or sickness began; and
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you re-enrolled for other coverage you must include the name of the other carrier(s).

Submit your claims to the address for the Claims Administrator listed at the end of this SPD.

Benefit Determinations

The Claims Administrator will make a benefit determination as set forth below. Benefits will be paid to you unless either of the following is true:

- The provider notifies the Claims Administrator that your signature is on file, assigning benefits directly to that provider (assuming the Plan Administrator, in its sole discretion, chooses to recognize the assignment); or
- You make a written request for the out-of-network provider to be paid directly at the time you submit your claim.

Pre-Service Urgent Care

Urgent Care Claims are those for medical care or treatment with respect to which the failure to process the claim immediately could seriously jeopardize: (i) the life or health of you or your dependent; (ii) the ability of your or your dependent to regain maximum function; or (iii) subject you or your dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

This type of claim generally includes those situations commonly treated as emergencies. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72-hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition; and
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the

information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or
- The end of the 48 hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will set forth the specific reason or reasons for the denial, refer to specific Plan provisions on which the denial is based, contain a description of any information necessary for the claim to be granted (if applicable) an explanation of why such information is necessary. This letter will also describe the process for filing a formal appeal and the time limits for filing an appeal, including your right to bring a civil action following an adverse determination upon appeal. If the denial is based on medical necessity or experimental treatment, the denial notice will contain information on the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances. The denial notice will also contain information about the internal rule, guideline or protocol that was relied on, if applicable.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post service or pre-service timeframes, whichever applies.

Pre-Service Claims

Pre-service claims are those claims that require certification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a pre-service claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received, and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45 day timeframe, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied.

A denial notice will set forth the specific reason or reasons for the denial, refer to the specific Plan provisions on which the denial is based, contain a description of any information necessary for the claim to be granted and an explanation of why such information is necessary, and describe the process and time limits for filing a formal appeal including your rights to bring a civil action following an adverse determination upon appeal. If the denial is based on the medical necessity or experimental treatment, the denial notice will contain information on the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances. The denial notice will also contain information about the internal rule, guideline or protocol that was relied on, if applicable.

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45 day timeframe and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied.

A denial notice will set forth the specific reason or reasons for the denial, refer to the specific Plan provisions on which the denial is based, contain a description of any information necessary for the claim to be granted and an explanation of why such information is necessary, and describe the process and time limits for filing a formal appeal including your right to bring a civil action following an adverse determination upon appeal. If the denial is based on the medical necessity or experimental treatment, the denial notice will contain information on the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances. The denial notice will also contain information about the internal rule, guideline or protocol that was relied on, if applicable.

Appeals

If your question or concern is about a benefit determination you may informally contact the appropriate Claims Administrator before requesting a formal appeal. If the customer service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact customer service and later wish to request a formal appeal in writing, you should contact customer service and request an appeal. If you request a formal appeal, a customer service representative will provide you with the appropriate address of the claims administrator.

If you are appealing an Urgent Care Claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" section below and contact customer service immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service or post-service claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. Your request may be required to include:

- The patient's name and the identification number from the ID card;
- The date(s) of medical 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.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a healthcare professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon written request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

You will be provided notification of decision on your appeal as follows:

- For appeals of pre-service claims, the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from the receipt of a request for appeal of a denied claim.
- For appeals of post-service claims, you will be notified by the Claims Administrator of the decision within 60 days from receipt of a request for appeal of a denied claim.
- For procedures associated with urgent claims, see "Urgent Claim Appeals that Require Immediate Action" below.

Notice of Decision on Appeal

If your appeal is denied, you will receive a notice explaining the following: the reason for the denial, specific references to the part of the Plan on which the denial is based, a statement that you are entitled by law to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim, a statement regarding any voluntary appeal procedures offered by the Plan and your right to bring a civil action after an adverse determination on appeal, information about the internal rule, guideline or protocol that was relied on, if applicable, information on the scientific or clinical judgment for the determination if the adverse decision is based on medical necessity or experimental treatment,

and a description of the external review process, including how to initiate an external review and the time limits that apply.

Please note that the Claims Administrators' decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Urgent Claim Appeals That Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt by the Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

External Review Process

For purposes of any Benefit Program considered a "Group Health Plan," if your claim involving medical judgment or involving a rescission of coverage is denied by the Plan, you can request an external review. In the case of an urgent care claim, you can file a request for an expedited external review at the same time you file an internal appeal.

You must file your request for an external review with the Claims Administrator within four months after the date you received the final internal appeal denial.

Preliminary Review

Within five business days of receipt of your request, the Claims Administrator will complete a preliminary review to determine that:

- You were covered by the Plan at the time the service was requested or provided;
- The adverse claim determination was not related to your failure to meet the plan's eligibility requirements;
- You had exhausted the plan's internal appeals process, if required under law; and
- You had provided all of the necessary information and forms to process an external review.

Within one business day after completing the preliminary review, the Claims Administrator will contact you in writing. If your request was complete but not eligible for an external review, the notice will tell you why and provide you with the contact information for the Employee Benefits Security Administration. If your request is incomplete, the notice will describe what information is needed to perfect your review request. You have 48 hours from receipt of this notice, or up to the original four month external appeal filing deadline, to provide the requested information.

Referral to Independent Review Organization

If your claim qualified, the Claims Administrator will assign your review request to an accredited Independent Review Organization ("IRO") that will conduct the external review. The Claims Administrator will provide the IRO with the documents and any information considered in previously denying your claim.

The IRO will notify you in writing of your eligibility and acceptance for external review. The notice will inform you of your right to submit additional information for review in writing to the IRO within 10 business days following receipt of the notice.

Within one business day of receiving any additional information from you, the IRO will forward that information to the Claims Administrator. The Claims Administrator may then reconsider its benefits denial. If the Claims Administrator decides to reverse its previous denial, the external review will be terminated, and you will receive a written notice of the Claims Administrator's decision within one business day.

The IRO will review your claim without regard to any previous decision or conclusions reached during the internal claims and appeals processes. You will receive written notice of the IRO's decision within 45 days after the IRO received your review request.

If the IRO reverses the Plan's adverse benefit decision, your claim will be immediately paid or coverage must be immediately provided (whichever applies to your claim).

The written decision of the IRO will include the following:

- A general description of the reason for the external review request, including information sufficient to identify the claim (including the date or dates of service, the healthcare provider, the claim amount (if applicable), notice regarding the availability of the diagnosis code and its corresponding meaning and/or the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Claim Administrator and you;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

For urgent care claims and appeals, there is an expedited external appeal process. In such a case, the Claims Administrator will immediately determine if the claim is eligible for an external review and provide all documents and information to the IRO electronically or by phone or fax to expedite the process. The IRO will make a decision on your claim within 72 hours of receiving it.

The decision of the IRO is binding upon all parties, however you still have the right to bring an action under section 502(a) of ERISA.

Exhaustion of Administrative Remedies

In no event can you (or any other person) challenge a decision in court until this claims procedure has been complied with and exhausted. If you have complied with and exhausted the appropriate claims procedures and intend to exercise your right to bring civil action under ERISA Section 502(a), you must bring the civil action under ERISA Section 502(a) within two years after your initial claim or within six months from the date of the final claim decision on appeal, whichever comes first, or if shorter, the date specified in the Benefit Program.

Subrogation

General Principle

When you or your eligible dependent receives benefits under the Plan which are related to medical expenses that are also payable under workers' compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, you or your eligible dependent shall reimburse the Plan for the related benefits received out of any funds or monies you or your eligible dependent recovers from any third party.

Specific Requirements and Plan Rights

Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that you or your eligible 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, even if you or your eligible dependent has not been paid or fully reimbursed for all 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 you or your eligible dependent to assert a claim to any of the benefits to which you or your eligible dependent may be entitled. The Plan will not pay attorneys' fees or costs associated with the claim or lawsuit without express written authorization from Company.

If the Plan should become aware that you or your eligible 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 you or any of your eligible dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of you or your eligible dependents.

Participant Duties and Actions

By participating in the Plan you and your eligible 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. In accordance with that constructive trust, lien or equitable lien by agreement, you and your eligible dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once you or your eligible dependent has any reason to believe that you or your eligible dependent may be entitled to recovery from any third party, you or your eligible dependent must notify the Plan. At that time, you and your eligible dependent (and your or your eligible dependent's attorney, if applicable) must 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 you or your eligible dependent to any payment, amount or recovery from a third party.

If you or your eligible dependent fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to you and any of your eligible dependents until the agreement is signed. Alternatively, if you or your eligible dependent fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of you or your eligible dependent, your or your eligible dependent's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

You and your eligible dependent consent and agree that you or your eligible dependent shall not assign your or your eligible dependent's rights to settlement or recovery against a third person or party to any other party, including your eligible dependent's 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 Company.

Coordination of Benefits

The Plan has a coordination of benefits feature with respect to medical benefits. This prevents duplication of benefits if you or an eligible dependent is covered by more than one medical plan. When a claim is made, the "primary" plan pays benefits first, without regard to the other plan. When the Plan is secondary, the Plan calculates what it would have paid if it were primary and reduces benefits by what the other plan has paid.

The Plan will not supplement the other plan to bring reimbursement up to 100%, but will coordinate with the other plan to bring your reimbursement up to the Plan's benefit level. Generally, the plan covering a person as an employee is the "primary" plan while the plan covering the same person as a dependent is the "secondary" plan.

Coordination of benefits rules apply whenever you or your eligible dependent is covered by more than one insurance plan. Plans include any other type of coverage for persons in a

group—whether the plan is fully-insured or self-funded. No-fault auto insurance that is required by law is also included, even if it is not provided on a group basis. The level of benefits required by law will be considered when benefits are coordinated.

Coordination with other Plans

The Plan describes the coordination of benefits rules in greater detail. Generally, primary and secondary plans are determined as follows:

- The plan covering a person as an employee is the primary plan, and the plan covering the same person as a dependent is the secondary plan.
- For dependent children, the plan of the parent whose birthday occurs earlier in the calendar year is primary (regardless of the year of birth). If both parents have the same birthday, the plan that has covered a parent for the longer period is primary. If the other plan follows a gender rule (i.e., male's plan pays first) instead of the birthday rule to determine order of benefits, the other plan's provision will apply.

In the case of separated or divorced parents, primary and secondary plans are determined as follows:

- If a court decree awards joint custody but does not specify which parent is responsible for healthcare expenses, the rules above apply.
- If a court decree has given financial responsibility for medical care for eligible dependent children to one parent, the plan of this parent is primary.
- If there is not a court decree establishing financial responsibility for medical care for eligible dependent children,
  - The plan that covers the parent with custody pays first; and
  - If the parent with custody has remarried, the plan of the custodial parent pays first, then the plan of the stepparent and last, the plan of the parent without custody.
- In the case of a stepchild the plan of the parent will be primary.

If none of these rules apply, the plan that has covered the individual for the longest period of time is primary.

Coordination with Medicare

If you are a Participant or an eligible dependent and you become eligible for Medicare, the Plan will be your primary source of coverage (with Medicare secondary), unless you elect otherwise. If you choose to be covered under both plans, your Plan coverage will be primary and Medicare secondary. If you also cover your spouse (and he or she is not covered as an employee under another employer's plan), your Plan coverage is primary for your spouse as well, regardless of whether your spouse is under or over age 65.

If you are receiving long-term disability benefits from the Company and become Medicare-eligible, you may no longer be eligible for group-sponsored medical coverage through the Company. Your eligible dependents who are not Medicare-eligible continue to be covered by the Plan Medical Benefit Program, assuming they continue to satisfy the dependent eligibility requirements.

No Assignment

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void, unless otherwise agreed to, in the sole discretion of the Plan Administrator. The assignment of rights or benefits, as well as the assignment of the right to file a lawsuit, are prohibited, except that a participant may assign covered benefits to an appropriate medical service provider solely for the purpose of allowing the provider to submit a claim and allowing the Plan to pay covered benefits directly to the provider. The payment of benefits directly to a provider, if any, shall be done as a convenience to the covered person and shall not constitute an assignment of benefits under the Plan. No compensation reduction elections or other contributions under this Plan shall cause the Company to be liable for, or subject to, any manner of debt or liability of any participant. Notwithstanding the foregoing, wage garnishments under applicable state law shall be permitted to reach cash benefits reflecting deductions from the garnishee's cash account under this Plan, unless otherwise prohibited by law.

Recovery of Excess Payments

You will be required to return to the Company any benefits, or portion thereof, paid under the Plan by a mistake of fact or law.

Plan Administrative Information

The Plan is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). This section provides important legal and administrative information you may need such as:

- How to contact the Plan Administrator;
- Information about the Insurers that insure and administer the Benefit Programs of the Plan and how to contact them; and
- Your rights under ERISA.

If you have any questions about any of the information contained in this SPD, contact the Plan Administrator.

Plan identification

This Plan is named The Segal Company Staff Insurance Plan. The Plan number is 501.

Plan sponsor

The Plan is sponsored by The Segal Group, Inc. ("Company"). The Company's address is:

66 Hudson Boulevard East, 20th Floor

New York, NY 10001

The employer identification number (EIN) assigned to the Plan sponsor by the Internal Revenue Service is 06-0839113.

Plan Administrator

The Plan Administrator is the Company, other entity or individual designated by the Board of Directors of the Company to supervise the administration of the Plan. The Plan Administrator is your primary source of information about the Plan. The Plan Administrator's business address and telephone number are:

The Segal Group, Inc.

66 Hudson Boulevard East, 20th Floor

New York, NY 10001

212.251.5000

The Plan Administrator (or its designee) has sole discretionary authority to interpret and construe the provisions of the Plan, to grant or deny benefits, to determine eligibility for benefits under the Plan, and to resolve any disputes that arise under the Plan. Benefits under this Plan will be paid only if the Plan Administrator (or its designee) decides in its sole discretion that the applicant is entitled to them. Decisions of the Plan Administrator (or its designee) shall be final and binding.

Plan year

The Plan year is January 1 to December 31.

Plan type, funding, and administration

The Plan is an ERISA welfare benefit plan. The Benefit Programs of the Plan may be fully-insured by the Insurers pursuant to group insurance contracts entered into between Company and the insurers or self-funded by the Company. For fully-insured benefits, premiums are paid to the insurers from Company's general assets. The insurers are responsible for paying benefit claims incurred while the applicable group insurance contracts are in effect. For self-funded benefits, the Company is responsible for paying benefit claims for its general assets.

Agent for service of legal process

The agent for service of legal process on the Plan is the Company's General Counsel:

General Counsel

The Segal Group, Inc.

66 Hudson Boulevard East, 20th Floor

New York, NY 10001

212.251.5000

Legal process on the Plan may also be served on the Plan Administrator.

Your ERISA Rights

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

Receive information about your plan and benefits

Examine (without charge) at the Plan Administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan (if applicable) with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

Receive a written summary of the Plan's annual financial report, if applicable. 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 healthcare coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another plan.

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," 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, and 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.

Enforcing your rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of the 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 your ERISA rights. For instance:

- If you request a copy of plan documents or the latest annual report (if applicable) 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 (indexed for inflation) 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 after going through the appeals procedure—you may file suit in a state or federal court.
- If you disagree with the Plan's decision (or lack thereof) concerning the qualified status of 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 ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.
- If you file suit against the Plan, 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 the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Quick Benefit Contact Information

COBRA	See page 30	**WEX Participant Services** at 1(866) 451-3399 from 6am to 9pm CT Monday – Friday or customerservice@wexhealth.com
Dental Benefits	See page 14	Guardian, 800-541-7846, www.guardiananytime.com
Dependent Care Flexible Spending Account (DCFSA)	See page 19	**WEX Participant Services** at 1(866) 451-3399 from 6am to 9pm CT Monday – Friday or customerservice@wexhealth.com
Disability (short-term, long-term) Leave of Absence	See page 40: STD See page 42: LTD	The Hartford at 888-301-5615 Monday thru Friday 8:00am-8:00pm ET, in CA contact EDD @ www.edd.ca.gov, in other jurisdictions with mandated coverage contact your local benefits claim office and the Segal HR - Benefits Team

Employee Assistance Program (EAP)	See page 24	Lyra Health EAP: • Sign up or log in to Lyra Health at segal.lyrahealth.com • Call Lyra Health at 833-511-0845
Health Care Flexible Spending Account (HCFSA)	See page 18	**WEX Participant Services** at 1(866) 451-3399 from 6am to 9pm CT Monday – Friday or customerservice@wexhealth.com
Life Insurance: **Basic Term Life Insurance**	See page 20	**Segal Benefits Team:** Monica Infosino, 212-251-5159, minfosino@segalco.com Janet Arce, 212-251-5297, jarce@segalco.com Winnie Tang, 212-726-5515, wtang@segalco.com
Supplemental Life Insurance	See page 20	**The Hartford** at: 1-888-301-5615 Monday thru Friday 8:00am-8:00pm or log on to www.thehartford.com/mybenefits
Medical Benefits	See page 11	Aetna, 800-962-6842, www.Aetna.com; OR Your HMO or EPO (refer to the back of your member card for contact #) or Segal Benefits Team
Prescription Benefits for Aetna PPO and HDHP members	See page 63	Optum Rx, 866-837-9242, www.optumrx.com
Retiree Health Benefits		**Segal Benefits Team:** Janet Arce, 212-251-5297, jarce@segalco.com Winnie Tang, 212-726-5515 , wtang@segalco.com Monica Infosino, 212-251-5159, minfosino@segalco.com

Section 2:
Segal Prescription Drug Benefit Plan Document — Summary Plan Description

January 1, 2023

Introduction

The Segal Group, Inc. (the "Company"), as Plan Sponsor, establishes and maintains the Segal Company Staff Insurance Plan (the "Plan") for the exclusive benefit of its Employees and their Dependents. This Prescription Drug Benefit/Summary Plan Description (SPD), along with any Attachments, sets forth the terms of the Prescription Drug Benefit of the Plan as of January 1, 2023 and replaces all other plan documents, SPDs, and applicable amendments to those documents previously provided to Plan participants and beneficiaries.

This SPD summarizes the main provisions of the Prescription Drug Plan that is available to participants in the following group health plans:

- Aetna PPO
- Aetna HDHP

You are being provided this SPD to give you an overview of the Prescription Drug Benefit of the Plan. You must read the Attachments and this document together to understand your benefits.

Plan rules and requirements concerning the medical benefit are contained in the medical plan SPDs/Plan Documents. In addition, Plan eligibility rules are contained in the Segal Company Staff Insurance Plan Summary Plan Description, the Section 125 plan, and other documents provided to you at open enrollment.

This document will help you understand and use the benefits provided by the Plan. We encourage you to read it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the component programs, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to the Plan.

Important information: This SPD is only a summary of the prescription drug benefits. Complete details of the prescription drug benefits are contained in the legal plan documents for the Company. The Company reserves the right to change or discontinue these benefits, in whole or in part, at any time.

Eligibility and Participation Requirements

The Company offers a Group Health Plan to eligible employees and their eligible dependents that includes medical insurance, prescription drug benefits, and other ancillary health benefits coverage.

You are an Eligible Employee with respect to the Plan if you are an Employee who is eligible to participate in and receive benefits under the Group Health Plan as established by the Company and reflected in appropriate documents, including the Employee Handbook and Staff Insurance Plan SPD. All rules concerning eligibility, dependent eligibility, enrollment, and termination of eligibility are included in the Handbook or in the SPD for the medical plan in which you are enrolled.

In order to receive prescription drug coverage described in this SPD, you must be enrolled in one of the following group health plans:

- Aetna PPO
- Aetna HDHP

When you enroll in one of these plans, you are automatically enrolled in the Prescription Drug Plan. You do not need to make a separate election to receive prescription drug benefits.

Eligibility while on leave from work

Special circumstances may entitle you to continue eligibility for coverage under the Plan when on leave from work due to either family and medical leave reasons or service in the uniformed services of the United States. Please see the Employee Handbook for rules concerning benefit coverage during a leave of absence.

How to Contact your Prescription Drug Plan

The following information provides you with contact information for your Prescription Drug Plan Administrator, also known as a Pharmacy Benefit Manager (PBM). In 2023 and until further notice, the plan's PBM is OptumRx. However, the PBM may be changed from year to year by the Company.

Prescription Drug Plan	Telephone Number	Website Address
Member Services	For questions or concerns, please call the number on the back of your member ID card. Customer Service Phone Number: 1-800-356-3477 (TTY for the hearing impaired: 711). 866-837-9242	OptumRx.com
Prior Authorization or Exception Request	Customer Service Phone Number: 1-800-356-3477 (TTY for the hearing impaired: 711). 866-837-9242	https://www.optumrx.com/secure/benefits-and-claims/prior-authorization
Mobile App	Free from Android and Apple App Stores	

Prescription Drug Benefits

If you are participating in either the Aetna PPO or HDHP Plan, your prescription drug "Rx" coverage is not provided by Aetna, but rather by OptumRx, our Pharmacy Benefit Manager (PBM). Eligibility for the Rx program is the same as that for the medical program. As soon as

you enroll for either of the Aetna medical plans noted above, you will also be enrolled in the OptumRx prescription drug program. Employee contributions are included in the medical plan contributions.

You will receive separate ID cards. Do not use your Aetna ID card for prescription drugs, rather, always use your OptumRx ID card for prescriptions.

The choice of OptumRx as PBM vendor is reviewed annually and is subject to change at any time.

Preventive Medications

Prescription drugs are grouped into preventive and non-preventive medications under both the Aetna PPO and the Aetna HDHP with HSA. Preventive prescription medications are used to prevent conditions such as asthma.

The Affordable Care Act (ACA) lists preventive drugs that are covered at 100% and are not subject to the deductible.

View the ACA preventive drug list for 2026.

There is also an additional list of expanded preventive drugs that require a copay (for generic drugs) or coinsurance (for brand-name and specialty drugs). The copay and coinsurance apply without having to meet the deductible.

View the Optum Rx expanded preventive drug list for 2026.

For non-preventive medications, you pay the full cost of the drug (after OptumRx discounts are applied) at the time of purchase until you meet the deductible. Non-preventive medication expenses do apply to the deductible. Go to OptumRx to search for all covered drugs under the Plan and see how much they cost.

Once you meet your annual deductible, you pay the applicable copay or coinsurance.

There is no separate out-of-pocket maximum for prescription drugs.

2023 Benefit Schedule

Copays and coinsurance for prescription drugs, after the annual deductible has been satisfied (where applicable). The deductibles are different depending on whether you have selected the Aetna PPO or Aetna HDHP with HSA plan. Please see the section on preventive medications for information on how those medications are covered.

	Retail (30 day) at any Participating Retail Pharmacy	Retail (90 day) at Walgreens/ Duane Reade Only	Mail
Tier 1 (Generic)	$10% with $7.50 min and $30 max	$10% with $15 min and $60 max	$10% with $15 min and $60 max
Tier 2 (Preferred Brand)	20% with $20 min and $100 max	20% with $40 min and $200 max	20% with $40 min and $200 max
Tier 3 (Non-Preferred Brand)	30% with $40 min and $200 max	30% with $80 min and $400 max	30% with $80 min and $400 max
Specialty	**30 Days' Supply Limit at Optum Specialty Mail (formerly known as Briova)** Generics: 10% with $15 min and $60 max Preferred Brands: 20% with $40 min /$200 max Non-Preferred Brands: 30% with $80 min /$400 max **More than 30 Days' Supply at Optum Specialty Mail (formerly known as Briova) for select specialty drugs only** Generics: 10% with $30 min and $120 max Preferred Brands: 20% with $80 min/$400 max Non-Preferred Brands: 30% with $160 min/$800 max		

Prescription Plan Features

Network: OptumRx has a well-established national network of pharmacies through which you may fill prescriptions. If you use one of OptumRx's participating pharmacies, your out-of-pocket costs may be lower than if you use a non-participating pharmacy. You can obtain an up to date listing of participating pharmacies by visiting the OptumRx web site. You can also call OptumRx at 866-837-9242. Be sure to register at the OptumRx website, so that you have access to your medication information easily online, you can order renewals; print out ID cards, etc.

When obtaining your prescriptions, you can receive up to a 30-day supply at a retail Participating Pharmacy or up to a 90-day supply at OptumRx mail order. You can also receive a 90-day supply from Walgreens or Duane Reade.

Formulary: OptumRx has negotiated preferred pricing on certain drugs, included on a list called a formulary. As a result of this preferred pricing (which is often on drugs by different manufacturers for the same medical condition), lower co-payments are offered on the formulary drugs. You can obtain a copy of the formulary by contacting OptumRx at the phone number or web site shown above, or on SegalNet.

Mail Order Program: The mail order program is designed to be more convenient and less expensive for you to obtain medications you take on an ongoing basis, such as those used to treat chronic conditions.

Generic and Brand Drugs: If you insist on a brand name prescription drug when there is a generic equivalent and your physician does not indicate "Dispense as Written," you will be responsible for the cost difference between the brand name drug and its generic equivalent, plus the applicable co-payment or coinsurance.

Specialty Drug Program: In addition to the existing retail pharmacy network, OptumRx contracts with a specialty pharmacy, Optum Specialty. Optum Specialty can help you fill a new prescription. Please call Optum Specialty at 855-427-4682.

Step-Therapy: For certain prescriptions, participants are required to first try one or more specified drugs to treat a particular medical condition before the plan will cover another (usually more expensive) drug that the doctor may have prescribed.

The generic equivalent of the prescription drug will be dispensed to you at the Tier 1 copayment shown in the table above.

If there is no generic equivalent and you can use a drug on the Formulary, you will pay the Tier 2 payment shown in the table above. If you obtain a non-formulary drug, you will pay the Tier 3 payment shown in the table above.

If you insist on a brand name prescription drug when there is a generic equivalent and your physician does not indicate "Dispense as Written," you will be responsible for the cost difference between the brand name drug and its generic equivalent, plus the applicable co-payment or coinsurance.

Clinical Utilization Management

Prior Authorization, Fill Limits, and Exclusions: Some prescription drug medications are subject to prior authorization, to limitations on the amount for which the prescription will be filled, or to exclusions under this Plan. For a complete list of these medications, contact OptumRx.

Copay Card Accumulator Adjustment Program and Variable Copay Program: The copay card accumulator adjustment program provides that copay assistance program amounts will not count towards the member's cost share for the deductible and out of pocket maximum. The variable copay program allows members to receive maximum benefits from copay assistance programs by paying the copay indicated by the copay assistance program and not more than the current specialty design cost share.

Split Fill and Smart Fill Programs plus 30 Days' Supply Limit on Specialty Drugs: The Split Fill Program for Oral Oncology Medications fills half the prescription twice a month, rather than a full prescription once a month, when a patient starts a new regimen of oral oncology medications. Patients who tolerate the new drug for three months will be eligible for the standard days' supply for duration of therapy. Member copays would be pro-rated to reflect the lower days' supply.

The Smart Fill Program allows 90 days' supply fill for select specialty drug classes such as Multiple Sclerosis, Inflammatory Conditions, and Transplant drug classes.

There is a 30 days' supply limit on non-smart fill program specialty drugs.

Claims and Appeals: Claims and appeals should be submitted to OptumRx, at the address available through the website, telephone, or on your OptumRx prescription drug card.

Plan Benefits

Features of Your Prescription Drug Benefits

The prescription drug program consists of a retail prescription drug program, a home delivery prescription drug program, and a specialty prescription drug program. Your prescription drug benefit will be different depending on the group health plan option in which you are enrolled. Please see the schedule of benefits in this document for the benefits available in your plan option.

Under the Prescription Drug Benefit, you can obtain prescription drugs either through your local participating pharmacy or through a home delivery program. The Prescription Drug Plan will reimburse you for prescription drugs filled at non-participating pharmacies. However, you will pay 100% of the cost at the non-participating pharmacy and then submit a claim to the Company's Prescription Benefit Manager. The PBM will then reimburse you for the approved amount minus your applicable deductible and copay or coinsurance.

Your ID Card and Mobile App

When you first enroll in your group health plan, you will receive prescription drug identification cards from the Company's Prescription Benefit Manager (PBM). If you elect coverage for yourself and another person or your family, you will receive two cards in your name. If you need additional cards you can request them by calling the Prescription Benefit Manager at the number included in this SPD.

You may also print a temporary identification card from the PBM website, or you may use the PBM Mobile App to obtain an electronic copy of your identification card and present that to a participating pharmacy. Your card can also be electronically stored in your smartphone's wallet for future use.

The Mobile App can also be used to transfer ongoing prescriptions to home delivery, order refills, check order status and more. To download the app, go to www.optumrx.com or search for OptumRx on your smartphone app store.

Your Prescription Drug Benefit Deductible, Copay, Coinsurance, and Out-of-Pocket Limit

The amount that you will pay for your prescription drugs will depend on whether you have met your plan Deductible and what the Coinsurance or Copay is for the applicable drug. You are responsible for paying the Deductible before the plan will pay for benefits, unless the prescription drugs are Preventive Benefits, in which case the drugs are covered at no cost to you if you obtain them at a participating pharmacy.

In addition, the amount that you pay after the deductible is based on the type of drug you purchase and whether you use a retail pharmacy or the home delivery program described below.

The prescription drug Out-of-Pocket Limit is the amount of prescription drug expenses you are responsible for paying each year before the Plan pays 100% of your in-network covered prescription drugs. Each calendar year, after incurring the prescription drug out-of-pocket limit, the Plan will pay 100% of all in-network covered prescription drug charges that are incurred during the remainder of the calendar year.

The following are expenses that do not count toward your prescription drug out-of-pocket limit. You are always responsible for paying these expenses yourself:

- Expenses for prescription drugs that are not covered by the Plan;
- Charges in excess of any limitations under the Plan; and
- Any penalty because you failed to comply with the Pharmacy Benefit Manager's utilization and clinical management programs.

Retail Prescription Drug Program

Under the retail prescription drug program, you may receive covered prescription drugs filled at participating pharmacies. You can purchase up to a 30-day supply of a covered prescription drug at one time at any participating retail pharmacy. The generic equivalent of all prescriptions will be dispensed, unless no generic equivalent exists, or your physician strictly prescribes the brand name drug. Some drugs may require prior authorization.

In order to obtain prescription drugs through the retail prescription drug program, you must present your prescription drug identification card at the retail pharmacy and pay your portion of the cost for the prescription drug. You do not have to submit a claim form because your prescription drug information is submitted directly to the Pharmacy Benefit Manager by the pharmacy.

The Pharmacy Benefit Manager has contracted with nearly 60,000 retail pharmacies, including most major drug stores and grocery stores. You can ask your pharmacy if it is in your network by showing your prescription drug ID card. To locate a retail pharmacy, you can contact the Pharmacy Benefit Manager using the contact information beginning on page 53.

If you do not present your identification card at the time of purchase, you must pay the non-discounted price at that time and submit a claim for reimbursement with the Pharmacy Benefit Manager. The Pharmacy Benefit Manager will only reimburse the amount of its discounted price minus your applicable copay. Please contact the Pharmacy Benefit Manager if you need additional information on how to submit prescription drug claims for reimbursement.

Home Delivery Prescription Drug Program

For maintenance prescription drugs or prescriptions for more than a 30 day supply, you and your Dependents should utilize the home delivery prescription drug program. When you use the home delivery program, your copayment for a 90-day supply of medication will be lower than

what you would have paid at a local retail participating pharmacy. You will also have the convenience of having your medication delivered to you.

A 90-day program is also available at limited retail pharmacies (Duane Reade and Walgreens).

To start using the home delivery program, you will need a new prescription from your health care provider. You may wish to ask your health care provider to write you a prescription from a 30-day supply of medication to be filled at a retail pharmacy and one for a 90-day supply to be filled through the home delivery program so that you have medication on hand while your prescription is being processed. Your prescription will be sent to you by First Class Mail or UPS, generally within 14 days or less. Instructions for refilling your prescription will be included with your first order, postage paid.

You may purchase “maintenance” Prescription Drugs through the home delivery pharmacy. Maintenance prescription drugs are prescription drugs that are typically used to treat chronic or long-term conditions, such as high blood pressure, cardiac or pulmonary conditions, asthma, etc., and are generally taken for longer than 90 days.

Automatic refills: When you refill certain home delivery prescriptions, you'll be asked whether you want to enroll. Once you enroll and are ready for a refill or renewal, your medications will automatically ship to you.

Specialty Prescription Drug Program

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. Many of these drugs require injection and have special shipping and handling needs. These drugs could also be oral or infusion medications. Often specialty prescription drugs may not be readily available at a retail pharmacy.

Your PBM has a specialty pharmacy that is composed of therapy-specific teams that provide an enhanced level of individual service to patients with special therapy needs. Whether they are administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service. By ordering your specialty medications through your PBM, you can receive:

- Toll-free access to specialty-trained pharmacists and nurses 24 hours a day, 7 days a week;
- Delivery of your medications within the United States, on a scheduled day, Monday through Friday, at no additional charge;
- Most supplies, such as needles and syringes, provided with your medications;
- Safety checks to help prevent potential drug interactions;
- Refill reminders; and
- Up to a 30-day supply of your specialty medication unless the specialty drug falls under OptumRx’s Split Fill Program for oncology medications or OptumRx’s Smart Fill Program for select specialty medications.

All Specialty Drugs must be filled through OptumRx’s Specialty Pharmacy.

For more information about specialty pharmacy, or to order your specialty medications, please call Member Services toll-free at the number in this SPD.

Prior Authorization: When is a Coverage Review Necessary?

Some medications, including but not limited to specialty medications and certain brand name drugs, are not covered unless you first receive approval through a coverage review (prior authorization). This review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective.

There are other medications that may be covered, but with limits (for example, only for a certain amount or for certain uses), unless you receive approval through a coverage review. During this review, the PBM asks your health care provider for more information than what is on the prescription before the medication may be covered under your plan. To find out whether a medication requires a coverage review, log in to OptumRx anytime, select "Drug Pricing Information under “Member Tools" and search for your medication.

If precertification is obtained, you will pay your applicable coinsurance. If precertification is not obtained and you still have the prescription filled, you must pay the full price for that drug.

Generic, Preferred, and Non-Preferred Drugs

Prescription drugs covered by the Plan are classified as either generic or brand-name drugs. Brand-name drugs are then considered either preferred brand-name or non-preferred brand-name. Preferred brand-name drugs are part of the PBM formulary, and non-preferred brand-name drugs are non-formulary.

You will pay a different amount depending on whether your prescription is filled as a generic, preferred brand-name, or non-preferred brand name drug. Generic drugs will generally cost you less. If you are prescribed a drug for which there is a generic equivalent available and you request a brand name prescription drug, you will be responsible for 100% of the difference in cost between the generic and brand name drug.

Step Therapy

Step therapy is a program designed to help you use the most cost-effective treatment if you have certain health conditions that require maintenance medications. It requires that you try “first-line” prescription drugs (often a generic medication) before “stepping up” to more expensive “second-line” prescription drugs. Then, based on your health care provider’s review, if necessary, you may be able to move to a brand-name drug. However, if a brand-name drug is dispensed and there is a generic available, you will pay the cost difference between the generic and the brand-name drug.

First-line prescription drugs are generic and lower-cost brand name drugs approved by the U.S. Food & Drug Administration (“FDA”). They are proven to be safe, effective and affordable. First-line prescription drugs should be tried first because, in most cases, they provide the same health benefits as more expensive drugs, but at a lower cost. Second-line prescription drugs typically are brand name drugs and are the most expensive options. They are best suited for patients who don’t respond to first-line prescription drugs.

Examples of the types or classes of prescription drugs that require step therapy include, but are not limited to, inhaled corticosteroids, nonsteroidal anti-inflammatory drugs ("NSAIDs"), proton pump inhibitors (PPIs), attention-deficit hyperactivity disorder ("ADHD") drugs, long-acting opioids, topical antifungals, and oral tetracyclines, topical acne/rosacea drugs, overactive bladder drugs, selective serotonin reuptake inhibitors ("SSRIs") and other antidepressants. The prescription drugs subject to the step therapy requirement can change from time to time.

If your prescription drug requires step therapy (i.e., your prescription drug is a second-line prescription drug and you have not tried a first-line prescription drug), you or your pharmacist should contact your physician to obtain a new prescription for a first-line prescription drug.

To determine whether a prescription drug is subject to any utilization or clinical management programs, contact the Pharmacy Benefit Manager.

Supply Limits

Some prescription drug medications are subject to supply limits based on criteria established by the Pharmacy Benefit Manager. These supply limits restrict the amount dispensed per prescription order or refill and/or the amount dispensed for each month's supply.

Limits are based on manufacturer suggested prescribing guidelines and may change from time to time. This does not affect the day supply limits which are part of the plan design.

Covered Prescription Drugs

The Prescription Drug Plan covers prescription drugs that are federal legend drugs, which means drug products bearing the legend "Caution: Federal law prohibits dispensing without a prescription." The Plan also covers certain prescription supplies, oral contraceptives, and some compound medications.

For the Prescription Drug Plan to cover a prescription, the item must meet the following requirements:

- It must be a prescription written by a licensed health care provider which has not exceeded the date range of validity, generally one year for most drugs, but prescriptions for controlled substances will expire more quickly;
- It must be approved by the Federal Food and Drug Administration (FDA);
- It must be dispensed by a pharmacy;
- It must be a covered medication under this Plan; and
- It must not be listed as an exclusion under this Plan.

The Prescription Drug Plan covers the following drugs:

- Federal legend drugs;
- State-restricted drugs;
- Compounded medications of which at least one ingredient is a Federal legend drug;
- Prescribed injectable insulin, needles, and syringes;

- Certain over-the-counter diabetic supplies;
- Oral contraceptives and contraceptive injections;
- Inhaler assisting devices; and
- Prenatal vitamins.

ACA Covered Preventive Benefits

This Plan provides coverage for certain Preventive Care prescription drug benefits as required by the Affordable Care Act (ACA). Coverage is provided on an in-network basis only, with no cost-sharing (for example, no deductibles, coinsurance, or copayments), for prescription drug benefits and over-the-counter items on the following:

- Evidence-based items or services with an A or B rating recommended by the United States Preventative Services Task Force;
- Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventative care and screening provided for in the comprehensive guidelines support by the Health Resource and Services Administration (HRSA) for infants, children, and adolescents; and
- Other evidence-informed preventative care and screening provided for in comprehensive guidelines supported by HRSA for women.

In-network preventive services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing by the participant or dependent. This means that the service will be covered at 100% of the Plan's allowable charge, with no coinsurance, copayment, or deductible. To obtain these benefits you must purchase them at a participating pharmacy with a prescription from your physician.

ACA covered preventive benefits include the following:

- Aspirin products to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk;
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use;
- Statin preventive medication for adults 40 to 75 at high risk;
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs);
- Folic acid supplements for women who may become pregnant;
- Fluoride chemoprevention supplements for children without fluoride in their water source;
- Fluoride varnish for all infants and children as soon as teeth are present;
- Iron supplements for children ages 6 to 12 months at risk for anemia;
- Smoking cessation products (for patients 18 years of age and older);

- Bowel preps;
- Primary prevention of breast cancer (for patients 35 years of age or more, if coverage criteria is met);
- Covered immunizations include those that are routine vaccines recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and that meet the US Food and Drug Administration approved indications for age and/or gender limitations. Coverage also includes immunizations used to prevent illnesses associated with travel such as typhoid, yellow fever, and Japanese encephalitis;
- Contraceptive methods (for patients through the age of 50 years old); and
  - Covered products include OTC contraceptive methods (female condom, spermicides, etc.), oral contraceptives (including emergency contraception), and contraceptive devices (diaphragms, skin patch systems, injectable contraception, intrauterine systems, and implants).
- Tobacco cessation products, including FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider.

The list of covered ACA Preventive Drugs may change from time to time based on federal guidance. A complete list of preventive benefits, including both prescription drug and medical, is available at healthcare.gov.

You can also view the current ACA covered medication list on the Company benefit microsite.

COVID-19 Vaccine Coverage

Effective January 1, 2021, the Plan will cover a preventive vaccine as of the date it becomes a Qualifying Coronavirus Preventive Service on an in-network basis, without participant cost sharing (such as a copayment, coinsurance, or a deductible), prior authorization, or other medical management requirements.

Effective January 1, 2021 through the end of the COVID-19 Public Health Emergency, the Plan will cover a preventive vaccine as of the date it becomes a Qualifying Coronavirus Preventive Service on an out-of-network basis, without participant cost sharing (such as a copayment, coinsurance, or a deductible), prior authorization, or other medical management requirements. The plan will reimburse an out-of-network provider for the item or service in an amount that the Plan determines is reasonable.

Limitations and Exclusions

The Prescription Drug Plan will not cover certain drug categories. The following is a partial list of the drug categories not covered by the plan. The exclusion list may be updated from time to time.

- Non-federal legend drugs;
- Federal legend non-drugs;
- Non-federal legend non-drugs;
- Continuous blood glucose monitors and continuous blood glucose monitor supplies;

- Traditional blood glucose monitors and traditional blood glucose monitor supplies;
- Cosmetic agents (ex: pigmenting/depigmenting agents, facial wrinkle medications, hair growth agents);
- Alternative medicines;
- Homeopathic products;
- Nutritional supplements;
- Dietary management products;
- Weight loss medications;
- Mouth/throat antiseptics;
- Cervical caps;*
- Diaphragms;*
- IUDs and Implants;*
- Dental and periodontal products;
- Needles and syringes;
- Fluoride products;*
- Urine glucose test strips;
- Prenatal vitamins;*
- Vaccines and Toxoids;*
- Impotence devices;
- OTCs;*
- Durable Medical Equipment (colostomy supplies, insulin pump supplies, continuous and other diabetic supplies;
- Alcohol swabs;
- Dapsone Gel 7.5%;

Standard Exclusion List Elections (these are continually updated with negative changes)

- Premium Exclusion List;
- Vigilant Drug Program Exclusions;
- New Drugs to Market;
- Non-FDA Approved Medications;
- Pain Patches and Creams;
- Clinical Duplicates (formerly known as Me Too);
- High Cost Generics;
- High Cost Brands with Generics;
- Medical Benefit Specialty;

- Compound Management Program;
- Compound Kit Exclusion
- Bulk Chemical Exclusion.
- Repackaged products (excluded by default);
- Unit dose package (unless only available as unit dose); and
- Diagnostic tests, prescription and OTC (does not include diabetic testing)

Route of Administration Exclusions

- Intrauterine.*

*Except where certain products are required to be covered as an Affordable Care Act Preventive medications.

Definitions

Brand Name Prescription Drug or Brand Name Drug

A Prescription Drug that has been approved and granted a patent by the U.S. Food and Drug Administration ("FDA"). This patent protection means that only the company who holds the patent has the right to sell that brand name prescription drug. A brand name drug cannot have competition from a generic prescription drug until after the brand name patent has expired and the FDA grants approval for a generic version.

Brand name drugs may be preferred brand name drugs or non-preferred brand name drugs. Under the retail prescription drug program, you pay a lower copay for preferred brand name drugs and a higher copay for non-preferred brand name drugs.

Compound Prescription Drug

A prescription drug that has more than one ingredient and at least one ingredient is a federal legend drug. Pharmacy compounding is a practice in which a pharmacist combines, mixes, or alters ingredients in response to a prescription to create a medication tailored to the medical needs of an individual patient. Not all compound prescription drugs are covered. Some compound prescription drugs are only available at a retail pharmacy location, not home delivery.

Federal Legend Drug

A medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled "Caution–Federal Law prohibits dispensing without prescription" or "Rx Only."

Formulary

Formulary: OptumRx has negotiated preferred pricing on certain drugs, included on a list called a formulary. As a result of this preferred pricing (which is often on drugs by different manufacturers for the same medical condition), lower co-payments are offered on the formulary

drugs. You can obtain a copy of the formulary by contacting OptumRx at the phone number or web site shown above.

Coverage for any prescription drug on the formulary is subject to Plan provisions and limitations, including prescription drug utilization and/or clinical programs.

Generic Prescription Drug or Generic Drug

A generic version of a brand name drug (basically a copy of an FDA-approved brand name drug that contains the same active ingredients as the brand name drug and is the same in terms of dosage, safety, purity, strength, how it is taken, quality, performance and intended use).

Network

OptumRx has a well-established national network of pharmacies through which you may fill prescriptions. If you use one of OptumRx's participating pharmacies, your out-of-pocket costs may be lower than if you use a non-participating pharmacy. You can obtain an up to date listing of participating pharmacies by visiting the OptumRx web site at www.OptumRx.com. You can also call OptumRx at 866-837-9242. Be sure to register at the OptumRx website, so that you have access to your medication information easily online; you can order renewals, print out ID cards, etc.

When obtaining your prescriptions, you can receive up to a 30-day supply at a retail Participating Pharmacy or up to a 90-day supply at OptumRx mail order. You can also receive a 90-day supply from Walgreens or Duane Reade.

Off-Label Prescription Drug

An FDA-approved prescription drug that is prescribed for indications other than those stated in the labeling approved by the FDA.

Prescription Drug

For the purposes of the Plan, a prescription drug is defined to include a federal legend drug, or compound prescription drug that is covered under the Plan, or any other medication that has been specifically designated as eligible for coverage as if it were a prescription drug.

Specialty Prescription Drug

Generally refers to a high-cost, low volume, biotechnology-engineered FDA approved, non-experimental prescription drug used to treat complex, chronic or rare diseases. Examples of specialty prescription drugs include medications to treat hemophilia, immunity disorders, multiple sclerosis, rheumatoid arthritis, hepatitis or certain types of cancer. Specialty prescription drugs are managed by the Pharmacy Benefit Manager's Specialty Pharmacy.

Qualifying Coronavirus Preventive Service

Qualifying Coronavirus Preventive Service means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease (COVID-19) and that is, with respect to the individual involved:

a. An evidence-based item or service that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force, or
b. An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), which has been adopted by the Director of the CDC. This provision is in effect regardless of whether the immunization is recommended for routine use.

COVID-19 Public Health Emergency

COVID-19 Public Health Emergency means the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)), as determined by the Secretary of Health and Human Services pursuant to authority under Section 319 of the Public Health Service Act (42 U.S.C. 247(d)). The Public Health Emergency was initially declared as of January 27, 2020, and has been extended thereafter.

Claims and Appeals Information

When You Need to File a Claim Form

If you are filling a prescription at a participating pharmacy you should show your ID card and you will not need to file a claim. However, if you do not have a paper or electronic copy of your Prescription Drug Plan ID card when you fill a prescription, you may need to submit a claim for reimbursement. You will also need to file a claim form for reimbursement if you go to a non-participating pharmacy to have a prescription filled.

To obtain a claim form, call the toll-free Member Services number or visit www.optumrx.com to access and print claim forms. You should submit your claim forms to:

OptumRx Claims Department
PO Box 650334
Dallas, TX 75265-0334

Your claim will be reimbursed according to the type of drug you purchased at a participating pharmacy. If you filled a prescription at a non-participating pharmacy, you will be reimbursed for the approved amount minus your applicable deductible and copay or coinsurance.

Prescription Drug Reviews and Appeals Overview

Generally, you must use and exhaust the Plan's claims and appeals procedures in order to obtain a review if your medication is not covered either through the retail, home delivery, or specialty pharmacy. There are two phases of review. The first is called the initial coverage review and the second is an appeal.

Failure to following the plan's prescribed procedures in a timely manner will cause you to lose your right to sue regarding an adverse benefit determination.

Initial Coverage Review

You have the right to request that a medicine be covered or be covered at a higher benefit (such as a lower copay or higher quantity). The first request for coverage is called an initial coverage review. To request an initial clinical coverage review, also called prior authorization, the prescriber submits the request electronically.

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request.

In general, an urgent situation is one, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If the patient or provider believes the patient's situation is urgent, the provider must request the expedited review by phone at: 1-800-711-4555

The initial determination and notification to patient and provider will be made within the specified timeframes as follows:

	Decision Timeframe	**Notification of Decision**	
Type of Claim	Decisions are completed ASAP from receipt of request and no later than:	***Approval***	***Denial***
Pre-Service	15 days	*Patient:* Letter *Provider:* Electronic or fax (and letter, if fax unsuccessful)	*Patient:* letter *Provider:* Electronic or fax (and letter, if fax unsuccessful)
Post-Service	30 days		
Urgent	72 hours	*Patient:* Letter *Provider:* Electronic or fax (and letter, if fax unsuccessful)	*Patient:* Letter *Provider:* Electronic or fax (and letter, if fax unsuccessful)

For standard pre and post-service reviews, if the necessary information needed to make a determination is not received from the health care provider within the decision timeframe, a letter will be sent to the patient and provider informing them that the information must be received within 45 days or the claim will be denied.

For urgent reviews, the 72-hour timeframe assumes all information necessary is provided. If necessary information is not provided within 24 hours of receipt, a 48-hour extension will be granted.

Level 1 Appeal or Urgent Appeal

How to request a level 1 appeal or urgent appeal after an initial coverage review is denied

When an initial coverage review has been denied, also referred to as an adverse benefit determination, a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax:

- Name of patient;
- Member ID;
- Phone number;
- The drug name for which benefit coverage has been denied;
- Brief description of why the claimant disagrees with the initial adverse benefit determination;
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents; and
- First level appeal requests can be mailed or faxed to the following addresses and fax numbers:

  OptumRx Appeals
  CA106-0286
  3515 Harbor Blvd
  Costa Mesa, CA 92626

  Fax
  Non-Specialty (orals, topicals, and insulin) 1-844-403-1029
  Specialty 1-877-342-4596

If the patient's situation meets the definition of urgent care under the law, an urgent care appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent care situation means the following:

- The standard appeal timeframe could seriously jeopardize your life or health or your ability to regain maximum function; or
- In the opinion of a physician with knowledge of the complaint's medical condition, the standard appeal timeframe would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent:

Depending on the type of appeal, appeal decisions are made by a pharmacist, physician, trained prior authorization staff member or independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe Decisions are completed ASAP from receipt of request and no later than:	Notification of Decision ***Approval***	Notification of Decision ***Denial***
Non-urgent Pre-Service	30 calendar days	Letter	Letter
Non-urgent Post-Service	60 calendar days	Letter	Letter
Urgent	72 hours	*Patient:* Automated call and letter *Provider:* Electronic or fax (and letter, if fax unsuccessful)	*Patient:* Live call and letter *Provider:* Electronic or fax (and letter, if fax unsuccessful)

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and provider together with an opportunity to respond prior to issuance of any final adverse determination. In an urgent care situation, only one level of internal appeal is provided prior to an external review.

Level 2 Appeal

How to request a level 2 appeal after a level 1 appeal is denied

When a level 1 appeal has been denied, also called an adverse benefit determination, a request for a level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination.

To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient;
- Member ID;
- Phone number;
- The drug name for which benefit coverage has been denied;
- Brief description of why the claimant disagrees with the adverse benefit determination; and
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills, or any other documents.

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent:

Appeal decisions are made by a pharmacist, physician, panel of clinicians or an independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

	Decision Timeframe	**Notification of Decision**	
Type of Appeal	Decisions are completed ASAP from receipt of request and no later than:	***Approval***	***Denial***
Non-urgent Pre-Service	30 calendar days	Letter	Letter
Non-urgent Post-Service	60 calendar days	Letter	Letter
Urgent	72 hours	*Patient:* Automated call and letter *Provider:* Electronic or fax (and letter, if fax unsuccessful)	*Patient:* Live call and letter *Provider:* Electronic or fax (and letter, if fax unsuccessful)

For Urgent Level 2 Appeals, if new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

External review

When and how to request an external review

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization (IRO) with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to:

OptumRx
c/o Appeals Coordinator
P.O. Box 25184
Santa Ana, CA 92799

Phone: 1-888-403-3398
Fax: 1-877-239-4565

The request must be received within 4 months of the date of the final internal adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day).

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO.

The IRO will notify the claimant in writing that it has received the request for an external review, and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO.

Any additional information the claimant submits to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent external review

Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life, health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO and the claimant will be notified of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

Exhaustion of Internal Appeals Process:

An internal appeal is deemed exhausted, allowing you to move to an external review without completing the internal appeals process in the following cases:

- The Plan waives an internal appeal;
- Urgent care situations (expedited external review may be initiated at the same time as the expedited internal appeals); and
- Failure to comply with all the requirements of the internal appeals process except in cases where the violation was:
  - De minimis
  - Non-prejudicial

- Attributable to good cause or matters beyond the Plan's control
- In the context of an ongoing good-faith exchange of information: and
- Not reflective of a pattern or practice of non-compliance.

Lawsuits and Limitations

You may not normally start a lawsuit to obtain benefits until after you have exhausted the Plan's appeal process and final decisions have been reached on those appeals, or until the appropriate time frame described above has elapsed after you submitted a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision.

No lawsuit may be started more than one year after the end of the year in which services were provided.

Additional Plan Information

Medicare Notice of Creditable Coverage

The Company will annually provide you with a Notice of Creditable Coverage. This notice will have information about your current prescription drug coverage and your options under Medicare's prescription drug coverage. This information will help you decide whether or not you want to join a Medicare drug plan. A copy of the Notice of Creditable Coverage is posted on SegalNet.

HIPAA Special Enrollment Rights

This Prescription Drug Plan is considered a part of your group health plan. Under federal law you have the right to make enrollment changes for you and your dependents under the HIPAA special enrollment rules related to acquiring a new dependent, loss of eligibility for other medical coverage, and loss or gain of eligibility for a State Children's Health Insurance Program (CHIP) or Medicaid. Please refer to your medical plan SPD or employee handbook for information on special enrollment periods.

COBRA Continuation Coverage

This Prescription Drug Plan is considered a part of your group health plan. Your coverage under this Prescription Drug Plan will end when your coverage ends under your group health plan option. Please refer to your medical plan SPD for information about when coverage ends.

Under federal law, if you lose your eligibility for group health plan coverage you may have the right to extend it under COBRA continuation coverage. If you elect to extend your medical plan coverage through COBRA, your coverage under the Prescription Drug Plan is also extended. You also may be able to continue coverage if you are on military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA). For information about COBRA and USERRA please refer to your medical plan SPD.

HIPAA and Your Right to Protect your Health Information

Your individually identifiable health information is protected under a federal law called the Health Insurance Portability and Accountability Act (HIPAA). The Company will provide you with a Notice of Privacy Practices that provides information about how your privacy is protected and how the Plan uses and discloses protected health information. Please refer to the Company's website for a copy of your HIPAA Notice of Privacy Practices.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

This Plan complies with the Women's Health and Cancer Rights Act (WHCRA) that indicates that for any Covered Person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending physician and the patient, including:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and the treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Benefits for these services shall be subject to the same Deductible, Copayments and/or Coinsurance as for other services covered under this Plan.

Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

Mental Health Parity

The Mental Health Parity and Addiction Equity Act generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements of limitations applied to substantially all medical/surgical benefits.

Qualified Medical Child Support Orders (QMSCOs)

You may be eligible to enroll your children in the Plan due to a Qualified Medical Child Support Order (QMCSO), including a National Medical Support Order (NMSO). These are support orders of a court or state administrative agency that usually results from a divorce or legal separation. A copy of the Plan's QMCSO procedures is available from the benefits office.

Subrogation and Reimbursement

The Plan has certain rights to subrogation and reimbursement. Please contact the Plan Administrator for more information on the plan's rights.

Discretionary Authority

The Plan Administrator, and any other fiduciary with respect to the Plan to the extent that such individual or entity is acting in its fiduciary capacity, shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan (including component benefit programs), and to determine all questions arising in connection with the administration, interpretation, and application of the Plan (including component benefit programs), including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

Amendment or Termination of the Plan

The Company, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Company or any of its delegates.

Section 3:
Health Savings Account and Health Reimbursement Arrangement Benefits

Health Savings Account

If you are enrolled in the Aetna HDHP, you are eligible to establish a Health Savings Account. You may also make a pre-tax contribution to your HSA and use the funds in your HSA to help pay for medical and prescription drug expenses.

Deductible Phase – HSA

While you are in the Deductible phase, meaning before you have met your deductible, you will pay 100 percent of your expenses until you meet your annual deductible. The annual deductible is combined for medical and prescription drug coverage. ACA Preventive Benefits are covered at 100% if received from a participating pharmacy.

Copayment Phase – HSA

Once you have met your annual deductible, you pay the coinsurance and/or copayment amounts listed in the Schedule of Benefits until you reach your (medical and prescription drug combined) Out-of-pocket maximum. ACA Preventive Benefits are covered at 100% if received from a participating pharmacy.

100 Percent Coverage Phase – HSA

Once you have reached your Out-of-Pocket maximum limit, including your deductible, your plan pays 100 percent of eligible medical and prescription drug expenses for the remainder of the benefit year.

Preventive Medications

Under the Aetna HDHP with HSA, prescription drugs are grouped into preventive and non-preventive medications.

Preventive prescription medications are used to prevent conditions such as asthma or high cholesterol. Certain preventive drugs are required by the Affordable Care Act (ACA) to be covered at 100%. These drugs are not subject to the deductible. You can see the list of ACA preventive drugs on the Company's benefits microsite.

There are additional preventive drugs that are covered with a copay (for generic drugs) or coinsurance (for brand-name and specialty drugs). For these drugs, the amounts you pay for the copay and coinsurance are not subject to the deductible, because the medications are

preventive. You can see the list of preventive drugs that can be covered before you meet your deductible on the Company's benefits microsite.

Non-Preventive Medications

For non-preventive medications, you pay the full cost of the drug (after the PBM's discounts are applied) at the time of purchase. Non-preventive medication expenses are not covered until you have met the applicable deductible. Go to OptumRx to search for all covered drugs under the Plan and see how much they cost.

Once you meet your annual deductible, you pay the applicable copay or coinsurance.

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Section 4:
The Segal Group, Inc. Client Vision Care Plan (VSP)

Evidence Coverage provided by:

Eastern Vision Service Plan, Inc.
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

Client Name: **The Segal Group, Inc.**
Client Number: **12322369**
Effective Date: **January 1, 2019**

Notice to Client: In the event this document is used to develop a Summary Plan Description, complete the information below, as applicable.	
Name Of Client:	Segal
Name Of Plan:	The Segal Company Staff Insurance Plan
Primary Address Of Client:	66 Hudson Boulevard East, 20th Floor, New York, NY 10001
Plan Administrator:	Segal
Address:	66 Hudson Boulevard East, 20th Floor, New York, NY 10001
Phone Number:	212-251-5000

This Evidence of Coverage is a summary of the Policy provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Policy itself. In the event of any dispute between this Evidence of Coverage and the Policy, the provisions of the Policy will prevail. A copy of the Policy will be furnished on request. If any changes are made to this document by anyone other than VSP, VSP disclaims responsibility for such changes and cannot guarantee this document will comply with any statutory requirements including but not limited to ERISA.

Eligibility For Coverage

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee;
- Legal Spouse or Domestic Partner of Enrollee; and
- Children of Enrollee, including enrollee's natural Children, legally adopted Children, step Children, and Children for whom Enrollee is the proposed adoptive parent without regard to financial dependence, residency with Enrollee, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting

period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which Child turns 26 years of age. Coverage also includes Children for whom Enrollee is the legal guardian if the Children are chiefly dependent upon Enrollee for support and Enrollee has been appointed the legal guardian by a court order. Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon Enrollee for support and maintenance, will remain covered while Enrollee's insurance remains in force and Enrollee's Child remains in such condition. Enrollee has 31 days from the date of Enrollee's Child's attainment of the termination age to submit an application to request that the Child be included in Enrollee's coverage and proof of the Child's incapacity. Foster and grandchildren are not covered. VSP has the right to check whether a Child is and continues to be eligible for coverage.

Open Enrollment

The initial period of eligibility for this plan must not be less than thirty (30) days. Specified periods of open enrollment must be provided once every twelve (12) months, for a period of not less than thirty (30) days.

How To Use This Plan

VSP provides Plan Benefits to Covered Persons based on the level of coverage purchased by the Client. Refer to the Schedule of Benefits and Additional Benefit Rider (if applicable) for specific Plan Benefits.

1. Contact VSP to obtain a list of participating providers, and/or to view available benefits, (see below for contact information).
2. Contact a VSP Preferred Provider's office to schedule an appointment and indicate that Covered Person is a VSP member. Should Covered Persons fail to identify themselves as VSP members, Plan Benefits shall be limited to those of an Open Access Provider, if such Plan Benefits are available.
3. Once the appointment is made, the VSP Preferred Provider will obtain benefit verification from VSP. The VSP Preferred Provider will bill VSP directly and the Covered Person is responsible for payment of any applicable Copayments, non-covered services or materials, or amounts which exceed plan allowances, and annual maximum benefits.
4. If the Policy includes Plan Benefits for Open Access Providers, Covered Person may be responsible for paying for all services and/or materials in full and submitting a claim to VSP. If an Open Access Provider agrees to submit a claim to VSP on behalf of Covered Person, VSP will reimburse the Provider directly if the claim includes a valid Assignment of Benefits. All reimbursement will be in accordance with the Open Access Provider fee schedule, less any applicable Copayment. Obtaining services from an Open Access Provider will typically result in higher out of pocket expenses for Covered Persons. All claims must be submitted to VSP within [365] calendar days from the date services are rendered and/or materials provided. Claims received by VSP after [365] days will be denied unless prohibited by applicable state or federal law.

5. If the cost of services is less than the Copayment for the service, the Covered Person is responsible for the lesser amount.

To Obtain Further Information

Contact VSP at 800-877-7195 or vsp.com.

Exclusions And Limitations Of Benefits

This Plan is designed to cover visual needs rather than cosmetic materials.

Some vision care services and/or materials are not covered under this Plan and certain other limitations may apply. Please refer to the EXCLUSIONS AND LIMITATIONS OF BENEFITS section of the attached Schedule of Benefits and/or Additional Benefit Rider (when purchased by Client) for details.

Coordination of Benefits

A. This coordination of benefits (COB) provision applies when a Covered Person has vision care coverage under more than one plan. "Plan" is defined below. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

B. Definitions

   a. A "plan" has the meaning defined in the Definitions provision of this Evidence of Coverage, but for the purposes of this section also includes the provisions herein described. A plan is any of the following that provides vision care services or materials.

      i. "Plan" includes: group insurance and Medicare or other governmental benefits, as permitted by law.

      ii. "Plan" does not include: individual or family insurance; coverage through health maintenance organizations (HMOs) or closed panel plans; blanket insurance policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

      iii. “This plan” refers to the part or parts of this Policy providing vision care benefits to which the COB provision applies and which may be reduced on account of the benefits of the other plans. Each contract for coverage under a. or b. is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan

   b. The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person. When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

   c. "Allowable expense" means a vision care service or expense that is covered at least in part by any of the plans covering the Covered Person except where a statute requires

a different definition. An expense or service that is not covered by any of the plans is not an allowable expense.

i If a Covered Person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.

ii. If a Covered Person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the lowest of the negotiated fees is not an allowable expense.

iii. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the plan whose payment arrangement is based on a negotiated fee shall be the allowable expense for all plans.

iv. The amount a benefit is reduced by the primary plan because a Covered Person does not comply with the plan provisions.

v. Amounts for Plan Benefits under the Computer VisionCare, Repair or Safety Plans are not allowable expenses under this plan.

d. "Claim determination period" may be either a calendar year or a benefit year, but shall be no less than twelve (12) consecutive months. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

e. "Closed panel plan" is a plan that provides vision care benefits to Covered Persons through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

f. "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

C. Order of Benefit Determination Rules:

a. When two or more plans pay benefits the primary plan pays or provides its benefits as if the secondary plan or plans did not exist. The plan that does not contain a coordination of benefits provision, or that contains a coordination of benefits provision that differs from those permitted by this Coordination of Benefits section is always primary. If all plans which cover the Covered Person use the order of benefits determination rules required by this section and under those rules a plan determines its benefits first, that plan is primary.

b. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

c. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

i. The benefits of a plan which covers the Covered Person as an Enrollee is primary.

ii. The order of benefits when a child is covered by more than one plan is:

1. The primary plan is the plan of the parent whose birthday (based only on the month and day within a calendar year) falls earlier in the year whether the parents are married, are not separated (whether or not they ever have been married); or a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

2. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

3. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is: the plan of the custodial parent; the plan of the spouse of the custodial parent; the plan of the noncustodial parent; and then the plan of the spouse of the noncustodial parent.

iii. The plan that covers a person as an Enrollee who is neither laid off nor retired, is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

iv. If none of the above rules determines the order of benefits, the plan that covered the person as an Enrollee longer is primary.

D. Effect On Plan Benefits: When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses, or of the total billed amount, whichever is less.

E. Right To Receive And Release Needed Information: VSP has the right to decide which facts it needs to implement COB provisions. VSP may get needed facts from or give them to any other organization or person. VSP need not disclose to nor obtain permission from the Covered Person in order to obtain these facts, except as required by applicable state or federal law.

F. Facility Of Payment: A payment made under another plan may include an amount that should have been paid under this plan. If it does, VSP may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. VSP will not have to pay that amount again.

Right Of Recovery: If the amount of the payments made by VSP is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

Urgent Vision Care

Services for conditions of a medical nature are covered by VSP only under specific supplemental eye care Plans purchased by Client. If Client purchased one of these plans, such coverage will be evidenced in an Additional Benefit Rider. When vision care is necessary for Urgent Conditions, Covered Persons with a supplemental eye care plan may obtain Plan Benefits by contacting a VSP Preferred Provider or Open Access Provider. No prior approval from VSP is required for the Covered Person to obtain vision care for Urgent Conditions of a medical nature. If Client has not purchased one of these plans, Covered Persons are not covered by VSP for medical services and should contact a physician under Covered Persons' medical insurance plan for care.

Hold Harmless

Covered Persons shall be held harmless for any sums owed by VSP to the VSP Preferred Provider, other than those sums not covered by the Plan.

Complaints and Grievances

Covered Persons have the right to expect quality care from VSP Preferred Providers. More information is available under "Patient's Rights and Responsibilities" on VSP's web site at vsp.com. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Covered Persons may submit any complaints and/or grievances, at any time, in writing to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670-7985 or verbally by calling VSP's Customer Care Division at 1-800-877-7195. VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than forty-five (45) calendar days after VSP's receipt of all necessary information. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution VSP will notify the Covered Person of the outcome in writing.

If a Covered Person is not satisfied with the resolution of any complaint and/or grievance, the Covered Person may file an appeal in writing to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670-7985 or verbally by calling VSP's Customer Care Division at 1-800-877-7195. A Covered Person has up to sixty (60) business days from receipt of the complaint and/or grievance determination to file an appeal. VSP will make a determination of an appeal within thirty (30) business days of receipt of all necessary information. If Covered Person remains dissatisfied with VSP's appeal determination or at any other time, Covered Person may call the New York State Department of Financial Services at 1-800-342-3736 or write them at New York State Department of Financial Services, Consumer Assistance Unit, One Commerce Plaza, Albany, NY 12257

Claim Payments And Denials

Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of receipt. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Claim Denial Appeals: If a claim is denied in whole or in part, under the terms of the Policy, Covered Person or Covered Person's authorized representative may submit a request for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

Initial Appeal: The request for review must be made within one hundred eighty (180) calendar days following denial of a claim and should contain sufficient information to identify the claim and the Covered Person affected by the denial. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

Second Level Appeal: If Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies: When Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Covered Person may contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a) (1) (B) [29 U.S.C. 1132(a) (1) (B)], Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

Time of Action: No action in law or in equity shall be brought to recover on the Policy prior to the Covered Person exhausting his/her grievance rights under the Policy and/or prior to the expiration of sixty (60) days after the claim and any applicable documentation have been filed with VSP. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of the Policy.

Individual Continuation Of Benefits

In the event this Plan is terminated, VSP coverage may be available for individuals to purchase online www.vsp.com.

The Consolidated Omnibus Budget Reconciliation Act Of 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that under certain circumstances health plan benefits be made available to eligible participants and their dependents upon the occurrence of a COBRA-qualifying event. If, and only to the extent,

COBRA applies to Covered Person's Plan, VSP shall make the statutorily required continuation coverage available for purchase in accordance with COBRA.

Definitions:

Additional Benefit Rider	The document, attached as Exhibit C to the Policy (when purchased by Client), which lists selected vision care services and vision care materials which a Covered Person is entitled to receive under the Policy. Additional Benefits are only available when purchased by Client in conjunction with a Plan Benefit offered under the Schedule of Benefits.
Assignment Of Benefits	A written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing VSP to pay available Plan Benefits to a named Open Access Provider.
Client	An employer or other entity which contracts with VSP for coverage under the Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents, if such dependent coverage is provided.
Coordination Of Benefits	Procedure which allows more than one insurance plan to consider Covered Persons' vision care claims for payment or reimbursement.
Copayments	Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.
Covered Person	An Enrollee or Eligible Dependent who meets Client's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under the Plan.
Enrollee	An employee or member of Client who meets the criteria for eligibility established by Client.
Plan Or Plan Benefits	The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Policy, as defined in the attached Schedule of Benefits and Additional Benefit Rider (when purchased by Client).
Open Access Provider	Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.
Plan Administrator	The person specifically so designated on the Client application, or if an administrator is not so designated, the Client. The Plan Administrator shall have authority to control and manage the operation and administration of the Plan on behalf of the Client.
Policy	The contract between VSP and Client upon which this Plan is based.

Schedule Of Benefits	The document(s), attached as Exhibit A to the Client Policy maintained by the Plan Administrator and to this Evidence of Coverage, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan.
Vsp Preferred Provider	An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to Plan Benefits on behalf of Covered Persons of VSP.
Urgent Care	Services for a condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical, action.

Exhibit A

Eastern Vision Service Plan, Inc.
Schedule Of Benefits
VSP Signature Plan®
Buy Up Plan with 2nd Pair

General

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of EASTERN VISION SERVICE PLAN, INC.("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

Benefit Period

A twelve-month period beginning on January 1st and ending on December 31st.

Eligibility

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee;
- Legal Spouse or Domestic Partner of Enrollee; and
- Children of Enrollee, including enrollee's natural Children, legally adopted Children, step Children, and Children for whom Enrollee is the proposed adoptive parent without regard to financial dependence, residency with Enrollee, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which Child turns 26 years of age. Coverage also includes Children for whom Enrollee is the legal guardian if the Children are chiefly dependent upon Enrollee for support

and Enrollee has been appointed the legal guardian by a court order. Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon Enrollee for support and maintenance, will remain covered while Enrollee's insurance remains in force and Enrollee's Child remains in such condition. Enrollee has 31 days from the date of Enrollee's Child's attainment of the termination age to submit an application to request that the Child be included in Enrollee's coverage and proof of the Child's incapacity. Foster and grandchildren are not covered. VSP has the right to check whether a Child is and continues to be eligible for coverage.

Plan Benefits/VSP Preferred Providers

Copayment

There shall be a Copayment of $15.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $15.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Covered Services And Materials

Eye Examination- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

Lenses - Covered in full* once every 12 months**

Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular).

Standard Progressive Lenses covered in full.

Lens Options

- Anti-reflective coating covered in full once every 12 months.**
- Scratch coating covered in full once every 12 months.**
- Polycarbonate Lenses covered in full once every 12 months.**
- Tinted/Photochromic covered in full once every 12 months.**

Frames - Covered up to the Plan allowance* once every 12 months**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients as determined by VSP Preferred Provider.

Contact Lenses

Elective

Elective Contact Lenses (materials only) are covered up to $150.00 once every 12 months.**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a maximum $60.00 Copayment.

Necessary

Necessary Contact Lenses are covered in full* once every 12 months.**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**Beginning with the first day of the Benefit Period.

Low Vision

Professional services for severe visual problems not correctable with regular lenses, including:

- Supplemental Testing: Covered in full*; and
  - Includes evaluation, diagnosis and prescription of vision aids where indicated.
- Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00.*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Exclusions And Limitations Of Benefits

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

Not Covered

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed in the Frames benefit section, above.
- Two pair of glasses instead of bifocals.
- Replacement of spectacle lenses, frames and/or contact lenses furnished under this plan which are lost or damaged, except at the normal intervals when services are otherwise available.

- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

Reimbursement Schedule/Open Access Providers

Copayment

There shall be a Copayment of $15.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $15.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Covered Services and Materials

Eye Examination: Up to $ 50.00* once every 12 months.**

Comprehensive examination of visual functions and prescription of corrective eyewear.

Spectacle Lenses

- Single Vision Up to $ 50.00* once every 12 months.**
- Bifocal Up to $ 75.00* once every 12 months.**
- Trifocal Up to $100.00* once every 12 months.**
- Lenticular Up to $125.00* once every 12 months.**
- Frames: Covered up to $ 70.00* once every 12 months.**

Contact Lenses

Elective

Elective Contact Lenses are covered up to $105.00 once every 12 months.**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

Necessary

Necessary Contact Lenses are covered up to $210.00* once every 12 months.**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**Beginning with the first day of the Benefit Period.

Low Vision

Professional services for severe visual problems not correctable with regular lenses, including:

- **Supplemental Testing: Up to $125.00*:** Includes evaluation, diagnosis and prescription of vision aids where indicated.
- **Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00***

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Open Access Providers

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

Exhibit B

Eastern Vision Service Plan, Inc.
Schedule Of Benefits
VSP Signature Plan®
Base Plan

General

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of EASTERN VISION SERVICE PLAN, INC.("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

Benefit Period

A twelve-month period beginning on January 1st and ending on December 31st.

Eligibility

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee;

- Legal Spouse or Domestic Partner of Enrollee;, and
- Children of Enrollee, including enrollee's natural Children, legally adopted Children, step Children, and Children for whom Enrollee is the proposed adoptive parent without regard to financial dependence, residency with Enrollee, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the year in which Child turns 26 years of age. Coverage also includes Children for whom Enrollee is the legal guardian if the Children are chiefly dependent upon Enrollee for support and Enrollee has been appointed the legal guardian by a court order. Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon Enrollee for support and maintenance, will remain covered while Enrollee's insurance remains in force and Enrollee's Child remains in such condition. Enrollee has 31 days from the date of Enrollee's Child's attainment of the termination age to submit an application to request that the Child be included in Enrollee's coverage and proof of the Child's incapacity. Foster and grandchildren are not covered. VSP has the right to check whether a Child is and continues to be eligible for coverage

Plan Benefits/VSP Preferred Providers

Copayment

There shall be a Copayment of $15.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $15.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Covered Services And Materials

Eye Examination- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

Lenses - Covered in full* once every 12 months**

Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular).

Standard Progressive Lenses covered in full.

Lens Options

- Anti-reflective coating covered in full once every 12 months.**
- Scratch coating covered in full once every 12 months.**
- Polycarbonate Lenses covered in full once every 12 months.**
- Tinted/Photochromic covered in full once every 12 months.**

Frames - Covered up to the Plan allowance* once every 12 months**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients as determined by VSP Preferred Provider.

Contact Lenses

Elective

Elective Contact Lenses (materials only) are covered up to $150.00 once every 12 months.**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a maximum $60.00 Copayment.

Necessary

Necessary Contact Lenses are covered in full* once every 12 months.**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**Beginning with the first day of the Benefit Period.

Low Vision

Professional services for severe visual problems not correctable with regular lenses, including:

- **Supplemental Testing: Covered in full*:**Includes evaluation, diagnosis and prescription of vision aids where indicated.
- **Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00***

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Exclusions And Limitations Of Benefits

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

Not Covered

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.

- Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed in the Frames benefit section, above.
- Two pair of glasses instead of bifocals.
- Replacement of spectacle lenses, frames and/or contact lenses furnished under this plan which are lost or damaged, except at the normal intervals when services are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

Reimbursement Schedule/Open Access Providers

Copayment

There shall be a Copayment of $15.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $15.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Covered Services And Materials

Eye Examination: Up to $ 50.00* once every 12 months.**

Comprehensive examination of visual functions and prescription of corrective eyewear.

Spectacle Lenses

Single Vision Up to $ 50.00* once every 12 months.**

Bifocal Up to $ 75.00* once every 12 months.**

Trifocal Up to $100.00* once every 12 months.**

Lenticular Up to $125.00* once every 12 months.**

Frames: Covered up to $ 70.00* once every 12 months.**

Contact Lenses

Elective

Elective Contact Lenses are covered up to $105.00 once every 12 months.**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

Necessary

Necessary Contact Lenses are covered up to $210.00* once every 12 months.**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**Beginning with the first day of the Benefit Period.

Low Vision

Professional services for severe visual problems not correctable with regular lenses, including:

- **Supplemental Testing: Up To $125.00*:** Includes evaluation, diagnosis and prescription of vision aids where indicated.
- **Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00***

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Open Access Providers

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

Eastern Vision Service Plan, Inc.
Additional Benefit Rider

Diabetic Eyecare Plus Program

General

This Rider lists additional vision care benefits to which Covered Persons of EASTERN VISION SERVICE PLAN, INC. ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. Plan Benefits under the Diabetic Eyecare Plus Program are available to Covered Persons who have been diagnosed with type 1 or type 2 diabetes and specific ophthalmological conditions. This Rider forms a part of the Policy or Evidence of Coverage to which it is attached.

Eligibility

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee;
- Legal Spouse or Domestic Partner of Enrollee; and
- Children of Enrollee, including enrollee's natural Children, legally adopted Children, step Children, and Children for whom Enrollee is the proposed adoptive parent without regard to financial dependence, residency with Enrollee, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the year in which Child turns 26 years of age. Coverage also includes Children for whom Enrollee is the legal guardian if the Children are chiefly dependent upon Enrollee for support and Enrollee has been appointed the legal guardian by a court order. Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon Enrollee for support and maintenance, will remain covered while Enrollee's insurance remains in force and Enrollee's Child remains in such condition. Enrollee has 31 days from the date of Enrollee's Child's attainment of the termination age to submit an application to request that the Child be included in Enrollee's coverage and proof of the Child's incapacity. Foster and grandchildren are not covered. VSP has the right to check whether a Child is and continues to be eligible for coverage.

Program Description

The Diabetic Eyecare Program (“DEP”) is intended to be a supplement to Covered Person’s group medical plan. Providers will first submit a claim to Covered Person’s group medical insurance plan, and then to VSP. Any amounts not paid by the medical plan will be considered for payment by VSP. (This is referred to as “Coordination of Benefits” or “COB." Please refer to the Coordination of Benefits section of Covered Person’s Evidence of Coverage for additional information regarding COB.) If Covered Person does not have a group medical plan, providers will submit claims directly to VSP.

Examples of symptoms which may result in an Covered Person seeking services under DEP Plus may include, but are not limited to:

- blurry vision;
- trouble focusing;
- transient loss of vision;
- “floating” spots;
- tunnel vision; and
- visual distortion.

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy;
- age-related macular degeneration;
- rubeosis;
- glaucoma; and
- diabetic macular edema.

Procedures for Obtaining Diabetic Eyecare Plus Services

Covered Person Has a Group Medical Plan

The DEP Plus Program provides coverage for certain vision-related medical services as a supplement to Covered Person’s group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine how to obtain plan benefits.

The provider should first submit a claim to Covered Person’s group medical insurance plan. Any amounts not paid by the medical plan may then be considered for payment by VSP. (This is referred to as “Coordination of Benefits” or “COB." Please refer to the Coordination of Benefits section of Covered Person’s Evidence of Coverage for additional information regarding COB.)

Covered Person Does Not Have A Group Medical Plan

When Covered Person does not have a group medical plan, the DEP Plus Program provides Plan Benefits as follows:

1. Covered Person contacts a VSP Network Doctor and makes an appointment.
2. Covered Person pays the applicable Copayment at the time of each DEP Plus Program visit and amounts for any additional services not covered by the Plan.

Referrals

If Covered Person's Member Doctor cannot provide Covered Services, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of DEP Plus, the Member Doctor will refer the Insured to a physician.

Referrals are intended to insure that Covered Persons receive the appropriate level of care for their presenting condition. **Covered Persons do not require a referral from a Member Doctor in order to obtain Plan Benefits.**

Plan Benefits/VSP Preferred Provider

Covered Services

Eye Examination: Covered in full after a Copayment of $20.00.

Special Ophthalmological Services: Covered in Full.

Exclusions And Limitations Of Benefits

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available to Covered Persons upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

Not Covered

1. Services and/or materials not specifically included in this Rider as covered Plan Benefits.
2. Frames, spectacle lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery of any type, and any pre- or post-operative services and/or supplies.
5. Treatment for any pathological conditions.
6. An eye exam required as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where VSP is required by law to pay.

Diabetic Eyecare Plus Program Definitions

AMD	Age-related macular degeneration (AMD) is a disease that destroys the clear, “straight ahead” central vision necessary for reading, driving, identifying faces and performing other daily tasks.
Diabetes	A disease where the pancreas has a problem either making, or making and using, insulin.
Type 1 Diabetes	A disease in which the pancreas stops making insulin.
Type 2 Diabetes	A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.
Diabetic Retinopathy	A weakening in the small blood vessels at the back of the eye.
Rubeosis	Abnormal blood vessel growth on the iris and the structures in the front of the eye.
Diabetic Macular Edema	Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula.
Glaucoma	A disease in which damage to the optic nerve leads to progressive, irreversible vision loss.
Special Ophthalmological Services	Medical eyecare procedures for the investigation and management of ocular disorders associated with diabetic eye disease, glaucoma and/or AMD.

Exhibit D

Eastern Vision Service Plan, Inc.

Additional Benefit Rider

Second Pair

General

This Rider entitles Covered Persons of EASTERN VISION SERVICE PLAN, INC.("VSP") to an additional pair of glasses or contact lenses, subject to any Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated, and forms a part of the Policy or Evidence of Coverage to which it is attached.

Benefit Period

A twelve-month period beginning on January 1st and ending on December 31st.

Eligibility

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee;
- Legal Spouse or Domestic Partner of Enrollee; and
- Children of Enrollee, including enrollee's natural Children, legally adopted Children, step Children, and Children for whom Enrollee is the proposed adoptive parent without regard to financial dependence, residency with Enrollee, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the year in which Child turns 26 years of age. Coverage also includes Children for whom Enrollee is the legal guardian if the Children are chiefly dependent upon Enrollee for support and Enrollee has been appointed the legal guardian by a court order. Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon Enrollee for support and maintenance, will remain covered while Enrollee's insurance remains in force and Enrollee's Child remains in such condition. Enrollee has 31 days from the date of Enrollee's Child's attainment of the termination age to submit an application to request that the Child be included in Enrollee's coverage and proof of the Child's incapacity. Foster and grandchildren are not covered. VSP has the right to check whether a Child is and continues to be eligible for coverage.

Plan Benefits/VSP Preferred Providers

Copayment

There shall be no Copayment for the examination. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be a Copayment of $15.00 payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Covered Services And Materials

Lenses: Covered in full* once every 12 months.**

Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular).

Standard Progressive Lenses covered in full.

Lens Options

- Anti-reflective coating covered in full once every 12 months.**
- Scratch Coating covered in full once every 12 months.**
- Polycarbonate Lenses covered in full once every 12 months.**
- Tinted/Photochromic covered in full once every 12 months.**

Frames: Covered up to the Plan allowance* once every 12 months.**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

Contact Lenses

Elective

Elective Contact Lenses (materials only) are covered in full up to $150.00 once every 12 months.**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a maximum $60.00 Copayment.

Necessary

Necessary Contact Lenses are covered in full* once every 12 months.**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**Beginning with the first day of the Benefit Period.

Exclusions and Limitations Of Benefits

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

Not Covered

- Services and/or materials not specifically included in this Rider as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).
- Two pair of glasses instead of bifocals.
- Replacement of spectacle lenses, frames or contact furnished under this Plan which are lost or damaged, except at the normal intervals when services are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.

Reimbursement Schedule/ Open Access Providers

Copayment

There shall be no Copayment for the examination. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be a Copayment of $15.00 payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Covered Services

Special Ophthalmological Services: Payable benefits will be limited to 80% of the amount allowed by Medicare for each service rendered, not to exceed the billed amount.

Spectacle Lenses

Single Vision Up to $50.00* once every 12 months.**

Bifocal Up to $75.00* once every 12 months.**

Trifocal Up to $100.00* once every 12 months.**

Lenticular Up to $125.00* once every 12 months.**

Frames: Covered up to $70.00* once every 12 months.**

Contact Lenses

Elective

Elective Contact Lenses are covered up to $105.00 once every 12 months.**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

Necessary

Necessary Contact Lenses are covered up to $210.00* once every 12 months.**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**Beginning with the first day of the Benefit Period.

Exclusions and Limitations Of Benefits/Open Access Providers

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP’s quality standards.

Summary Of Benefits And Coverage
Signature Plan
Base And Buy Up

Prepared For: **The Segal Group, Inc.**
Group Id: **12322369**
Effective Date: **January 1, 2019**

The Affordable Care Act requires that health insurance companies and group health plans provide consumers with a simple and consistent benefit and coverage information document, beginning September 23, 2012. This document is a Summary of Benefits and Coverage (SBC).

The grid below is being provided for your convenience and mirrors the sample SBC that the U.S. Department of Labor has published. All the information provided is relative to your plan and described in detail in the preceding Evidence of Coverage.

Common Medical Event	**Services You May Need**	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations and Exceptions
If you or your dependents (if applicable) need eyecare	Eye Exam	$15.00 Copay	Reimbursed up to $50.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Glasses: $15.00 Copay (lenses and/or frames only); Up to $60.00 copay for Contact Lens Exam	Frames reimbursed up to $ 70.00 SV Lenses reimbursed up to $ 50.00 Bi-Focal Lenses reimbursed up to $75.00 Tri-Focal Lenses reimbursed up to $100.00 Lenticular Lenses reimbursed up to $125.00 ECL reimbursed up to $105.00	Frames covered every 12 months** Lenses covered every 12 months**

**Beginning with the first day of the Benefit Period.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.

Section 5:
Pension Plan of the Segal Company — Summary Plan Description

As Restated Effective January 1, 2014 and Amended Through January 1, 2020

Overview

The Pension Plan of the Segal Company (Plan) offers retirement benefits in the form of a lifetime monthly pension to you and continuing payments after your death to your Spouse or Other Beneficiary. The Company[5] pays all costs for the Plan. The benefits it provides are a means to acknowledge the hard work and important contributions of Segal's employees toward the Company's success.

Your benefits from the Plan are based on a combination of factors. You earn retirement income as you complete Years of Service with the Company. Your salary history, including certain bonuses and incentives you may receive, is another factor in determining your benefits.

Generally, if you were employed by the Company before January 1, 2015, and become a vested Participant, your benefit will be calculated based on the Plan's Final Average Pay Benefit Formula. You vest in the benefits when you have five Years of Service (or attain Normal Retirement Age, if sooner). If you are in the above category, you are referred to in this SPD as a "Pre-2015 Participant."

If you were first employed by the Company on or after January 1, 2015, you will be covered by the Plan's combined Cash Balance Benefit Formula and the Career Average Benefit Formula, and you will vest in your benefits when you have three Years of Service. If you are in this category, you are referred to in this SPD as a "Post-2014 Participant."

There are certain exceptions to this date of employment distinction that affect you only if you were first hired prior to 2015, left employment, and then were rehired after 2014. These exceptions are discussed later in this Summary Plan Description (SPD).

Special rules apply if you are a member of the United Food and Commercial Workers (UFCW) Local 881 and a Participant in the Pension Plan of The Segal Company (Plan). See *Appendix 1* — UFCW Formula.

Depending on your age and Years of Service, you will have a choice as to when you want to commence receiving retirement payments. You will also have a choice as to the form of the payments.

[5] The Plan is offered to employees of these Participating Companies:
- The Segal Company (Eastern States), Inc.
- The Segal Company (Western States), Inc.
- The Segal Company (Midwest), Inc.
- The Segal Company (Southeast), Inc.
- Segal Advisors, Inc.
- Segal Select Insurance Services, Inc.

In this SPD, you will find information about Plan benefits, how those benefits are calculated, and available payment methods. If you have any questions about the Plan after reading through this information, please contact the Human Resources Department.

Important Note:

This SPD is intended to be a general overview of the plan. It is intended to be accurate, but in all cases, the official Plan documents govern and are the final authority on the terms of the Plan. If there are any discrepancies between the information in this SPD and the Plan, the Plan documents will control.

Information in this SPD should not be treated as legal or tax advice. You should consult with your tax advisor or attorney, as appropriate, for such advice.

Highlights of the Plan

- Plan participation commences on the first January 1 following your completion of six months of service as an Eligible Employee.
- The Company pays the entire cost of the Plan.
- The Plan provides benefits for different types of retirement — such as a normal or early retirement — based on you satisfying certain age and service requirements.

Your benefits are calculated under formulas that take into account a combination of factors, such as your age when you retire, your Years of Service, and your Pay history. What benefit formula applies to you depends, generally, on whether you were first hired before January 1, 2015, or after December 31, 2014. Special rules apply if you are a member of the United Food and Commercial Workers (UFCW) Local 881 and a Participant in the Pension Plan of The Segal Company (Plan). See *Appendix 1* — UFCW Formula.

- Your benefits under the Plan are vested when you have either three Years of Service (Post-2014 benefit formula) or five Years of Service (Pre-2015 benefit formula and UFCW formula) depending on the benefit formula that applies to you.
- When you retire under the Plan, you will receive monthly benefits for life with continuing payments to your Beneficiary. If you are married, your Spouse is automatically your Beneficiary unless your Spouse consents to you naming another Beneficiary.
- If you leave the Company before you are eligible to retire but after your benefits are vested, you will be able to receive Plan benefits at retirement age as provided under the Plan.

If you die before your retirement benefits begin but after your benefits are vested, a pre-retirement survivor benefit will be available to your Spouse. Your Marriage Partner (defined below) will be eligible for the same type of pre-retirement survivor annuity. If you meet specified age and service standards, in certain cases a pre-retirement lump-sum death benefit is available to whomever you designate.

Forms and Electronic Elections

A hard copy of the Beneficiary Form can be found on SegalNet under Human Resources. Notarized Spousal consent must be submitted in hard copy. It cannot be done on-line.

Joining the Plan

Pre-2015 participant and post-2014 participant

Effective January 1, 2015, different benefit formulas apply to Pre-2015 Participants and Post-2014 Participants. Generally, a Pre-2015 Participant is a person hired before January 1, 2015, and a Post-2014 Participant is a person hired on or after January 1, 2015. However, you are a Post-2014 Participant (and not a Pre-2015 Participant) even though you were hired before January 1, 2015 if;

- You terminated Employment before vesting (i.e., you did not have 5 Years of Service or attain Normal Retirement Age when you terminated), had 5 consecutive one-year Breaks in Service and were rehired as an Employee on or after January 1, 2015; or
- You terminated Employment before January 1, 2015, were fully vested at the time of termination, received a complete cash-out of your accrued benefit at that time, and were rehired on or after January 1, 2015.

Bargained Legacy Marco Employees and Bargained Segal Marco Advisors Employees who become Participants are neither Pre-2015 Participants nor Post-2014 Participants, and instead accrue benefits under the formula provided in the Plan. See Appendix 1 — UFCW Formula of this SPD.

Eligibility

The Plan is offered to employees of these Participating Companies

- The Segal Company (Eastern States), Inc.
- The Segal Company (Western States), Inc.
- The Segal Company (Midwest), Inc.
- The Segal Company (Southeast), Inc.
- Segal Advisors, Inc.
- Segal Select Insurance Services, Inc.

Throughout this SPD, references to “the Company” include the Participating Companies listed above.

You must complete six months of Service to become eligible for the Plan. For employees who transfer from one Participating Company to another Participating Company, or from The Segal Company, Ltd. (Toronto) to a Participating Company, all prior Service will count toward this eligibility requirement.

Anyone working for the Company as an independent contractor is not considered an Employee and is not eligible to participate. If the Company hires you as an Employee after you have been working on a contract basis, your eligibility will be based on the date you are formally classified as an “Employee.” Similarly, your eligibility ends when you are no longer classified as an “Employee,” even if you provide some services to the Company as an independent contractor after that.

An Employee is not eligible to become a Participant in the Plan if the Employee is a member of a bargaining unit represented by a union with which a Participating Company has entered into an agreement to contribute to a different employee pension benefit plan or not to maintain such a plan for its members.

When participation begins

You become a Participant on the first January 1 following the completion of six months of Service.

If you leave the Company before that January 1, but later return to work, your Plan participation will begin on the January 1 following the date you return or after one Year of Service, whichever is earlier.

Service includes the time you work for the Company, are on a paid absence from work, or take an unpaid approved leave of absence for up to one year. If you leave the Company and are rehired within one year, the time between your leaving and returning to work will count as Service (but only for vesting purposes). A period of qualified military service, or parental or sick leave, also may count as Service.

Enrollment

You do not need to take any steps to enroll in the Plan. You will automatically become a Participant on the date you are eligible to participate. However, you should name a Beneficiary at the time eligibility occurs.

Your beneficiary

Your Beneficiary is the person you name to receive benefit payments that might be available if you die before or after benefits commence. The benefits that might be available to your Beneficiary are explained later in this SPD under “How Benefits are Paid.”

If you are single, you may name anyone as your Beneficiary to receive benefits after your benefits commence and you die. If you are married, your Spouse is automatically your Beneficiary for retirement benefits. To choose a Beneficiary other than your Spouse for benefits, you must provide written notarized consent from your Spouse. If you are divorced, and your benefit is subject to a Qualified Domestic Relations Order (QDRO) treating your former spouse as your Spouse, your former spouse will be treated as your Spouse to the extent provided in the QDRO.

If you die after becoming vested, your Spouse (or your former Spouse pursuant to a QDRO) or your Marriage Partner is eligible to receive a survivor annuity. In some cases, you will be able to name a Beneficiary to receive a lump sum death benefit if, in general, 60 months of benefits have not been paid to you at your death. The rules for this benefit are discussed later in this SPD.

Effective June 26, 2013, you are treated as “married” for Plan purposes if your relationship is recognized as a marriage under the laws of the state in which the marriage was performed and the applicable laws of the United States. Your “Spouse” is defined as the person to whom you

are married. A “Surviving Spouse” is the Spouse to whom you had been married throughout the one-year period before your death.

The Plan provides a pre-retirement survivor annuity to your Spouse or Marriage Partner. As with a Spouse, a Marriage Partner must be your Marriage Partner throughout the one-year period before your death to be treated as Marriage Partner for survivor benefit purposes.

If you are claiming to be, or to have, a Spouse or a Marriage Partner, you will be responsible for demonstrating to the satisfaction of the Plan Administrator, in its discretion, the existence of the marriage or the Marriage Partnership under the applicable laws.

You should always keep the Plan informed as to your marital status and keep your Beneficiary designations filed with the Plan up to date.

Effective June 26, 2013, a person is a “Marriage Partner” if he or she is:

- The person with whom you are formally united in a Domestic Partnership, Civil Union, or similar relationship (other than marriage) based on the laws of the state in which you reside, and;
- Those laws grant a couple who have formalized their Domestic Partnership, Civil Union (or similar relationship) substantially the same rights under the laws of that jurisdiction as a married couple;
- The people in the relationship are the same gender, and;
- The couple would not be considered married under the laws of the United States.

How the Plan Works

Funding the plan

The Company pays the full cost of the Plan. Employees participating in the Plan do not make contributions. The Company’s contributions are paid into a Trust Fund that is used to provide benefits to Participants and their Beneficiaries and to cover certain administrative expenses associated with the Plan.

Vesting

“Vesting” refers to your right to receive the benefits that you have earned. Under the Final Average Pay Benefit Formula applicable to Pre-2015 Participants, you become 100% vested when you have five Years of Service. In the case of Post-2014 Participants, 100% vesting occurs under the combined Cash Balance Benefit Formula and the Career Average Benefit Formula after three Years of Service.

Break in service

Under the Plan, you have a “Break in Service” if you have a Severance from Service and you perform no Service for one year. A Severance from Service occurs on the earlier of the day on which you quit, are discharged, die, are terminated after your Normal Retirement Date, or have the first anniversary of your absence for any other reason.

Some situations do not count towards a Severance from Service or a Break in Service. These include:

- An approved leave of absence, including leave under the Family and Medical Leave Act;
- An absence (for up to a year) due to pregnancy, childbirth or placement of an adopted child, or to care for the child following birth or adoption; or
- A period of military service within certain time limits.

In the circumstances listed above, if you return to work after the absence, the time you were not at work would be credited as Service.

Reemployment

If you leave the Company prior to retirement and are rehired at a later date, whether you are vested when you leave, and for how long you leave, govern what happens when you are rehired.

If your Employment ends before you vest, the following rules apply:

- If you return to work before you have 5-consecutive one-year Breaks in Service, you become a Participant again on the date you are rehired. You will be credited for your prior Years of Service and that prior Service will count toward the vesting of future benefits. In addition, the new Years of Service you earn will count towards Years of Service for purposes of vesting the unvested benefits earned prior to your leaving.
- If you return to work after 5-consecutive one-year Breaks in Service, you will be considered a new Employee. Participation will begin under the normal eligibility requirements. Your prior Service with the Company and the benefit amount you forfeited will not be restored.

If your Employment ends after you vest and you return to work at any time, you will become a Participant immediately and your prior Service will be restored. You will be fully vested in all past benefits and any benefits you earn in the future (unless you received a complete cash-out of your accrued benefit at the time of termination).

When Benefits Are Paid

Normal retirement

You are eligible for normal retirement benefits when you reach Normal Retirement Age. Your Normal Retirement Age is the later of age 65 or five years after your Employment Commencement Date. Your benefit payments may begin as of the first day of the month after you retire.

The discussion under Part A below applies to you if you are a Pre-2015 Participant. Pre-2015 Participants continue to be subject to the Final Average Pay Benefit Formula. If you are a Post-2014 Participant, your benefits are discussed in Part B below. You will be subject to the Cash Balance Benefit Formula and the Career Average Benefit Formula.

Part A — pre-2015 participants

Your retirement benefits are based on a combination of several factors, including:

- Your Years of Service with the Company (up to a maximum of 25 Years);
- Your age at the time you commence payments; and
- Your Final Average Pay.

"Final Average Pay" or "FAP" is the average monthly Pay you receive during the five consecutive years (or the total years, if less than five) of your highest earnings. Your Pay includes any amounts deducted as Before-Tax 401(k) contributions, and any deductions for medical and transit benefits. It also includes certain bonuses and sales incentives (100% up to $40,000 and one-half of any amount over $40,000) and any overtime pay. Pay for any year is limited by Section 401(a)(17) of the Code. In 2020, that limitation is $290,000. The limitation is adjusted annually by the Secretary of the Treasury based on a cost-of-living index and rounding rules.

You accrue a benefit of 1.65% of your FAP for every Year of Service (capped at 25). This represents your Normal Retirement Benefit, i.e., the annuity you will receive starting at age 65. If you commence benefits earlier, your benefit will be reduced as discussed later in this SPD.

The benefit formula used to calculate your retirement benefits considers your Years of Service up to a maximum of 25 Years. However, any additional years that you work for the Company will be considered when determining your period of highest earnings Pay.

Normal Retirement Formula

1.65% of Final Average Pay
multiplied by Years of Service[6] (yearly benefit)
divided by 12 (monthly benefit)[6]

Example

If $31,000 was your Final Average Pay and you had 24 Years of Service, your monthly benefit for a retirement at age 65 would be:

Normal Retirement Benefit[7]

$31,000 x 1.65% = $511.50
$511.50 x 24 = $12,276.00 (yearly benefit)[8]
$12,276.00 ÷ 12 = $1,023.00 (monthly benefit)[8]

Part B — post-2014 participants

Your benefit as a Post-2014 Participant is the sum of your benefits under two formulas:

- The Career Average Benefit Formula
- The Cash Balance Benefit Formula

[6] Up to a maximum of 25 Years of Service.
[7] Assumes a life annuity for you with no benefits continuing to a beneficiary.
[8] Appropriate income tax not applied to amount shown.

Career average benefit formula

Under the Career Average Benefit Formula, your benefit is the sum of each year's accrual. The accrual for a Plan Year is equal to 1% of your Pay in the Plan Year (or part thereof). Your Career Compensation Accrual is the sum of the accruals for all Years of Service (not to exceed the 30 consecutive Years of Service in which your Pay was highest).

Cash balance benefit formula

Under the Cash Balance Benefit Formula, you will have a cash balance account in the Plan to which amounts are credited each year. This account is a "hypothetical" account and used for bookkeeping purposes. (This differs from The Segal Group Profit Sharing Plan, where your account is real and actual earnings in the account determine your account balance and benefits.) You receive a Contribution Credit of 2% of your Pay for each Plan Year or part of a Plan Year (limited to 30 consecutive Years of Service). Your account is also credited with an annual Interest Credit equal to the account balance as of the first day of the Plan Year times the annual rate of interest on 30-year Treasury Securities for the month of November preceding the Plan Year. (For 2020, the rate is 2.28 percent.)

While the amount of the Contribution Credit and Interest Credit is determined based on your account balance as of the first day of the Plan Year, the actual crediting of the amounts is on the last day of the Plan Year. (For the Plan Year in which you start benefit payments, the amount is credited as of the last day of the month preceding the Annuity Starting date and is adjusted proportionately for the number of months of the Plan Year that precede the Annuity Starting Date.)

To determine your benefit under the Cash Balance Formula Benefit, your hypothetical account balance is converted to a straight life annuity commencing on your normal retirement date. This conversion is done by projecting your cash balance account on the Determination Date to your Normal Retirement Date based on the rate of the Interest Credit in effect on the Determination Date, and then converting the account balance to an annuity using the Plan's Actuarial Equivalent factors.

Normal retirement benefit

Your Normal Retirement Benefit is the sum of your benefit under the Cash Balance Benefit Formula and the Career Average Benefit Formula expressed as a straight life annuity at Normal Retirement Age.

Example

You start working for the Company in 2015 when you are age 35. You work for 10 years before separating from service on the last day of 2024 at age 45. At age 65, your Normal Retirement Benefit would be determined by calculating your benefit separately under the Career Average Benefit Formula and under the Cash Balance Benefit Formula and adding them together.

Career Average Benefit Formula Calculation

Year	Assumed Pay	Career Average Accrual (1% times Pay)

2015	$50,000	$500
2016	$55,000	$550
2017	$60,000	$600
2018	$65,000	$650
2019	$70,000	$700
2020	$75,000	$750
2021	$80,000	$800
2022	$85,000	$850
2023	$90,000	$900
2024	$95,000	$950
Total	**$725,000**	**$7,250**

Career Average Monthly Annuity at Age 65: The $7,250 represents your annual annuity at age 65. To calculate your monthly annuity divide $7,250 by 12 = **$604.17 per month**.

To obtain your total monthly benefit at age 65, your benefit under the Cash Balance Benefit Formula component must also be determined.

Cash Balance Benefit Formula Calculation

The Contribution Credit is made on the last day of each year. For simplicity, the example assumes an Interest Credit of 3% (although in reality it will vary with the rate of return for the year on 30-year Treasury securities).

Year	Assumed Pay	Contribution Credit (2% x Pay)	Cumulative Cash Balance Account Value at the end of the Year
2015	$50,000	$1,000	$1,000.00
2016	$55,000	$1,100	$2,130.00
2017	$60,000	$1,200	$3,393.90
2018	$65,000	$1,300	$4,795.72
2019	$70,000	$1,400	$6,339.59
2020	$75,000	$1,500	$8,029.78
2021	$80,000	$1,600	$9,870.67
2022	$85,000	$1,700	$11,866.79
2023	$90,000	$1,800	$14,022.79
2024	$95,000	$1,900	$16,343.47

To determine your **Cash Balance Monthly Annuity at age 65:**

- Step 1: Increase the $16,343.47 account balance at the end of 2024 at 3% interest for 20 years (until you are age 65) – $16,343.47 x $(1.03)^{20}$ = $29,518.12

- Step 2: Convert the $29,518.12 account balance at age 65 to a yearly annuity by dividing it by the appropriate actuarial factor (to reflect mortality and interest rate) — $29,518.12/13.3801 = $2,206.12 per year
- Step 3: Convert the annual benefit into a monthly benefit by dividing by 12 — $2,206.12/12 = **$183.84 per month**

Monthly annuity calculation

Your Total Monthly Annuity at age 65 is a monthly annuity equal to the sum of the monthly annuities under the Career Average Benefit Formula and the Cash Balance Benefit Formula.

$604.17 + $183.84 = $788.01 per month, which is rounded up to the next whole dollar. Thus, your monthly annuity would be $789 per month.

Section 415(b) of the Code sets limits on the maximum benefit amount that can be earned and paid to individual Plan Participants. The Plan Administrator will notify anyone who is affected by these maximum benefits, which generally will apply to only a few Participants.

Early retirement

You are eligible for Early Retirement Benefits if you are not yet age 65, but are at least age 55 at the time of your termination and have 10 or more Years of Service. You may start receiving benefits as of the first day of the month after you retire; or, you may elect to defer the start of payments.

Your benefit amount is calculated under the same formula used for your Normal Retirement Benefit. However, because payments begin before age 65, the monthly Normal Retirement Benefit is actuarially reduced to account for the longer period of time that payments will be made. The reduction is 3% for each year before age 65 that benefits begin. Partial years are pro-rated at ¼ of 1% for each month. Generally, months are counted back from the first day of the month following your retirement. However, if your birthday is the first day of the month, months are counted back from the month of your retirement.

The table below shows the actuarial reduction factors at each age.

Early Retirement Formula

If You Are This Age When Benefit Payments Begin	You Will Receive This Percentage of Your Normal Retirement Benefit[9]
65	100%
64	97%
63	94%
62	91%
61	88%
60	85%
59	82%

[9] Percentage based on whole years under age 65 (partial years are prorated at ¼ of 1% for each month).

58	79%
57	76%
56	73%
55	70%

Example

You take an Early Retirement at age 59 years and four months. Your monthly Normal Retirement Benefit is $946. Starting from the benefit amount you would receive at your Normal Retirement Age of 65, your monthly payments will be reduced to account for the fact that you are retiring 5 years and 8 months before age 65.

As shown in the Early Retirement Formula table, you will receive approximately 82% of your Normal Retirement Benefit. Taking into account the prorated benefit reduction for partial years, your Early Retirement Benefits are calculated as shown below.

Step 1: Early Retirement Benefit Reduction

3% x 5 = 15% (3% for each year under 65)
¼ of 1% x 8 = 2% (¼ of 1% for each month under age 65)
15% + 2% = 17% (total benefit reduction)

Step 2: Early Retirement Monthly Benefit[10]

17% x $946.00 = $160.82
$946.00 – $160.82 = $785.18[11]

Even if you are eligible to receive an Early Retirement Benefit, you may choose to wait until a later time, up to your age 70½, to start your benefit payments. An advantage of having payments begin at or after age 65 is that your monthly benefit amount will not be reduced for an early start of benefits and will be increased for the delay after age 65. See "Delayed Retirement" below for the increase in benefits that occurs if you delay beyond age 65. (The disadvantage is that you would lose the subsidy built into the Early Retirement factors.)

Deferred vested retirement

A Deferred Vested Retirement provides you with a pension if your Employment ends before reaching Early or Normal Retirement Age, but after your benefits are fully vested under the Plan.

- If you leave the Company before age 55 and you have 10 or more Years of Service, you may start receiving benefits when you reach age 55.
- If you leave the Company at any age and you have at least five, but less than 10, Years of Service, you may start receiving benefits at age 65.

[10] Assumes a lifetime-only payment method, with no benefits continuing to a beneficiary.
[11] Appropriate income tax not applied to amount shown.

The benefits paid under a Deferred Vested Retirement are a specific percentage of your Normal Retirement Pension. You will receive 100% of your Normal Retirement Pension if you wait until age 65 to start receiving benefits. If you start benefit payments at an earlier age, the benefit amount is reduced for each year and month before age 65. (Unlike the Early Retirement reduction factors, the reductions for Deferred Vested Retirement are full reduction factors, resulting in a greater reduction for commencement before age 65 than if you were receiving an Early Retirement Benefit.) Generally, months are counted back from the first day of the month following your retirement. However, if your birthday is the first day of the month, months are counted back from the month of your retirement.

Deferred Vested Retirement Formula

If You Are This Age When Benefit Payments Begin	You Will Receive This Percentage of Your Normal Retirement Benefit[12]
65	100%
64	93-⅓%
63	86-⅔%
62	80%
61	73-⅓%
60	66-⅔%
59	63-⅓%
58	60%
57	56-⅔%
56	53-⅓%
55	50%

Example

You leave the Company before age 55. You are eligible for a Deferred Vested Retirement Pension payable at or after age 55. You choose to have your benefits start at age 62. Your Normal Retirement Monthly Benefit is $1,028.50.

Deferred Vested Retirement Monthly Benefit[13]
At age 62, you will receive 80% of your Normal Retirement Benefit
80% x $1,028.50 = $822.80[14]

Delayed retirement pension

If you are entitled to a retirement benefit and choose to start receiving your pension after your Normal Retirement Age, your Plan benefits will be paid as a Delayed Retirement Pension. The benefit amount will be first calculated as a Normal Retirement Benefit. An additional 0.9% will then be added to your pension for each full month after your Normal Retirement Age that benefit

[12] Percentage based on whole years under age 65 (partial years are prorated at 1/12th for each month).
[13] Assumes a lifetime-only payment method, with no benefits continuing to a beneficiary.
[14] Appropriate income tax not applied to amount shown.

payments were delayed, but excluding any month in which benefits were suspended because you were working. (See Frequently Asked Questions later in this SPD for more details about suspension of benefits.)

Example

You attain Normal Retirement Age at age 65. If you had commenced payments at age 65, your Normal Retirement Benefit would have been $1,000 per month. You commence benefits at age 67. The adjustment is 0.9% per month of delay.

Delayed Retirement Monthly Benefit[15]

There are 24 months between age 65 and age 67
24 x 0.9% = 21.6
$1,000 plus [21.6% x $1,000] per month
= $1,216 per month[16]

If you become disabled

If you terminate employment because you become disabled (as defined by the Plan) before Normal Retirement Age, you will be credited for all Years of Service before your disability began plus Years of Service from the date your disability began until you reach the earliest of Normal Retirement Age, the date you start receiving retirement benefits from the Plan, or you recover from the disability.

If you recover from your disability and start working for the Company again, your participation in the Plan would resume. In that case, at retirement you would be credited for your Service before your disability began, while you were disabled, and for Service after your return to work.

Effective January 1, 2020, for Participants who incur a disability on or after January 1, 2020, the Plan is amended with respect to imputed service credit for Participants who incur a disability (as defined under the terms of the Plan). Participants who incur a disability on or after January 1, 2020, are required to have earned 10 Years of Service before incurring a disability in order to be eligible to receive future imputed service on account of disability. In addition, the number of Years of Service that would be imputed is limited to the number of Years of Service the participant earned before incurring the disability and is subject to the maximum number of Years of Service that can be credited under the Pension Plan.

For purposes of determining your benefits, your Pay will be based on your rate of pay on the day before your disability began. Your Pay will include certain bonuses, spot awards and sales incentives (in amounts up $40,000 and one-half of any excess over $40,000) you received during the consecutive 12-month period immediately preceding the month in which the period of disability began; or, in the event of multiple instances of disability, the consecutive 12-month period immediately preceding the month in which the most recent instance of disability began.

If your pension begins at age 65 (Normal Retirement Age), your monthly retirement payments will be calculated under the same formula used for Normal Retirement Benefits. If you are eligible to retire at or after age 55, but before Normal Retirement Age, your payments are calculated as Early Retirement Benefits, with the Early Retirement reduction for each year before age 65 that benefits begin based on the early retirement table. While you are on

[15] Assumes a lifetime-only payment method, with no benefits continuing to a beneficiary.
[16] Appropriate income tax not applied to amount shown.

disability, you will receive benefits from the Company's long-term disability program and not from this Plan.

Required beginning date for retirement benefits

Regardless of whether you are still working for the Company, your benefit payments must begin no later than April 1 of the year following the calendar year in which you reach age 70½.

In the event that you are not vested in your Plan benefits on your Required Beginning Date(because you have not yet attained Normal Retirement Age), your distributions must commence as of January 1 of the year following the year you become vested.

How Benefits Are Paid

Except if the value of your benefit is $1,000 or less when your Employment ceases, we will not commence benefits until the earlier of when you notify us you would like benefits to commence or the Required Beginning Date. See the FAQs later in this SPD for details on how and when to apply.

If the value of your total pension at termination of employment is $1,000 or less, your benefits will be paid in one lump-sum payment as soon as practicable after termination.

Post-retirement benefits

Annuity payments

If the value of your pension is over $1,000, the Plan offers you several benefit payment annuity options. The payment method you select will affect the amount of your monthly benefit payment and what happens after you die. With the lifetime-only method, you receive your full benefit amount in monthly payments until your death; there are no annuity payments to a Beneficiary after your death. (However, see lump sum death benefits later in this SPD.) With most other methods, your monthly payments are smaller because part of your retirement benefits will be used to provide your Spouse or other Beneficiary with lifetime benefit payments, either in the same amount or as a certain percentage of the monthly benefit payable to you.

If you are married at the time your payments start, payments will be in the form of a 50% joint and survivor annuity to your Spouse unless you elect otherwise. You may elect a 75% joint and survivor annuity or a joint and a 100% survivor annuity without your Spouse's consent. The joint benefit (i.e., the monthly benefit you will receive) will be actuarially reduced to reflect the higher survivor benefit. If you wish to elect an alternative form such as a single life annuity (i.e., an annuity with no survivor benefit), a joint and survivor annuity with a survivor other than your Spouse, the Social Security Option or the Joint and Survivor Annuity Method with Pop-Up Option, you will need your Spouse's notarized consent to make the election.

If you are not married at the time your payments start, payment will be in the form of a single life annuity. When you die, no benefit (other than possibly the 60-month lump sum described below) will be paid to anyone unless you elect to have your benefit paid in the form of a joint and survivor annuity to a Beneficiary that you name (including a Marriage Partner). Generally, the

survivor portion can be 50%, 75%, or 100%, as you choose. However, if your non-Spouse Beneficiary is more than 10 years younger than you, you may not elect the 100% survivor option, and, if your non-Spouse Beneficiary is more than 19 years younger than you, you may elect only the 50% survivor annuity (i.e., neither the 75% nor the 100% is available).

For purposes of the rules above, if a former Spouse is required to be treated as your current Spouse (Alternate Payee) under a qualified domestic relations order (QDRO) with respect to part or all of your benefit, you will be considered to have a Spouse with respect to that part of the benefit, and the rules for married Participants will apply to that part.

For purposes of Spousal consent, you must be married (or be treated as having a Spouse pursuant to a QDRO) on the day as of which your benefits start. If you have not been married for one year at the time that benefits begin, your Spouse will be treated as a non-Spouse Beneficiary at the time of your death if you die before you have been married for one year.

The Plan offers a Social Security Option that is available only if you start receiving Plan benefits before age 65. This method allows you to temporarily increase your monthly payments from the Plan until a certain age (between 62 and 67), then receive lower payments from the Plan once you are eligible for Social Security. The pre-Social Security increase is intended to give you roughly the same retirement income from the Plan in the initial years of your retirement as you can expect from both the Plan and Social Security in later years. If you are married, Spousal consent is required to elect this option.

The Plan's Joint and Survivor Annuity Method with "Pop-Up" Option pays you a monthly benefit equal to 98% of the amount that otherwise would be payable under the joint portion of the joint and survivor annuity. However, if your Beneficiary dies before you, your pension will increase to the amount that would have been payable if you had not chosen a joint and survivor payment method (i.e., if you had chosen a single life annuity). The increase would go into effect on the first day of the month following the death of your Beneficiary. If you are married, Spousal consent is required to elect this option.

You will receive a notice describing your benefit options prior to the time you have to make an election, and you can change your election up until the Annuity Starting Date (with Spousal consent where necessary).

Pre-retirement survivor benefits

Pre-retirement surviving spouse (and marriage partner) annuity

The Pre-Retirement Surviving Spouse Annuity (or Marriage Partner Annuity) provides monthly benefits to your Surviving Spouse (or Surviving Marriage Partner) throughout his or her lifetime. For these benefits to be paid, you must have been married to your Spouse (or together with your Marriage Partner as recognized by the State in which you live) for at least one year prior to your death. The benefit amount and payment date depends on your age, Years of Service and employment status at the time of your death, as described in the following chart.

Pre-Retirement Surviving Spouse Annuity for a Spouse (or Marriage Partner)[17]

	Your Age, Years of Service and Employment Status	Benefits Payable to Your Surviving Spouse (or Marriage Partner)
A.	You die after attaining age 55 with at least 10 Years of Service and you either had been working for the Company at time of death, or had stopped working before that age due to a disability that had continued until your death. **OR** You die after reaching age 65 (or, if later, NRA), regardless of Years of Service, and you had been working for the Company at age 65 (or, if later, NRA).	Benefits are paid as a 100% survivor annuity in the amount that would have been payable if you had retired on the date of death and commenced payments in the form of a 100% joint and survivor annuity. Benefit payments may start on or after the first day of the month following the date of death.
B.	You die after attaining age 55 with at least 10 Years of Service, and you had terminated employment with the Company before age 55 for reasons other than disability.	Benefits are paid as a 50% survivor annuity in the amount that would have been payable if you had commenced payments on the date of death in the form of a 50% joint and survivor annuity. Benefit payments may start on or after the first day of the month following the date of death.
C.	You die before attaining age 55 with at least 10 Years of Service, regardless of whether you are still working for the Company (provided that employment did not terminate before 1976).	Benefits are paid as a 50% survivor annuity in the amount that would have been payable if you had severed employment on the earlier of actual severance or the date of death and commenced payment in the form of a 50% joint and survivor annuity at age 55. Benefit payments may start on or after the date you would have reached age 55.
D.	You die before attaining NRA (generally, age 65) with at least five but less than 10 Years of Service.	Benefits are paid as a 50% survivor annuity in the amount that would have been payable if you had terminated employment on the earlier of actual severance or the date of death and commenced benefit payments in the form of a 50% joint and survivor annuity at NRA. Benefit payments may start on or after the date you would have reached NRA.
E.	You die before attaining age 55 with at least 25 Years of Service and you either had been working for the Company at your death or had stopped working due to a disability that had continued until your death.	Benefits are paid as a 50% survivor annuity in the amount that would have been payable if you had commenced payments at age 55 in the form of a 50% joint and survivor annuity.
F.	For deaths occurring after January 1, 2019, you die after attaining age 50 but not age 55 with at least 25 Years of Service, and you either had been working for the Company at your death or had stopped working due to a disability that had continued until your death.	Benefits are paid as in E. above. Benefit payments may start on or after the first day of the month following the date of your death but are reduced for each month of payment that precedes your age 55.

[17] For this purpose a person is a Spouse or Marriage Partner only if they were a Spouse or Marriage Partner, respectively, for the one-year period before the date of death.

If a Participant elects a form of payment for the OJSA before the Annuity Starting Date and dies after making the election and before the Annuity Starting Date, the elected form is treated as the QJSA, and the amount of the Survivor Annuity is based on that form.

Lump-sum survivor benefit

If your death occurs after the month in which you attain:

- Age 55 with at least 10 Years of Service;
- Normal Retirement Age with at least five but less than 10 Years of Service; or
- Normal Retirement Age while you are still working for the Company, regardless of Years of Service; and

no benefit is payable to a Surviving Spouse or Joint Annuitant, the person you name as your designated Beneficiary for this purpose may receive a death benefit.

That benefit is equal to the difference between 60 monthly payments of your benefit in the form of a single life annuity reduced by (i) payments, if any, already made to you (or to you and your Beneficiary under a joint and survivor annuity) and (ii) basic death benefits under Segal's group life insurance plan (up to $50,000).

These benefits shall be paid or begin to be paid within one year of death. If the benefit is over $1,000, the Beneficiary may choose to receive the benefit in the form of an annuity instead of a lump sum.

Pre-retirement survivor benefits if you die while serving in qualified military service

If you die while performing Qualified Military Service, your Beneficiary will be entitled to any additional benefits (other than benefit accruals relating to the period of Qualified Military Service) that would have been provided under the Plan if you had returned to employment on the day before your death. In addition, your period of Qualified Military Service will be treated as Vesting Service under the Plan. "Qualified military service" is service in the uniformed services while on active or inactive duty, including training periods. "Uniformed services" include the Army, Navy, Air Force, Marines, Coast Guard, Reserves, Army and Air National Guards, the commissioned corps of the Public Health Service, and any other persons designated by the President.

Direct rollovers

If (1) the present value of your distribution is less than $1,000 (so you will receive a lump sum payment), or (2) your Beneficiary is entitled to a lump sum death benefit, you or your Beneficiary may elect, at the time and in the manner specified by the Trustees, to have any portion of an eligible rollover distribution from this Plan paid directly to an eligible retirement plan specified by you or your Beneficiary.

An eligible rollover distribution is any distribution of all or any portion of the balance due you or your Beneficiary, except that an eligible rollover distribution does not include:

- Any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the distributee or the joint lives (or joint life expectancies) of you and your designated beneficiary, or for a specified period of ten years or more; or
- Any distribution to the extent such distribution is the Required Minimum Distribution under Section 401(a)(9) of the Code.

An eligible retirement plan is an individual retirement account or annuity (IRA); an annuity plan described in Section 403(a) of the Code; a qualified plan described in Section 401(a) of the Code; an annuity contract described in Section 403(b) of the Code that accepts the your eligible rollover distribution; or an eligible retirement plan under Section 457(b) of the Code maintained by a state, state agency or political subdivision of a state which agrees to separately account for amounts transferred into such plan from this Plan.

In the case of a Marriage Partner or other non-Spouse Beneficiary, the rollover may only be accomplished as a “direct rollover” and the direct rollover may only be made to an Individual Retirement Account (IRA) or annuity that is established on behalf of the designated Beneficiary. This “inherited IRA” is subject to specific distribution requirements. If the rollover is made to any of these accounts, then the distribution will be tax deferred.

In addition, a Roth individual retirement account or Roth individual retirement annuity is eligible to receive rollover distributions. However, in that case, the distribution will first be subject to income tax.

Applying for benefits

To start receiving benefits, you must complete and return an application form to the Human Resources Department. In general, you should request a retirement package, which will include the application form, more than three months prior to your retirement date. If you want to get benefit estimates or you have questions about your payment options or other issues, the Human Resources Department also can help you with that. Benefit estimates may not reflect actual Plan benefits. The Plan reserves the right to correct any errors. Specifically, if there is an inconsistency between the benefit estimate provided and Plan documents, the terms of the Plan documents will control. Under the law, the Plan must be operated in accordance with its terms.

After you notify us, but not more than 180 days before your Annuity Starting Date, the Trustees will provide you with a written notice that explains:

- The terms and conditions of the 50% Joint and Survivor Pension and the Optional 75% and 100% Joint and Survivor Pensions;
- Your right to make, and the effect of, the election to waive the Joint and Survivor Pension;
- That you cannot waive the Joint and Survivor Pension without your Spouse’s consent;
- Your right to revoke your election up to the Annuity Starting Date and the effect of any revocation;
- The relative values of the various optional forms of benefit under the Plan; and
- The right to defer any distribution and the consequences of failing to defer distribution of benefits, in accordance with applicable Treasury and IRS guidance.

In the case of survivor benefits, your Surviving Spouse, Surviving Marriage Partner or Beneficiary should notify the Plan Administrator in writing of your death to receive a Survivor Annuity or the Pre-Retirement or Lump-Sum Death Benefit. The Trustees of the Plan will send your Surviving Spouse, Surviving Marriage Partner or Beneficiary information about the benefits available and the application forms. Payments under the lump sum death benefit provisions must be taken or begin within one year after death.

Once you start receiving benefits, be sure to keep the Company informed of your current mailing address. Otherwise, your payments and important Plan information or announcements could be delayed. You should also keep the Plan advised of the death of any Beneficiary.

Restrictions based on funding level

Federal law requires that plans apply certain restrictions if the Plan's funding level falls below certain thresholds or if the Company goes bankrupt. Currently, the Plan is funded above those levels and the Company intends to continue funding the Plan at sufficient levels so that these restrictions will not apply. You will receive a notice if these restrictions ever apply to the Plan. The restrictions, if applicable, could include, depending on funding level, (1) limitations on the Social Security Option or on lump sum payments in excess of $5,000; (2) limitations on amendments increasing benefits; and (3) automatic freezing of future benefit accruals.

Assignment of benefits

In most cases, you cannot assign, transfer, or pledge any benefits to which you are entitled under the Plan. One exception is that the Plan allows you to elect to have part or all of a monthly benefit used to pay contributions for medical coverage provided by the Company for retired Plan Participants or their Beneficiaries.

In addition, the Company will honor certain court and administrative domestic relations orders requiring that part or all of your benefit be paid to your Spouse, former Spouse, child, or other dependent, but only if the Plan Administrator determines that the court order is a QDRO as defined under the Internal Revenue Code. You will be notified if the Plan receives any such order. A copy of the Plan's QDRO procedures is available to you, without charge, on request to the Plan Administrator. The Plan also may be required to pay out your benefits to satisfy a lien for delinquent taxes.

ERISA and the Code do not treat Marriage Partners as Spouses for QDRO purposes (even if they are dependents eligible to be alternate payees under a QDRO). Contact the Human Resources Department if you have questions.

Powers and duties of Trustees

The Trustees, who are appointed by the Company, serve collectively as the Plan Administrator. The Trustees have the powers and duties necessary for proper administration of the Plan. These include, but are not limited to, the discretion to make decisions with respect to the application and interpretation of the Plan and as to any questions of fact related to such decisions. To the extent permitted by law, the determinations of the Trustees with respect to the interpretation, application, or administration of the Plan, including the Plan provisions regarding eligibility and benefit amounts and payment forms, apply on a uniform, non-discriminatory basis among persons similarly situated and shall be final, binding, and conclusive upon each person or party interested or concerned. A Trustee who is also a Participant cannot vote or act as a Trustee upon any matter relating solely to that Trustee.

Paying taxes on your retirement benefits

Plan benefits are subject to federal (and possibly state and local) income taxes. Each year that payments are made to you from the Plan, you will receive the appropriate tax form indicating the taxable amount of your benefit payments to be included on your income tax returns.

Before your benefits begin, you will receive an election form for federal income tax withholding. When you elect withholding, taxes will be taken out of your benefit payments. If you elect not to have taxes withheld, you will be responsible for paying taxes directly to the government, including any estimated tax payments required. If you do not complete and return your election form, the Company will automatically withhold federal taxes at federally required levels. Special automatic withholding rules apply if you have a foreign address or your address is a post office box. See IRS Publication 15 at www.irs.gov or contact the Human Resources Department.

If your benefit is payable as an eligible rollover distribution (for example, your benefit is payable as a lump sum because the present value is $1,000 or less) and you elect to receive the distribution directly (as opposed to a direct rollover), the Plan must withhold 20 percent of the distribution unless you elect a higher percentage.

Information in this SPD should not be treated as legal or tax advice. You should consult with your tax advisor or attorney, as appropriate, for such advice.

Frequently Asked Questions

Do I have to retire when I reach age 65?

The Company does not have a mandatory retirement provision. If you work past your Normal Retirement Age, your Pay and Years of Service after age 65 will count in determining your benefits in the same manner as years before age 65 (unless you have already reached the maximum Years of Service considered). Under the Plan, the mandatory distribution date of a pension is April 1 of the calendar year following the calendar year in which you reach age 70½. Your benefit payments will begin on the mandatory distribution date even if you are still working for the Company at that time. Your pension will be calculated as if you had retired in December of the calendar year in which you reached age 70½ and recalculated each January 1 while you are still employed.

How can I find out what my estimated benefit amount will be?

You may contact the Human Resources Department for an estimated benefit calculation at any time. Your request will be fulfilled in several weeks. This is only an estimated benefit calculation and it could change.

How much notice should I give the Company when I apply for my benefits?

You should apply for benefits at least three months before you retire. It is important to apply for your benefits as far in advance as possible because the Plan generally does not pay retroactive retirement benefits.

What documents do I need when I apply for my retirement benefits?

In general, you will need to provide a copy of your birth certificate and, if married, a copy of both your marriage certificate and your Spouse's birth certificate. If you had been married but are now divorced, you will need to provide a copy of the divorce documents.

Am I allowed to change my form of payment or beneficiary once I've started receiving benefits?

No. No changes are allowed after your benefit payments have started. However, you may make a change up until your Annuity Starting date (which is the date "as of which" your payments began).

What happens to my benefits if I were to die without naming a Beneficiary?

If you do not name a Beneficiary (with Spousal consent where required), the Plan will pay benefits to your Spouse or Marriage Partner, if any, or if there is none, your children, other dependents, or your estate (as the Trustees in their discretion shall decide). The Trustees of the Plan will decide how to allocate the benefits based on applicable law. When you choose your benefit payment method, you may name a second Beneficiary to receive payments should your primary Beneficiary die before your benefits start.

With the Social Security Adjustment payment option, why do I choose a start date for my benefits between the ages of 62 and 67? Don't my Social Security benefits begin at age 65?

For anyone born on or before January 1, 1938, full Social Security benefits begin at age 65. If you were born after that date, full benefits begin between ages 65 and 67, depending on your date of birth. Reduced Social Security benefits can begin any time after you reach age 62.

How are my benefit payments made?

Once your retirement application is received and processed, it will be entered into the payroll system. Payments are made on the first business day of each month either by check or direct deposit, whichever you choose. You will receive the check or the notice of direct deposit at the beginning of each month. You may elect to receive the notice of direct deposit electronically.

If I retire, then later return to work, how would that affect my benefits?

If you are rehired by the Company after you retired and begun receiving monthly payments from the Plan, or you continue in Employment after Normal Retirement Age with or without applying for a pension, your benefits are suspended for each month preceding the Required Beginning Date (i.e., the April 1 of the calendar year following the calendar year in which you reach age 70½) in which you work 57 or more hours in eight or more days.

Your payments will be recalculated as soon as practicable after your subsequent termination of Employment. If you are over 70 ½ and still in Employment, your annuity payments will be recalculated each January. Recalculated payments are reduced by the actuarial value of any payments you already received, and adjusted for Early Retirement, if applicable. A final calculation is done when you subsequently terminate Employment. However, your monthly payments will not decrease below the amount of the original payments you received.

Other Important Information You Should Know

Claims and appeals procedures

If your application for benefits is denied by the Trustees, in whole or in part, you will be sent a written notice of the denial within 90 days of the date your application was received. Special circumstances may require up to an additional 90 days, in which case you will be notified of the delay extension, the special circumstances requiring the extension, and the expected date of a decision within the initial 90-day period. The notice will describe the specific reason or reasons for the denial, the Plan provisions on which the denial is based, any additional information or material that you might need to provide in order to support your application and an explanation of why it is necessary, and the Plan's review procedures.

You or your authorized representative may request a review of the denial within 60 days of the date you get the denial notice. Requests for review must be in writing and be submitted to the Trustees. In connection with your appeal, upon request and free of charge, you or your authorized representative may review documents relevant to your claim and may submit written comments, documents, records and other information relating to the claim (regardless of whether they were submitted with your original claim). A document is considered "relevant" to your claim only if it was relied upon in making the benefit determination, was submitted, considered or generated in the course of making the benefit determination, or demonstrates compliance with the Plan's administrative processes and safeguards under federal law.

The Trustees will make its decision on the appeal no later than 60 days after receiving the appeal, unless special circumstances require up to an additional 60-day extension, in which case you will be notified of the extension, the special circumstances requiring the extension, and the date by which the Plan expects to render a decision. In deciding an appeal of an adverse determination that is based in whole or in part on medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the applicable field of medicine. That person can be neither: (1) the person involved in the initial determination; nor (2) a subordinate of that person.

Written notice of the decision regarding your appeal will be provided no later than 60 days after the Plan's receipt of the appeal unless special circumstances require up to an additional 60 days. If your appeal is denied, in whole or in part, you will receive a written notice stating: (1) the specific reason or reasons for the decision; (2) the Plan provisions upon which the decision is based; (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents and other information relevant to the claim; and (4) a statement describing your right to bring a civil action under Section 502(a) of ERISA.

Top-heavy plans

A top-heavy plan, as defined by the Internal Revenue Service, is a plan with at least 60% of the present value of all accrued benefits payable to certain key employees. Although this Plan is unlikely to become top-heavy, certain provisions are included in the Plan documents that would take effect under those circumstances. These provisions include, for example, more rapid vesting and special minimum benefits.

Recovery of overpayment

If you or your beneficiary are overpaid or otherwise paid in error, you must return the overpayment. The Board of Trustees have the right to recover any benefit payments made that were based on false or fraudulent statements, information or proof submitted, as well as any benefit payments made in error. Amounts recovered may include interest. In the event you are overpaid, the Plan Administrator will request a refund. If the refund is not received, the Trustees have the right, in their discretion, to take any action deemed necessary to recover such overpayment, including but not limited to, reducing future benefit payments by an amount projected to repay the Plan or initiating a lawsuit.

Special benefit payment procedures

In the event that a Participating Company is part of a transaction that results in multiple participants being eligible for and requesting benefits on a common Annuity Starting Date, the Plan will follow its normal administrative procedures regarding applications, calculations and approval of benefit payments. However, designated representatives of the Human Resources Department may accept oral requests as to the time and form of payment and other information pending receipt of actual documentation.

Amendment and termination

While the Company expects and intends to maintain the Plan permanently, the Company reserves the right at any time to amend or terminate the Plan by formal action of its Board of Directors at any time and executed by an officer authorized to do so by the Company. Except as otherwise permitted by Federal law, no amendment may reduce benefits that have accrued or are in payment status at the time of the amendment.

In the event of plan termination, the right of each Participant to benefits accrued to the day of termination, to the extent then funded, is fully vested. The assets remaining in the Plan after providing for administrative expenses will be allocated among Participants and Beneficiaries in accordance with Federal law. Any residual assets will be distributed to the Company.

Plan insurance

Your pension benefits under this plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers: (1) Normal and early retirement benefits; (2) disability benefits if you become disabled before the plan terminates; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) Benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; (2) some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the time the plan terminates; (3) benefits that are not vested because you have not worked long enough for the company; (4) benefits for which you have not met all of the requirements at the time the plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has and on how much the PBGC collects from employers.

For more information on PBGC insurance protection, the benefits it guarantees and its limitations, contact the Human Resources Department or the PBGC's Technical Assistance Division, 1200 K Street, NW, Suite 930, Washington, DC 20005-4026, or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website at www.pbgc.gov.

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in the Pension Plan of The Segal Company, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA), ERISA provides that all Plan participants are entitled to:

Receive information about your plan and benefits

- Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts, copies of all documents filed with the U.S. Department of Labor, including the latest annual report (Form 5500 Series) and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report

(Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's Annual Funding Notice. The Plan Administrator is required by law to furnish each participant with a copy of this Annual Funding Notice.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age, and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.

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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce your rights

If your claim for a pension 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations 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. Notwithstanding the foregoing, no legal proceeding may be filed in any court or before any administrative agency against the Plan or its Trustees unless all review procedures with the Trustees have been exhausted.

Assistance with your questions

If you have any questions about your Plan, you should contact the Human Resources Department or the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents, you should contact

the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling EBSA's toll-free Employee and Employer Hotline at (866) 444-3272 or visiting EBSA's website at www.dol.gov/ebsav.

Plan directory

Here is some information about the Plan and the people who are responsible for its operation.

Plan Name: Pension Plan of The Segal Company

Plan Sponsor: The Sponsor of the Plan is:

The Segal Group, Inc.
66 Hudson Blvd. East, 20th Floor
New York, NY 10001

Plan Administrator: The Plan is administered by:

The Trustees of the Pension Plan of the Segal Company
c/o Segal

66 Hudson Blvd. East, 20th Floor
New York, NY 10001

Plan Number: The Plan number, as assigned by the Plan Sponsor, is 001.

Plan Trust Fund: The Trust Fund holds the assets of the Plan. It exists for the exclusive benefit of employees participating in the Plan and their beneficiaries and cannot revert to the Company. All contributions to the Plan are managed by the Plan Trustees.

Cost of the Plan: The Plan is funded through employer contributions, although the Company may pay certain expenses related to administering the Plan. To the extent that the administrative costs of the Plan are not paid by the Company, they will be paid out of the Plan Trust Fund. Investment management fees are paid by the Plan.

Employer Identification Number: The Internal Revenue Service has assigned the Employer Identification Number 06-0839113 to the Company. If you need to correspond with a government agency about the Plan, use this number along with the Plan name and the Company's name and address.

Plan Year: The Plan year runs from January 1 to December 31.

Agent for Service of Legal Process: Legal process against the Plan can be served on The Trustees of the Pension Plan of The Segal Company c/o Segal,66 Hudson Blvd. East, 20th Floor, New York, NY 10001. Service of legal process may be made upon a Plan Trustee or the Plan Administrator in addition to the agent for service of legal process.

The Trustees of the Plan as of January 1, 2020 are:

Ms. Jennifer Benz
Ms. Eileen M. Flick
Mr. Daniel G. Fries
Mr. Robert D. Krinsky
Mr. Joseph A. LoCicero

All can be reached at:

66 Hudson Blvd. East, 20th Floor
New York, NY 10001
212.251.5000

About the Plan...

This booklet describes the main features of the Pension Plan of The Segal Company in easy-to-understand terms. A complete description of all details and provisions of the Plan is provided in the official Plan documents. If any questions arise that are not covered in this booklet, or if this booklet appears to conflict with the Plan documents, the text of the Plan documents will govern.

Participation in the Plan does not give any employee the right to continued employment and will not interfere with the right of The Segal Group, Inc. or any participating company to discharge any employee.

The Plan is intended to constitute a plan described in Section 3(2) of the Employee Retirement Income Security Act of 1974 (ERISA) and Section 401(a) of the Internal Revenue Code. Although it is hoped that the Plan will continue indefinitely, The Segal Group, Inc. (by action of its Board of Directors) reserves the right to modify, suspend, or terminate the Plan, in whole or in part, at any time, but not to reduce any benefits already earned. No additional benefits will be earned under the Plan after its termination date.

Section 5 — Appendix 1
UFCW Formula

If you are a member of the United Food and Commercial Workers (UFCW) Local 881 and a Participant in the Pension Plan of The Segal Company (Plan) special rules apply to you, as described below.

- If you were an employee of The Marco Consulting Group, Inc. (Marco) on December 31, 2016, and became an Employee of Segal Advisors, Inc. on January 1, 2017 under the terms of the Asset Acquisition agreement in accordance with which The Segal Group, Inc. acquired substantially all the business assets of Marco, we refer to you below as a "Bargained Legacy Marco Employee." Bargained Legacy Marco Employees received past service credit under the Plan for their service with Marco and became Plan Participants as of January 1, 2017.
- If you became an Employee of Segal Advisors, Inc. after January 1, 2018, and were hired as a member of UFCW Local 881, we refer to you below to as a "Bargained Segal Marco Advisors Employee." Bargained Segal Marco Advisors Employees are not Bargained Legacy Marco Employees and do not receive any past service credit with regard to service with a prior employer, but generally, are covered under the provisions of the Plan as applied to Bargained Legacy Marco Employees, but without past service credit as of their Employment Commencement Date.

Participation and service crediting

Bargained legacy Segal Marco Advisors employees — vested

If you are a Bargained Legacy Marco Employee, you became a Participant in the Plan on January 1, 2017.

If you had a vested benefit under the UFCW Unions and Employers Midwest Pension Plan (UFCW Pension Plan) as of December 31, 2016, you were immediately 100% vested under the Plan.

Your service as an employee of Marco will be credited as Service under the Plan for all purposes except for benefit accruals. Service credit for benefit accruals and all other purposes on and after January 1, 2017 shall be in accordance with the Plan, Appendix B, and Exhibit I as applicable.

You should refer to the UFCW Pension Plan to determine the benefits you are entitled to under that plan for your prior service.

Bargained legacy Segal Marco Advisors employees — non-vested

If you are a Bargained Legacy Marco Employee, you became a Participant in the Plan on January 1, 2017.

If you are a Bargained Legacy Marco Employee who did not have vested right to a benefit from the UFCW Pension Plan as of December 31, 2016, the service you had earned as an employee of Marco under the UFCW Pension Plan will be credited as Service under the Plan for all purposes, including benefit accrual. Service shall be credited as of January 1, 2017 with the

same amount of benefit under the Plan as you had accrued under the UFCW Pension Plan as of December 31, 2016. Service credit for benefit accruals and all other purposes on and after January 1, 2017 shall be in accordance with the Plan, Appendix B, and Exhibit I as applicable.

Bargained Segal Marco Advisors employees

Service credit for all purposes, including benefit accruals after January 1, 2018, will be in accordance with the Plan, Appendix B, and Exhibit I as applicable.

Pension eligibility and amounts

Benefit Formula and Forms of Payment for Both Bargained Legacy Marco Employees and Bargained Segal Marco Advisors Employees

Effective January 1, 2017, Bargained Legacy Marco Employees shall accrue benefits under the Plan in accordance with the benefit formula set out in Appendix B, Exhibit I to the Plan. Exhibit I is intended to reflect the terms of the benefit formula and forms of payment applicable to the Bargained Legacy Marco Employees under the UFCW Pension Plan in accordance with the CBA in effect on January 1, 2017, as amended by the Memorandum of Understanding (MOU), effective January l, 2017 and any subsequent CBA and/or MOU.

For purposes of Appendix B, Exhibit I and the Plan, individuals who became Employees of Segal Advisors Inc., who were hired as members of the United Food & Commercial Workers Local 881, and who became Participants in the Plan after January l, 2018 (Bargained Segal Marco Advisors Employees) shall not be Legacy Marco Employees and generally shall be covered by the provisions of Appendix B, Exhibit I, and the Plan as applied to Bargained Legacy Marco Employees but without prior service or accrual credit of any type as of their Employment Commencement Date.

The term Bargained Legacy Marco Employees shall be used to describe the formula and forms of payment available to both Bargained Legacy Marco Employees and Bargained Segal Marco Advisors Employees in the sections below.

Normal pension

If you are a Bargained Legacy Marco Employee whose employment terminates on or after you have attained Normal Retirement Age, you shall be eligible to receive a Normal Pension for the Participant's lifetime, beginning as of the first day of the month after your termination.

If you are a Bargained Legacy Marco Employee who was vested in your benefits under the UFCW Pension Plan as of December 31, 2016, your benefit is the sum of the products of (I) each of your Years of Service accrued under the Plan beginning on and after January 1, 2017, and as determined for purposes of determining the amount of the Normal Pension of a Participant under Section 1.35(b) of the Plan, multiplied by (II) the formula benefit rate in effect for the calendar year (or portion thereof).

If you are a Bargained Legacy Marco Employees who was not vested in your benefits under the UFCW Pension Plan as of December 31, 2016, your benefit is an amount equal to (I) the monthly amount of benefit accrued under the UFCW Pension Plan as of December 31, 2016, plus (II) the sum of the products of (A) each of your Years of Service accrued under the Plan

beginning on and after January 1, 2017, and as determined for purposes of determining the amount of the Normal Pension of a Participant under Section 1.35(b) of the Plan, multiplied by (B) the formula benefit rate in effect for the calendar year (or portion thereof).

The formula benefit rate per Year of Service in effect from January 1, 2017, to and including September 23, 2018, is $35.00, and continues to be $35.00 in 2020.

Early retirement pension

If you are a Bargained Legacy Marco Employee who completes l0 Years of Service and whose Employment is terminated after you attain age 55 but before Normal Retirement Age, you shall be eligible to receive an Early Retirement Pension beginning on the first day of any month after termination of Employment and continuing for your lifetime. The monthly amount of your Early Retirement Pension shall be the amount of the Normal Pension reduced by 1/4 of 1% for each preceding month. Generally, the reduction will be from the month after the month in which you attained Normal Retirement Age. However, if you attained your Normal Retirement Age on the first day of the month, reduction starts from that month.

Deferred retirement pension

If you are a Bargained Legacy Marco Employee whose employment is terminated after you have completed 5 Years of Service, you shall be eligible to receive a Deferred Retirement Pension for your lifetime, payable as follows:

- If you have attained age 55 and have completed 10 Years of Service, you shall be eligible to receive a Deferred Retirement Pension beginning on the first day of any month after you attain age 55.
- If your employment is terminated before you have attained your Normal Retirement Age and after you have completed 5 but less than 10 Years of Service, you shall be eligible to receive a Deferred Retirement Pension beginning on the first day of the month coincident with or next following your attainment of Normal Retirement Age.

The monthly amount of your Deferred Retirement Pension shall be the amount of your Normal Pension, except that, if the Deferred Retirement Pension begins before your attainment of your Normal Retirement Age, such amount shall be reduced by 1/180 for each of the first 60 months, and by 1/360 for each such month in excess of 60. Generally, the reduction will be from the month after the month in which you attained Normal Retirement Age. However, if you attained your Normal Retirement Age on the first day of the month, reduction starts from that month.

Delayed retirement pension

If your Annuity Starting Date is later than the first day of the month of your Normal Retirement Age, you shall receive a Delayed Retirement Pension for your lifetime. The monthly amount of your Delayed Retirement Pension shall be the amount of your Normal Pension increased by .9% for each complete month after your Normal Retirement Age and before your Annuity Starting Date except for months for which your pension is suspended on account of your continuation or resumption of employment.

Termination on account of disability

If you terminate employment because you become disabled (as defined by the Plan) before Normal Retirement Age, you may receive service credit for Years of Service after your disability began in accordance with the Plan's eligibility rules until you reach the earliest of Normal Retirement Age, the date you start receiving retirement benefits from the Plan, or you recover from the disability in accordance with the Plan's eligibility rules

Applicability of plan definitions and plan provisions

1. Except to the extent otherwise provided in Appendix B, and in Exhibit I, the general terms of the Plan apply to Legacy Marco Employees, to the extent applicable, unless the context clearly indicates otherwise.
2. Notwithstanding portions of Appendix B-8.3(iv) to the contrary, the following Sections of the Plan shall apply to Bargained Legacy Marco Employees as written, or in some cases as modified to apply to Bargained Legacy Marco Employees:
    a. Section 2.1 "Eligibility" shall apply to Bargained Segal Marco Advisors Employees.
    b. Section 3.4 "Very Small Benefits" shall apply by treating Bargained Legacy Marco Employees as Pre-2015 Participants."
    c. Section 3.8 "Preservation of Pension Amount" shall apply by treating "Section 3.1, 3.2, or 3.3" as replaced by "Appendix B, Exhibit I, Section 1(a), (b), or (c)."
    d. Section 3.22 "Automatic Cashout of Certain Benefits" shall apply.
    e. Section 3.13 "Commencement and Duration of Payment" shall apply.
    f. Section 4 "Alternative Forms of Pension Payments" shall apply. All of the annuity forms of benefit payable under Section 4 of the Plan are available to Bargained Legacy Marco Employees and Bargained Segal Marco Advisors Employees and are payable in accordance with the applicable terms of that Section and any other generally applicable terms of the Plan (as well as the applicable terms of Appendix B and Exhibit I).
    g. Section 5 "Death Benefits" shall apply. All of the forms of death benefit payable under Section 5 of the Plan are available to Bargained Legacy Marco Employees and are payable in accordance with the applicable terms of that Section and any other generally applicable terms of the Plan (as well as the applicable terms of *Appendix B* and *Exhibit 1*).
3. In addition, the following Sections of the Plan shall apply to Bargained Legacy Marco Employees by treating Bargained Legacy Marco Employees as "Pre- 2015 Participants" where applicable:
    a. Section 1.35 "Years of Service" for purposes of Section 1.35(a).
    b. Section 2.1 "Eligibility" for purposes of Section 2.1(c) "With regard to Severance from Service before becoming vested."

Section 5 — Appendix 2
Changes to the Segal Pension Plan

Summary of Material Modifications

Important Notice

This Overview of changes to the Pension Plan and Frequently Asked Questions (FAQs) will serve as the Summary of Material Modifications (SMM) with respect to the amendment of the Plan to provide the new Lifetime Variable Formula (LVF), for nonbargained employees, effective January 1, 2022.

Please note that while the Overview and the FAQs are intended to accurately reflect terms of the new formula as currently drafted, some portions of the formula are still to be determined. Segal reserves the right to continue to revise the formula and any related portions of the document prior to January 1, 2022.

Overview

Segal is adding a new formula to its Pension Plan which will change the way retirement benefits are calculated going forward. It affects current and future regular employees who are not under any collectively bargained agreements (nonbargained employees) and will apply to retirement benefits you earn beginning January 1, 2022.

The Old Formulas

As you learn about the new formula, it is important to keep in mind the Plan's old formulas. For benefits accrued through December 31, 2020, the Plan included two different formulas: the **final average salary formula (FAS)** and the **career average salary formula (CAS)**. Segal closed the FAS formula on December 31, 2014, and introduced the CAS formula for new employees hired on or after January 1, 2015. Accruals ceased under both formulas effective December 31, 2020. Nonbargained employees hired after July 1, 2019 had not become Plan participants as of December 31, 2020 and did not accrue a benefit under either the FAS or CAS formulas.

The New Formula

Effective January 1, 2022, Segal will add a new formula to the Plan: the **Lifetime Variable Formula (LVF)**. The new formula will apply to nonbargained employees who accrued benefits under either the old FAS or CAS formulas and are still employed on January 1, 2022. The new formula will also apply to nonbargained employees hired after July 1, 2019 once they become participants in the Plan.

Under the new LVF, you will earn benefits each year equal to a percentage of your eligible compensation in that year. These **annual salary accruals** are similar in concept to the old CAS formula. Unlike the old FAS formula, after you have earned an annual salary accrual, the amount of the benefit will not increase with future compensation increases.

Accrued benefits under the new LVF will automatically adjust each year based on LVF plan asset returns relative to a specified **5.0% hurdle rate**. In other words, your benefits under the LVF will be adjusted upward if returns on LVF plan assets in a given year exceed the 5.0% hurdle rate. Similarly, your benefits under the LVF will be adjusted downward if returns on LVF

plan assets in a given year fall short of 5.0%. We intend to mitigate benefit decreases by using a **stabilization reserve** mechanism combined with a prudent investment strategy.

A New Cap

Going forward, the LVF will limit your benefit accruals to **41.25% of final average salary**. This cap applies to your total benefit accruals under the Plan: the sum of your frozen accrued benefit under the FAS or CAS formula (whichever applied to you if you have an old formula benefit) and your accruals under the new LVF. For this purpose, final average salary is the average of the highest 5 consecutive years of your eligible compensation prior to termination.

The FAS formula (which applied to employees hired prior to January 1, 2015) was capped at 25 years of service. Because the accrual rate under the FAS formula was 1.65%, the cap amounted to 41.25% of final average salary (1.65% x 25 years = 41.25%). Under the FAS formula, when an employee attained 25 years of service, their benefit would be limited to 41.25% of final average salary but would continue to grow with compensation increases.

Redefining the cap to be 41.25% of final average salary will reward employees who began their careers with Segal at a relatively early age and who continue to work at Segal for many more years in the future. It will also ensure that no one will accrue a total benefit under the old and new formulas that is greater than what they would have accrued if the old formula had remained in place.

FAQs and Closing

For additional reference, we have provided some Frequently Asked Questions (FAQs) regarding the Plan changes and the new LVF. The FAQs include more detail on how the new formula works.

As you review the FAQs, please keep these two points in mind:

- **There is no change to benefits you've already earned.** The benefits you have already accrued under the old formulas as of December 31, 2020, whether the FAS or CAS formulas, are frozen to future service credits and compensation increases. The new LVF, including the annual adjustments based on returns on LVF plan assets, will apply only to benefits you earn on and after January 1, 2022.
- **There is no need to take action.** The new formula will go into effect on January 1, 2022. You do not need to take action, but we do ask all Plan participants to become familiar with the new LVF. Please review the upcoming communications and take advantage of the resources available to learn more about how the new formula will affect your future retirement planning.

Frequently Asked Questions

1. Why did Segal decide to implement this new plan design?

Segal considered several options for the "successor" plan design, including a cash balance design and an enhanced defined contribution plan. Guided by the results of the all employee survey, we ultimately decided on the Lifetime Variable Formula (LVF). The new LVF is established within the existing Pension Plan, which is a defined benefit plan. It also provides a lifetime pension, gives retirees the opportunity for benefit growth, and rewards employee loyalty to Segal. Each of these priorities was supported by the results of the recent employee survey.

The new plan design is also an important part of a broader strategy to help ensure that the Pension Plan remains well-funded and that future costs will be predictable and sustainable. Both the annual variable benefit adjustments and the annual salary accruals address concerns about unfunded liabilities and unpredictable costs. With the new LVF, we are confident that retirees and current employees will be able to count on their benefits under the Plan for years to come.

2. How are benefits calculated under the Lifetime Variable Formula?

Under the new LVF, each year, your benefit will automatically adjust based on the return on plan assets attributable to benefits under the LVF (LVF plan assets) for the immediately preceding plan year. If you are actively employed, you will also accrue additional benefits each plan year equal to a percentage of your eligible compensation in that year, subject to a cap on your total benefit accruals under the Plan. The plan year is the calendar year; it begins January 1 and ends December 31.

The new LVF works as follows:

LVF accrued benefit at beginning of year **x** **Variable benefit adjustment** **+** **Annual salary accrual** **=** **LVF accrued benefit at end of year**

Variable benefit adjustment

The annual variable benefit adjustment is determined based on the formula below. The annual variable benefit adjustment is based on the **5.0% hurdle rate**, which is defined in the Plan.

$$\text{Variable benefit adjustment} = \frac{1 + \text{LVF plan asset return}}{1 + 5.0\% \text{ hurdle rate}}$$

The LVF plan asset return is the investment return on the market value of plan assets, net of investment expenses, attributable to benefits earned under the LVF. This return is limited to a **10.0% ceiling rate.** Investment returns on LVF plan assets in excess of the 10.0% ceiling rate will be used to build up a **stabilization reserve**. As described later, this reserve can be used by the Board of Directors to mitigate potential future benefit decreases when LVF plan asset returns are lower than the 5.0% hurdle rate.

Also note that there is a one-year lag between the LVF plan asset return and when the variable benefit adjustment is applied. For example, the adjustment for the LVF plan asset return in the plan year ending December 31, 2022 will occur a year later, on December 31, 2023.

Annual salary accrual

The annual salary accrual is the amount of benefit you accrue each plan year under the new formula, and it is a percentage of your eligible compensation in that year. As shown below, the accrual rate is 0.75% times eligible compensation until the plan year following the completion of five (5) years of credited service with Segal, at which point the accrual rate becomes 1.00% times eligible compensation.

Annual Salary Accrual Rate

Plan years up to and including completion of 5 years of credited service	**0.75% x eligible compensation**
Plan years following completion of 5 years of credited service	**1.00% x eligible compensation**

Your total credited service with Segal counts in determining which percentage accrual rate applies in a given plan year. For example, if you already have completed at least 5 years of credited service as of January 1, 2022, you will earn benefits at the 1.00% accrual rate beginning on January 1, 2022. If you have not yet completed 5 years of credited service, you will earn benefits at the 0.75% accrual rate until the plan year that begins after your completion of 5 years of credited service.

Total cap of 41.25% of final average salary

The amount of your annual salary accrual in each plan year will be limited so that your total accruals under the Plan—including both your frozen benefit under the old formula and the sum of your annual salary accruals under the new formula—do not exceed 41.25% of your final average salary in that plan year.

For purposes of determining whether the 41.25% cap applies, annual salary accruals under the new formula are determined without regard to the annual variable benefit adjustments. In other words, the annual variable benefit adjustments that increase or decrease your benefits under the LVF are disregarded in determining whether your annual salary accrual for the year is limited by the overall cap on accruals equal to 41.25% of final average salary.

3. Is the definition of eligible compensation the same as before?

Yes. The definition of eligible compensation under the Plan remains the same for the new LVF as it was under the old frozen formulas. Specifically, eligible compensation considered for purposes of determining the amount of benefit you will accrue under the LVF each year is base salary, plus 100% the first $40,000 of your bonus, plus 50% of any bonus over $40,000.

Eligible compensation subject to IRS pay limits. This same definition of eligible compensation applies in determining your final average salary for purposes of the 41.25% cap.

4. What is the definition of final average salary?

For the sole purpose of determining the 41.25% cap, the definition of final average salary is the average of the highest 5 consecutive years of your eligible compensation prior to termination.

When the old FAS formula was frozen effective December 31, 2020, the definition was updated to the highest consecutive 12 months of eligible compensation prior to termination. This

definition remains in place with respect to frozen benefits under the old FAS formula, for employees hired prior to January 1, 2015.

5. How will my total benefits under the Plan be determined?

Beginning January 1, 2022, your total benefit under the Plan will be your frozen benefit under the old formula *plus* your benefit under the new LVF. Your benefit under the old formula is frozen based on your credited service and final average salary as of December 31, 2020. Your benefit under the new LVF is what you will earn beginning January 1, 2022.

Frozen benefit under old formula	**+**	**Benefit under new Lifetime Variable Formula**	**=**	**Total benefit**

As noted earlier, it is important to keep in mind that only the portion of your benefit under the new LVF is subject to annual variable benefit adjustments. Your benefit under the old formula is frozen to future service credits and compensation increases, and it will not be subject to the annual variable benefit adjustments.

6. Why is the cap set at 41.25% of final average salary?

Under the old FAS formula (which applied to employees hired prior to January 1, 2015), the benefit formula was capped at 25 years of service. Because the accrual rate under the old formula was 1.65% of final average salary for each year of service, the cap amounted to 41.25% of final average salary (1.65% times 25 years). Going forward, the cap on your total benefit accruals under the Plan will be redefined as 41.25% of final average salary, rather than 25 years of service.

It is important to keep in mind that imposing a 25-year service cap under the new formula would have a different impact than it would have under the under the old FAS formula. Under the old FAS formula, after an employee attained 25 years of service, their benefit would be limited to 41.25% of final average salary. Even though the employee would not receive any further *service credits*, the *dollar amount* of their benefit would have continued to grow with compensation increases. The same would not be true with annual salary accruals under the LVF. If there were a hard cap at 25 years of service, benefits under the LVF would not continue to grow with future compensation increases.

It is also important to keep in mind that imposing a 25-year service cap wouldn't just apply to employees who are close to retirement. Segal has many employees who have attained 25 years of service—and many more who are close to that number—and are still in the middle of their careers. We want to reward these employees for staying with Segal until they retire. Putting a hard cap on their pension at 25 years of service would do the opposite. If the dollar amount of their pension is capped at 25 years, their benefit would become a lower percentage of their final average salary with each passing year.

Redefining the cap to be 41.25% of final average salary rather than imposing a 25 years of service cap accomplishes two objectives. One, it rewards continued loyalty for long-service employees. Two, it ensures no one will accrue a bigger benefit than they would have if the old formula had remained in effect.

7. When do the annual variable adjustments take place?

Under the LVF, the annual variable adjustments take place at the end of each plan year, in other words, on December 31. As noted earlier, the adjustment is based on the net investment return on the market value of LVF plan assets for the immediately preceding plan year.

It is important to keep in mind, however, that the annual variable adjustment that takes place on December 31 of a given plan year will be reflected in the beginning accrued benefit on January 1 of the following plan year. For example, the annual variable adjustment that takes place on December 31, 2023 will be reflected in the accrued benefit as of January 1, 2024.

8. Can my Lifetime Variable Formula benefit fluctuate during my active career?

Yes, the portion of your benefit under the LVF will automatically adjust each year based on LVF plan asset returns throughout your active career. Over time, we are hopeful that LVF plan asset returns will exceed the 5.0% hurdle rate; the LVF plan assets will be invested with that goal in mind. If this happens, these variable benefit adjustments will increase the LVF portion of your benefit as you approach retirement.

9. Can my Lifetime Variable Formula benefit fluctuate during retirement?

Yes, the portion of your benefit under the LVF will continue to adjust each year, even after you retire. The annual variable benefit adjustment works the same way in retirement as it does before retirement. The only difference is that, after you retire, you will no longer earn additional annual salary accruals under the LVF.

With respect to benefit variability in retirement, please keep in mind the following points:

- Only the portion of your benefit earned beginning January 1, 2022 under the new LVF will adjust each year based on LVF plan asset returns. The frozen portion of your benefit under the old formula will remain fixed and will not adjust.
- The Board may decide to employ a stabilization reserve mechanism to mitigate potential decreases in benefits under the LVF. If there are sufficient funds in the stabilization reserve, the Board may amend the Plan to lessen (or perhaps even eliminate) the downward adjustment in the variable benefit following a year in which the LVF plan asset return was less than 5.0%.
- Any adjustment in your variable benefit will be communicated to you before the end of each year, so you have time to adjust your financial plans for the upcoming year.

10. How are investment returns determined under the new formula?

The annual variable benefit adjustment under the new LVF is based on the net investment return on the market value of LVF plan assets. Benefits and assets attributable to the LVF will be tracked separately from other benefits and assets under the Plan.

In the initial years of the LVF, the same investment program will apply to all assets in the Plan, both those attributable to benefits under the new LVF and those attributable to frozen benefits.

The current portfolio is diversified across a variety of asset classes and includes public market investments (e.g., equity and fixed income) and private markets strategies (e.g. real estate).

Over the long term, Segal may decide to utilize different investment strategies for LVF plan assets versus plan assets attributable to frozen benefits. For the first few years of the LVF, however, applying the current strategy across all plan assets provides immediate diversification and avoids any market timing risks with pension contributions.

11. How would actual investment returns over the last ten years have affected benefits under the Lifetime Variable Formula?

As an illustration, the table below shows how annual variable benefit adjustments would have played out over the last ten years, based on returns on plan assets from 2011 through 2020, if the LVF had been in effect during that time, and returns on LVF plan assets had been equal to returns on Segal Pension Plan assets in each of those years. This simplified example assumes a monthly benefit of $1,000 for an employee who retires effective January 1, 2012.

When reviewing this example, it is essential to keep in mind that the annualized return over the selected period can vary significantly depending on the period's beginning and ending dates.

For example, the results would look significantly different if they captured the strong investment returns from the 1990s or the volatility from the 2000s.

Please remember that the annual variable benefit adjustment is applied on December 31 of each plan year based on the return on plan assets for the immediately prior plan year. For example, the annual variable benefit adjustment that takes place on December 31, 2021 is based on the asset return for the 2020 plan year; the adjusted amount will apply to pension payments made in the plan year beginning January 1, 2022. Please also remember the annual variable benefit adjustment is based on a 5.0% hurdle rate, and the return on plan assets is limited to a 10.0% ceiling rate.

Hypothetical Illustration: Annual Variable Adjustments

Plan Year	LVF Benefit on January 1	Prior Year Asset Return	Limited Asset Return	Annual Variable Benefit	LVF Benefit on December 31
2012	$1,000.00	2.2%	2.2%	1.022 / 1.050 = 0.9733	$ 973.30
2013	973.30	10.3%	**10.0%**	1.100 / 1.050 = 1.0476	1,019.63
2014	1,019.63	20.1%	**10.0%**	1.100 / 1.050 = 1.0476	1,068.16
2015	1,068.16	11.5%	**10.0%**	1.100 / 1.050 = 1.0476	1,119.00
2016	1,119.00	-0.6%	-0.6%	0.994 / 1.050 = 0.9467	1,059.36
2017	1,059.36	9.7%	9.7%	1.097 / 1.050 = 1.0448	1,106.82
2018	1,106.82	17.6%	**10.0%**	1.100 / 1.050 = 1.0476	1,159.50
2019	1,159.50	-5.6%	-5.6%	0.944 / 1.050 = 0.8990	1,042.39
2020	1,042.39	18.4%	**10.0%**	1.100 / 1.050 = 1.0476	1,092.01
2021	1,092.01	12.4%	**10.0%**	1.100 / 1.050 = 1.0476	1,143.99

In this hypothetical example, the monthly benefit grows from $1,000.00 payable January 1, 2012 to $1,143.99 as of December 31, 2021, payable January 1, 2022. Note that the annual variable benefit adjustments for 2013, 2014, 2015, 2018, 2020, and 2021 were limited by the ceiling rate,

because the return on plan assets in the preceding plan year exceeded 10.0%. Because of this limitation, the LVF would have built up a stabilization reserve, which could be used to protect against possible benefit decreases in future years.

This simplified example, however, disregards any possible use of the stabilization reserve to mitigate benefit decreases in 2012, 2016, and 2019, when the asset return in the preceding plan year fell short of the 5.0% hurdle rate. In practice, the Board may have been able to use the stabilization reserve to lessen or eliminate benefit decreases in these years.

12. What is the stabilization reserve, and how does it work?

The stabilization reserve is a notional account under the LVF used to smooth benefit volatility. The stabilization reserve harvests investment gains in excess of the 10.0% ceiling rate. As the reserve builds up, the Board may use it to protect against benefit decreases following investment returns on the LVF plan assets below the 5.0% hurdle rate. If the reserve builds up to be larger than anticipated, the Board may use it to provide ad hoc benefit improvements to the LVF benefits. Any such protections against benefit decreases or ad hoc benefit improvements would be implemented by the Board through an amendment to the Plan.

The stabilization reserve will not be used to improve the overall funded status of the Plan, to reduce ongoing costs or contribution requirements, or to increase benefits accrued before January 1, 2022.

It is important to keep in mind that the Board may decide to use the stabilization reserve to protect against benefit decreases only when there are sufficient funds in the reserve. If the stabilization reserve is insufficient to protect against benefit decreases, benefits could go down.

13. How does my combined prior pension benefit and LVF benefit complement my other retirement benefits at Segal?

As with the prior formulas, the new formula provides you with a lifetime pension benefit when you retire from Segal. Your combined benefit under the Pension Plan—including your frozen benefit under the old formula and your benefit under the new LVF—represents a meaningful piece in building your financial security in retirement when combined with other sources: Segal 401(k) profit sharing benefits, Social Security, personal savings and other retirement income.

14. What happens during the period between the freeze of the old formulas and the start of the new formula?

The old FAS and CAS formulas were frozen to future service credits and compensation increases effective December 31, 2020, and benefit accruals under the new LVF formula will begin effective January 1, 2022. In other words, employees will not accrue benefits in the Pension Plan for the plan year beginning January 1, 2021 and ending December 31, 2021.

In lieu of benefit accruals in the Pension Plan, Segal is providing a supplemental profit sharing contribution to the 401(k) Profit Sharing Plan equal to 3% of your qualified salary for the period from January 1, 2021 through December 31, 2021 (or, if earlier, the date on which you terminate employment). These supplemental contributions are made on a quarterly basis and will no longer apply beginning January 1, 2022.

For this purpose, qualified salary is the total of your salary or wages plus the pre-tax amount you elected to contribute to the 401(k) plan and certain other non-taxable amounts, but

excluding bonuses, commissions, special bonuses, overtime pay or other forms of additional compensation. It also excludes amount in excess of the IRC 401(a)(17) compensation limit.

Non-bargained employees hired after July 1, 2019 had not become Plan participants as of December 31, 2020 and did not accrue a benefit under either the FAS or CAS formulas. These employees who remained employed as of January 1, 2021 also received a supplemental 3% contribution to the 401(k) Profit Sharing Plan on the qualified salary they earned from their date of hire through December 31, 2020, in addition to the supplemental contribution for 2021.

15. Are there any changes to the available optional forms of payment or to the calculation of the Early Retirement Pension or the Deferred Retirement Pension?

With regard to the optional forms of payment, the life annuity, the 50%, 75% and 100% J&S annuities, and the pop-up option remain available. The Social Security level income option will not be available with respect to accruals on and after January 1, 2022.

With regard to the calculation of the Early Retirement Pension and the Deferred Retirement Pension, under the new LVF, the calculation of the Early Retirement Pension is based on unsubsidized actuarial factors. There is no change to calculation of the Deferred Retirement Pension.

16. Are our pension benefits secure?

The Segal Pension Plan is well-funded, and adding the new LVF will help ensure it stays that way. No one can predict the future, but we are doing what we can to make our pension benefits as secure as possible. We value your long-term commitment to Segal, and we will continue to help you to build your future financial security.

17. What information will I receive about my benefits under the new plan formula design?

We are currently working on a new benefit modeler in the Segal Pension Portal. With this new modeler, you will be able to estimate your projected benefits under the Pension Plan under various scenarios. We are hoping this modeler will be ready by January 1, 2022, if not sooner. You currently have full modeling capabilities for the FAS and CAS formulas in the Segal Pension Portal.

You can access the Segal Pension Portal here. If you haven't already registered for the Segal Pension Portal, you will have to go through the initial set-up and security protocols, which will take a few minutes to complete.

18. How do I get help with financial planning?

The Segal Everyday Well-being program provides you with extra cash that you may use for certain financial planning services by a qualified financial planner (CFP, CLU, ChFC or RIA) or purchase of financial planning software (excludes tax preparation).

Any explanations contained herein are general in nature and are not a substitute for the information in the Plan documents, which govern the operation of the Plan as interpreted by the Plan Administrator in its sole discretion. If there is any discrepancy between these explanations and Plan Documents, or if there is a conflict between information discussed by any person acting on Segal's behalf and the Plan Documents, and the Plan Documents, as interpreted by the Plan Administrator in its sole discretion, will govern.

Section 5 — Appendix 3

204(h) Notice

Memorandum

To: Non-Bargained Employees of Segal who are Participants in the Pension Plan of the Segal Company with Accrued Benefits as of December 31, 2020 who also Accrue Benefits on and After January 1, 2022

From: Plan Administrator of the Pension Plan of the Segal Company

Date: November 15, 2021

Re: Required DOL/IRS Notice of a Change to the Pension Plan of the Segal Company

This notice is being provided to comply with the requirements of Section 204(h) of the Employee Retirement Income Security Act of 1974 and Section 4980F of the Internal Revenue Code and to notify you of an amendment to the Pension Plan of the Segal Company (the "Plan"). We are required by the DOL and the IRS to send this notice to you because, as previously announced, we are re-opening the Plan effective January 1, 2022 to admit new participants and to add a new formula, the Lifetime Variable Formula (LVF). Unlike the prior Final Average Salary (FAS) and Career Average Salary (CAS) formulas in the Plan, the new LVF does not subsidize the Early Retirement Pension. The LVF applies to non-bargained employees who are participants in the Plan effective January 1, 2022 and after. It is important to understand that this design feature has no impact on any benefits earned under the prior formulas, and applies only to benefits earned under the new LVF beginning January 1, 2022.

Change in Plan Formula

As we communicated during the October 12 Kitchen Table Talk, the LVF will be added to the Plan as of January 1, 2022. The new formula will apply to non-bargained employees who accrued benefits under either the old FAS or CAS formulas and are still employed on January 1, 2022. The new formula will also apply to non-bargained employees hired after July 1, 2019 once they become participants in the Plan.

Early Retirement Pension Actuarial Factors

Also as previously communicated, under the new LVF the calculation of the Early Retirement Pension is based on unsubsidized actuarial factors.

Application

The unsubsidized actuarial factors apply only to benefits accrued under the new LVF on and after January 1, 2022.

If you accrued benefits under either of the old FAS or CAS formulas, and you also accrue benefits under the new formula, the unsubsidized factors will apply only to the portion of your Early Retirement Pension that is accrued under the new formula on or after January 1, 2022. The portion you earned as of December 31, 2020, the date accruals under the old formulas ceased and the Plan was closed to new participants, remains subsidized for early retirement.

Example: Early Retirement Calculation – Accruals as of December 31, 2020 and on and after January 1, 2022

You retire on January 1, 2027 and take an Early Retirement Pension at age 59 years. (For simplicity, we are assuming that you take your Pension on your 59th birthday.) Your monthly Normal Retirement Benefit is $300 based on accruals as of December 31, 2020 and $200 for accruals on or after January 1, 2022, for a total Normal Retirement Benefit of $500. Starting from the benefit amount you would receive at your Normal Retirement Age of 65, your monthly payments will be reduced to account for the fact that you are retiring six years before age 65. To determine your Early Retirement Pension you would apply the factors for accruals as of December 31, 2020 to the $300 and factors for accruals on or after January 1, 2022 to the $200.

Step 1: Your $300 Normal Retirement Benefit based on accruals as of December 31, 2020 would be reduced to reflect an Early Retirement Pension at age 59, 6 years before Normal Retirement Age.

The reduction would be 3% per year. The total reduction would be 18% (3% x 6). The Early Retirement Pension would be 82% of $300, or $246 per month.

Step 2: Your $200 Normal Retirement Benefit based on accruals on and after January 1, 2022 would be reduced to reflect an Early Retirement Pension at age 59, 6 years before Normal Retirement Age.

The reduction would be 6 2/3% for 5 years and 3 1/3% for 1 year. (5 x 6 2/3% = 33 1/3% and 1 x 3 1/3% = 3 1/3%. The total reduction from the Normal Retirement Benefit would be 36 2/3%). Thus, the Early Retirement benefit would be 63 1/3% of $200, or $126.67 (rounded to $127) per month.

Step 3: Your total Early Retirement Pension would be the sum of the two parts: $246 per month (for accruals as of December 31, 2020) plus $126.37 (for accruals on or after January 1, 2022). Your total Early Retirement Pension would be $246 + $126.67 = $372.67 (rounded to $373) per month.

Section 6:
The Segal Group Profit Sharing Plan — Summary Plan Description

As restated effective January 1, 2014 and amended through January 1, 2020

Overview

The Segal Group Profit Sharing Plan ("Plan") is a savings and investment plan designed to increase your retirement income and help meet your long-term financial goals. The Plan is available to both full-time and part-time employees and is a valuable part of your employee benefits program and overall compensation package. The personal savings you are able to build through the Plan, along with your benefits from the Company's pension plan and Social Security can make a significant difference in your retirement years.

The Plan includes 401(k) features that let you automatically set aside a percentage of your annual salary on a pretax basis with Before-Tax Contributions. You can also choose to save for your future on an after-tax basis with Roth Contributions and After-Tax Contributions. When you have reached age 50 or older, the Plan allows Catch-Up contributions for additional Before-Tax and Roth Contributions as you move closer to your retirement years.

The Company contributes to your Plan account in two ways. First, the Company will match a portion of your Before-Tax and Roth Contributions (not including Catch-up contributions, if applicable). Second, the Company may allocate part of its yearly profits to the Plan as a Discretionary Match, or a Profit Sharing Contribution, or as a combination of both.

The Plan is intended to be a qualified plan under the Internal Revenue Code, which allows you and the Company to receive tax benefits. It has a determination letter, dated July 14, 2015 from the Internal Revenue Service.

This Summary Plan Description provides important information about the Plan including how contributions are made, what kind of investment options are offered, and when benefits are paid. Please review this information carefully to understand how the Plan works and the advantages you receive by participating.

Important Note:

This SPD is intended to be a general overview of the plan. It is intended to be accurate, but in all cases, the official Plan documents govern and are the final authority on the terms of the Plan. If there are any discrepancies between the information in this SPD and the Plan, the Plan documents will control.

Information in this SPD should not be treated as legal or tax advice. You should consult with your tax advisor or attorney, as appropriate, for such advice.

Highlights Of the Plan

- You become a Participant in the Plan as soon as administratively possible after your employment date.
- You may save through the Plan by making Before-Tax Contributions, Roth Contributions and/or After-Tax Contributions, via payroll deductions. You can also take advantage of the Annual Increase Program.
- As a new hire, you are automatically enrolled in the Plan at 6% of your annual salary on a Before--Tax basis; you may opt out of any contribution, elect a different contribution level, or elect that the contribution be on a Roth or After-Tax basis.
- If you do not provide direction with regard to investment, the default investment election is an age-appropriate target date fund. At this time, the Plan's target date funds are State Street Target Retirement Funds Class K.
- The Company provides Basic Matching Contributions on 50% of the amount you save with Before-Tax and Roth Contributions up to 6% of your annual salary.
- The Company also may make a Discretionary Matching Contribution and/or a Profit Sharing Contribution.
- If you are age 50 or over, you qualify to make Catch-Up Contributions, which allow additional Before-Tax or Roth savings over the yearly maximum Before-Tax Contribution limit.
- The Plan gives you several options for investing the money in your account. You choose the investment mix that is right for you, and can make changes to your investments over time. You will also be able to use the Portfolio Rebalance feature to help manage your investment mix. Special loan and withdrawal features offer access to your savings before you retire.
- Your Before-Tax, Roth and After-Tax Contributions are always 100% vested. The Company's Basic and Discretionary Matching Contributions and any Discretionary Profit Sharing Contributions vest at a rate of 20% for each year of service. This means that after completing five years of service, you are 100% vested in these contributions and their investment earnings. If you leave the Company before retirement, you are entitled to the current value of your vested benefits, including earnings on contributions.

Joining the Plan

Eligibility

The Plan is offered to employees of the following Participating Companies:

- The Segal Company (Eastern States), Inc.
- The Segal Company (Western States), Inc.
- The Segal Company (Midwest), Inc.
- The Segal Company (Southeast), Inc.
- Segal Advisors, Inc.
- Segal Select Insurance Services, Inc.

Throughout this Summary Plan Description, references to “the Company” include the Participating Companies listed above.

Anyone performing services for the Company as an independent contractor is not an employee and is not eligible to participate. If the Company hires you as an employee after you have been working on a contract basis, your eligibility will be based on the date you are formally classified as an “employee.” Similarly, your eligibility ends when you are no longer classified as an “employee,” even if you provide some services to the Company as an independent contractor after that.

Special rules may apply to employees who became participants as a result of an acquisition. Please contact the Fidelity NetBenefits website at 401k.com or call Fidelity at 800-835-5095 if you have any questions.

When Plan Participation Begins

Your enrollment as a result of automatic enrollment (unless you opt out) will become effective with the paycheck following 30 days from when your enrollment notice is mailed to you. Notice is mailed to you when Fidelity receives your new hire information with your first paycheck. Enrollment initiates the deduction of your contributions from your paychecks. If you opt out and then later decide to enroll, deductions will generally begin as soon as administratively possible after we receive your enrollment information.

For employees who transfer from one Participating Company to another, or from The Segal Company, Ltd. (Toronto) to a Participating Company, all prior service will count toward this eligibility requirement. If you are an employee of The Segal Company, Ltd. (Toronto) who has transferred to a Participating Company, your participation will begin on either the date of the transfer or the date you have six weeks of combined service, whichever is later.

Service includes the time you work for the Company, are on a paid absence from work, or take an unpaid approved leave of absence for up to one year. A period of qualified military service also may count as service. In addition, if you leave the Company and are rehired within one year, the time between your leaving and returning to work will count as service.

When Plan Participation Ends

Your Plan participation as an Active Participant continues until you leave the Company or transfer to a non-Participating Company within The Segal Group, Inc.\

Automatic Enrollment

A new hire will be automatically enrolled and an account will be established so that Before-Tax Contributions equal to 6% will be deducted from your annual salary under the Plan, unless you elect otherwise. The automatic deductions will normally commence on the first pay date that occurs at least 30 days after a notice of automatic enrollment is provided.

If you do not want to be automatically enrolled, or if you want to change your contribution rate or investment election, or make all or a part of your contributions as Roth Contributions, you must log on to the Fidelity NetBenefits website at 401k.com or call Fidelity at 800-835-5095.

Not Enrolled?
If you are not currently making contributions to the Plan, but are interested in doing so, you can go online to the Fidelity NetBenefits website at 401k.com or call Fidelity at 800-835-5095 to sign up.

Naming a Beneficiary

Upon being hired, you will be asked to name a beneficiary to receive the value of your Plan account in the event of your death.

If you are single, you may name anyone as your beneficiary. If you are married, or later marry, your spouse becomes the beneficiary automatically unless your spouse consents to another beneficiary. Any consent to a non-spouse beneficiary must be in writing and waive the spouse's right to the death benefit. The consent must acknowledge the effect of the designation and be physically witnessed by a notary public.

If there is a qualified domestic relations order (QDRO) naming a former spouse as the alternate payee for part or all of spousal benefits, the alternate payee is treated as your current spouse for those benefits. If at the time of your death, you have not been married to your spouse for one year, your spouse is not considered your spouse for purposes of being the beneficiary.

Beneficiary elections or changes must be made in writing. It is important to make an election and to keep that election current so that your Plan account can be paid out according to your wishes.

Beneficiary election forms should be filed electronically with Fidelity. The form can be accessed by going online to the Fidelity NetBenefits website at 401k.com or calling Fidelity at 800-835-5095. The form can also be filed on paper with Segal. You can access the form on SegalNet under Human Resources/Employee Benefits or by contacting your HRBP.

Please note that only election forms filed electronically with Fidelity can be later accessed electronically.

For more information about how death benefits are paid, please see the "Death Benefits" section.

How The Plan Works

Annual Salary
Under the Plan, "annual salary" means your gross yearly pay not including bonuses, commissions, overtime pay, or any other payments you may receive from the Company, up to the limits allowed under the Internal Revenue Code.

Your Contributions

Generally, you decide the percentage of your annual salary per pay period that you want to set aside for your Plan account. However, you are deemed to have elected 6% unless you instruct Fidelity that you wish the percentage to be higher or lower. The Company automatically deducts

your contributions from each paycheck. You may choose to save with Before-Tax Contributions, Roth Contributions, After-Tax Contributions, or a combination of the three.

Before-Tax Contributions may be in any whole percentage from 1% to 75% of your annual salary per pay period (in 1% increments). The 75% limit is a combined limit for Before-Tax Contributions and Roth Contributions. Before-Tax Contributions lower the amount of pay that is used to calculate your Federal income tax and, in most cases, state and local taxes. As a result, your current income tax is reduced. For example, if you earn $60,000 a year and save 10% of your pay (or $6,000) through the Plan, you're only paying income taxes on $54,000 now. Your savings, including any investment earnings, will not be taxed until you take the money out of the Plan. (Please note that your own Before-Tax Contributions are not exempt from Social Security taxes.)

Roth Contributions may be in any whole percentage from 1% to 75% of your annual salary per pay period (in 1% increments) reduced by any Before-Tax Contributions you made. Roth Contributions are credited to your Plan account after all applicable employment taxes have been withheld and do not reduce your current income tax. When you take your Roth Contributions and the associated earnings out of the Plan, the earnings could be tax-free depending on the situation. Specifically, if you get a "qualifying" distribution of Roth Contributions and earnings, the earnings are not subject to Federal income tax (the Roth contribution itself has already been taxed). A qualifying distribution is one made after your Roth Contribution account has been open for at least five years (starting with the year when you made the first Roth Contribution, even if you made it part way through that year), and if you are either age 59½ at the time of the distribution, or the distribution is made to you when you are disabled in accordance with IRS definitions, or the distribution is made to your beneficiary after your death.

Catch-Up Contributions are additional Before-Tax or Roth Contributions that may be made by Plan participants who (a) are at or over age 50 at year-end and (b) make regular Before-Tax or Roth Contributions up to the yearly maximum dollar amount allowed by the IRS. After reaching that yearly maximum, you may make Catch-Up Contributions up to the maximum amount allowed each year.

If you qualify for Catch-Up Contributions, you must contact Fidelity to designate the percentage of your annual salary you want to deduct for these contributions. You may make the election through the Fidelity NetBenefits website at 401k.com or by calling Fidelity at 800-835-5095. Your payroll deductions will automatically stop when you reach the total amount of Catch-Up Contributions allowed for the year. Payroll deductions for Catch-Up Contributions will begin again in January of the following year unless you elect to stop them. As with any contributions you make to the Plan, you may increase or decrease your contribution amount at any time during the year.

If your payroll deductions do not reach the yearly maximum allowed for regular Before-Tax or Roth Contributions, the contributions you designated as Catch-Up Contributions will be reclassified as regular Before-Tax or Roth Contributions, as applicable. Catch-Up Contributions are not eligible for matching contributions from the Company. This includes any contributions that have been reclassified as regular Before-Tax or Roth Contributions.

After-Tax Contributions may be from 1% to 10% of your salary. These contributions are credited to your Plan account after all applicable employment taxes have been withheld and do

not reduce your current income tax. However, any investment gains on these contributions accumulate tax-free until they are paid out from the Plan.

Contribution Limits

Federal law limits the total amount you may contribute as Before-Tax and Roth Contributions (other than catch-up contributions) to all your 401(k) plans each year (i.e., with all your employers). This amount is adjusted each year to reflect cost-of-living increases. For 2021, the combined maximum for Before-Tax and Roth-Contributions (other than Catch-up Contributions) is $19,500. If you are eligible to make Catch-Up Contributions, then you may contribute additional amounts (up to $6,500 for 2021) as Catch-Up Contributions. If your contributions to the Plan reach the maximum for any given year, your contributions will automatically stop. However, if you contributed to another 401(k) plan during the year, you are responsible for monitoring the limits. If your combined contributions exceed or are expected to exceed the limits, contact Fidelity at 800-835-5095.

Federal law also limits the total amount that can be contributed to your account in this Plan each year (including both Company Contributions and your own salary deferral contributions). The total annual contributions to your account for 2021, excluding rollover contributions, cannot exceed 100% of your pay, or, if less, $58,000 (excluding Catch-Up Contributions). IRS updates these limits to reflect increases in cost of living. The applicable limit for a year can be found each January on the website of the Internal Revenue Service at https://www.irs.gov/pub/irs-tege/cola_table.pdf

In addition, your total Before-Tax, Roth, and After-Tax Contributions may be limited if you are a highly compensated employee. You will be notified if these limits apply to you.

Company Contributions

Basic Matching Contributions

As an extra incentive for you to save through the Plan, the Company will match 50% of your Before-Tax or Roth Contributions up to 6% of your annual salary. Basic Matching Contributions are credited to your account each payroll period and are invested the same way as your contributions, according to your investment choices.

As an example, if your annual salary is $60,000, you could receive the following Basic Matching Contributions over a year's time:

If Your Before-Tax or Roth Contribution Is	The Company's Basic Matching Contributions Will Be
2% of $60,000, or $1,200	$600
4% of $60,000, or $2,400	$1,200
6% of $60,000, or $3,600	$1,800

If your annual salary changes during the year, the amount of your Basic Matching Contributions automatically changes. Contributions made on an after-tax basis, or contributions designated as Catch-Up Contributions when made or redesignated as such, are not eligible for the Company's Basic and Discretionary Matching Contributions.

Discretionary Matching Contributions

Participants who contribute on a Before-Tax or Roth basis may also receive a year-end Discretionary Matching Contribution. The Board of Directors determines whether there will be a Discretionary Match for a year, and if so, how much.

The Discretionary Match may be up to an additional 50% on top of the 50% you receive when making 401(k)/Roth 401(k) contributions on the first 6% of annual salary. For example:

- Assume the Board provides for a 25% Discretionary Match
- Annual Salary = $60,000
- Annual 401(k)/Roth 401(k) contributions = 6% of annual salary or $3,600
- Basic Match = 50% of the first 6% of annual salary or $1800 (credited every pay date)
- Discretionary Match = 25% of the first 6% of annual salary or $900 (credited as of the end of the year)
- Total combined matching contributions for plan year = 75% of the first 6% of Annual Salary or $2,700

To be eligible for the Discretionary Matching Contribution, you must be either:

- An Active Participant, either at work or on a leave of absence, who is still employed at the Company or an affiliate at the end of the year, who made Before-Tax or Roth Contributions during the year; or
- A former employee who made Before-Tax or Roth Contributions during the year, but whose participation ended during the year due to death or total disability or due to termination of employment on or after their normal retirement age (generally, age 65).

Profit Sharing Contributions

All eligible Plan Participants may receive a Profit Sharing Contribution of up to 5% of annual salary. The Board of Directors determines whether there will be a Profit Sharing Contribution for a year and if so, how much. At a salary of $60,000 and a full 5% Profit Sharing Contribution rate, for example, the contribution would be $3,000.

To be eligible for the Profit Sharing Contributions, you must be either:

- An Active Participant, either at work or on a leave of absence, who is still employed at the Company or an Affiliated Company at the end of the year; or
- A former employee whose Plan participation ended during the year due to death or total disability, or due to termination of employment on or after their normal retirement age (generally, age 65).

Profit Sharing Contributions, Basic Matching Contributions, and Discretionary Matching Contributions will be paid to the beneficiary(ies) of a participant whose Plan participation ends during the year due to death.

Rollovers

Rollovers are a way of moving retirement savings from one plan to another. If you receive a distribution from another qualified retirement plan, an individual retirement account (IRA) other than a Roth IRA, or certain other tax-favored plans such as 403(b) plans and government 457(b) plans, you may be allowed to roll over all or part of that distribution into this Plan. Rollovers are managed through a separate sub-account and invested according to the choices you make with Fidelity. Similarly, you may be able to roll over a distribution you receive from this Plan (including a distribution that may consist of After-Tax Contributions) into another eligible retirement plan, such as another qualified plan, an individual retirement account or annuity described in Section 408 of the Internal Revenue Code, a plan described in Section 403(b) of the Internal Revenue Code, or a plan described in Section 457(b) of the Internal Revenue Code sponsored by a state or local government that agrees to separately account for amounts rolled over. You may also be able to roll over your account into a Roth individual retirement arrangement described in Section 408A of the Internal Revenue Code; however, in that case, the distribution will be taxable.

Amounts can be rolled over to this Plan or another plan by direct trustee-to-trustee transfer. If you don't want to do a transfer, you can receive a distribution and roll it over to an eligible plan or IRA, generally within 60 days. The Plan will accept rollovers of CARES Act distributions from Qualified Individuals who are Active Participants, provided that the rollover is made within the three-year period beginning on the day after the date of the distribution.

Rollovers are subject to IRS guidelines on withholding and are not allowed for all distributions. If you have questions about rollovers to or from other retirement plans, please contact Fidelity at 800-835-5095.

Qualified Military Service Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you return to employment with the Company following a period of Qualified Military Service, you may be able to make additional contributions to make up for the time you were in military service. Also, the Company may be required to make additional contributions on your behalf upon your return for the period during which you were in Qualified Military Service. Further, you will not have to re-qualify for Plan membership upon your return and you will not forfeit any amounts that are credited to your account while you are in Qualified Military Service. In general, these protections are available if:

- You have given advance written or verbal notice of the uniformed service to the Company;
- The total length of the absence and of all previous absences from employment with the Company by reason of uniformed service does not exceed five years; and
- You report or submit an application for reemployment to the Company upon completing your uniformed service.

In addition, the Plan will suspend the repayment of a Plan loan during a period of Qualified Military Service.

In addition to the above, if you die while in Qualified Military Service, the Plan will treat you as if you had returned to employment and were an active employee the day before your death. Your spouse and/or beneficiaries will be entitled to any additional benefits (other than contributions related to the period of Qualified Military Service) that would have been provided under the Plan if you had resumed covered employment and then terminated covered employment on account of your death. In addition, the period of your Qualified Military Service will be treated as vesting service under the Plan.

If you have questions about military service with regard to your Plan benefits, please contact the Human Resources Department; if you have questions about how your contributions and loan repayments are handled, please contact Fidelity.

Changing Your Contributions

You can make changes to your contribution level at any time by contacting Fidelity. Changes could include:

- Raising or lowering your current contribution percentage;
- Authorizing payroll deductions to start making contributions;
- Changing your contributions between Before-Tax, Roth or After-Tax Contributions; or
- Stopping your contributions, with the option of starting them again at a later date.

To allow for payroll processing, changes to deferrals either made on-line or by phone are handled as follows:

- 1st -- 15th (or last business day prior to the 15th) of the month are effective with the paycheck received on the 28th of the month;
- 16th – last business day of the month are effective with the paycheck received on the 13th of the month.

Changes made on Fridays (after 8:00pm) or on weekends at the end of a pay cycle may be delayed until the following pay cycle.

If you choose to start contributing on a Before-Tax or Roth basis, the Company's Basic Match also would begin at that time.

Annual Increase Program

The Annual Increase Program enables you to automatically increase your contributions to the Plan each year. All you need to do is elect the contribution percentage and the date for your annual increase. Each year, on the date you designated, your contributions will increase by the percentage you elected. You can continue with the program as long as you wish — or withdraw at any time. To enroll, you can go online to the Fidelity NetBenefits website at 401k.com or call Fidelity at 800-835-5095.

Vesting

"Vesting" refers to your right to receive benefits from the Plan. Any contributions you make to your Plan account (*i.e.*, Before-Tax, Roth and After-Tax Contributions) and any rollovers are

100% vested from the start. That means you have full ownership of these funds, subject to any distribution restrictions, plus any investment gains, at all times.

The Company's contributions to your account (*i.e.*, Matching Contributions, Discretionary Matching Contributions and Profit Sharing Contributions) vest at a rate of 20% for each year of service. So, after completing five years of service, you are 100% vested in these contributions and their investment earnings. For vesting purposes, all service with all companies in The Segal Group, Inc. will be counted.

Company contributions automatically become fully vested if a Plan participant reaches normal retirement age (the later of age 65 or the fifth anniversary of participation in the Plan) while still working for the Company, or if Plan participation ends due to total disability or death.

Your own contributions to the Plan are portable. If you leave the Company, you may take the value of your contributions and any investment gains with you. Company contributions are portable once they become vested, and in accordance with the Plan's distribution rules.

Break in Service

Under the Plan, you have a "Break in Service" if you leave employment with the Company and do not work for the Company for the following five years. At the end of the fifth year, any portion of your Company contributions that was not vested is forfeited.

Some situations do not count toward a Break in Service. These include:

- An approved leave of absence, including leave under the Family and Medical Leave Act;
- An absence, up to one year, due to pregnancy, childbirth, or placement of an adopted child, or to care for the child following birth or adoption; or
- A period of military service within certain time limits, and provided you return to work within three months after you are eligible for separation from active military duty.

In the above situations, if you return to work after the absence, the time you were not at work would be credited as service.

If you have a Break in Service and you are later rehired by the Company you will become a Participant in the Plan again as soon as administratively possible after your re-employment date.

If your employment ends before you have at least one year of service, but you had contributed to the Plan on a Before-Tax or After-Tax basis and you return to work, you will become a Participant in the Plan again as soon as administratively possible after your re-employment date and the time you worked prior to the break will be restored, provided you have not had a Break in Service (a five-year break).

Reemployment

The Plan has certain provisions that determine how your Plan participation and benefits would be affected if you leave the Company and are rehired at a later date.

If your employment ends when you are not 100% vested in the Company's contributions to your Plan account, the non-vested portion of your account is forfeited and goes back into the Plan. In this case:

- If you return to work within five years of your termination date, you do not have a Break in Service for Plan purposes. Your Plan participation will begin again as soon as administratively possible after your re-employment you will be credited for your prior years of service, and that service will count toward the vesting of benefits. Also, the benefit amount you forfeited when you left the Company will be restored to your Plan account.
- If you return to work five or more years after your termination date and you were zero percent vested in all of the types of contributions, (i.e., you had not made any Before- or After-Tax Contributions and had not earned any years of vesting service) in your account at the time of termination, then prior Service with the Company will not be restored. Any benefit amount that was forfeited will also not be restored. Plan participation will begin again as soon as administratively possible after your re-employment.
- If you return to work five or more years after your termination date and you were vested at any percentage in any type of contribution to your account at the time of termination, then all prior service will be restored, but only for purposes of determining the vested percentage for contributions made after your return to work. Service after your return will not be taken into account with regard to contributions made before your termination. Any amount forfeited at the time of the previous termination will not be restored. Plan participation will begin again as soon as administratively possible after your re-employment.

If your employment ends when you are 100% vested in the Company's contributions to your Plan account, and you return to work at any time, your Plan participation will begin again as soon as administratively possible after your re-employment and your prior service will be restored. You will be fully vested in any future contributions made to your account. You also remain fully and immediately vested in any part of your Plan account that was not paid to you when you left the Company.

Managing Your Plan Account

Investment of Plan Contributions

The Plan offers you a number of different fund options to invest your Plan account. You may invest in one fund or a combination of funds in any whole percentage from 1% to 100%. If you do not designate a fund to invest in, your contributions will be automatically invested in an age-appropriate target date fund with the target retirement date being the closest to the year you would reach age 65. At this time, the Plan's target date funds are State Street Target Retirement Funds Class K.

For a description of the investment funds currently available through the Plan, please log in to the Fidelity NetBenefits website at 401k.com.

Please note: The Company may provide, through Fidelity or other third parties, information about basic investment principles and the available investment funds. However, by law, the Company is not allowed to give specific investment advice. You might want to contact an investment advisor or tax consultant to determine the best investment strategy for your financial

situation and savings goals. Fidelity offers information and tools to help make your investment choices through the Fidelity NetBenefits website at 401k.com.

Choosing Your Investment Mix

Having a broad range of fund choices helps you tailor your investments to meet your personal investment style, your stage in life, and your financial objectives. Some investments are relatively secure and may emphasize short-term results. Others are more volatile—likely to rise and fall in value over short periods of time—but may offer high growth potential over the long term.

Remember that every investment involves some degree of risk. The value could go down in response to market changes or may not grow as much as expected. Generally, the returns are potentially greater with aggressive or higher risk funds, while conservative or lower-risk funds tend to provide more modest returns but more protection for your initial investment. Combining several types of investments—known as diversifying—can be an effective way to manage different levels of risk. For example, you could invest in a combination of stocks, bonds, and cash funds or invest in one of the State Street Target Retirement Funds Class K that most closely tracks your likely retirement date.

The best investment strategy is the strategy that makes sense for you. No investment comes with guaranteed results over the long term and past results are not an indication of future performance. However, the Plan gives you ways to track your investment progress and adjust your investment mix over time to build toward a more secure financial future.

The Plan is intended to be a participant-directed plan as described in Section 404(c) of ERISA, which means that fiduciaries of the Plan are ordinarily relieved of liability for any losses that are the direct and necessary result of investment instructions given by a participant or beneficiary.

Key Investment Terms

Bonds — A debt obligation or loan contract representing money owed by companies, governments or municipalities to investors. A bond issuer agrees to make interest payments on the loan to the investors and to repay the principal loan amount by a specific date (the “maturity” date).

Capital — The amount of money invested in a particular security. A capital gain or loss is the difference between the purchase price and the selling price.

Diversification — Dividing money among different types of securities (such as stocks, bonds and stable value investments) that have varying investment goals, typically for the purpose of balancing the investor’s overall level of risk.

Dividend — Payments made by a company to its shareholders representing part of the company’s profits, or payments from a mutual fund to shareholders representing part of the income earned from the fund’s investments.

Mutual Fund — An investment vehicle that pools money from a group of investors to purchase securities according to a particular investment strategy or specific investment goals.

Portfolio — An assortment of investment securities (such as stocks and bonds) and other financial assets (such as real estate).

Rate of Return — The amount (when calculated as a percentage) earned or lost on an investment, which assumes that any dividends or capital gains have been reinvested. The "real rate of return" also takes into account the effect of inflation on the original investment.

Stocks — Securities that represent ownership in a company. The percentage of ownership is based on the number of "shares" of stock purchased by an individual investor or group of investors (such as a fund).

Making Investment Changes

As your savings goals or financial needs change, you may want to make changes to your investment choices. The Plan gives you two ways to do this.

An ***exchange*** lets you move all or part of your account balance between the various funds. Your investment choices for future contributions would not change, but the money already in your account would be allocated differently. There are no minimum or maximum amounts for exchanges under the Plan.

A ***contribution direction change*** affects where future contributions will be invested. For example, you could start investing a larger amount in one fund and less in another, or direct part of your contributions to a fund you hadn't invested in previously. Your existing balance in each fund from previous contributions will stay the same. Future contributions will be invested differently, according to the percentage you decide to contribute to each fund.

Portfolio Rebalance Services

The Plan's Portfolio Rebalance feature helps you manage your investment mix. Based on your preferred investment strategy, you can rebalance your portfolio and manage its asset allocation through a single transaction. Here's how it works: Suppose your current investment strategy is spread over five funds, but your preferred strategy is 25% within four funds. Previously, you would have had to place five exchanges (transactions) to reach your new preferred strategy. With Portfolio Rebalance, all you need to do is push a button ("one click") and the exchanges are made as one transaction.

Portfolio Rebalance also offers:

- Automatic Rebalance — annually rebalances your account so it is consistent with your chosen investment strategy. Simply identify an investment combination, adjust your account accordingly using the Portfolio Rebalance service, and Automatic Rebalance does the rest.
- Rebalance Notification — sends you an e-mail alert any time your account's investment mix moves away from your original specifications.

Call Fidelity at 800-835-5095 to learn more about this service. You can also log on to the Fidelity NetBenefits website at 401k.com.

You are never locked into your investment choices. You can make changes in your investment mix and to the amount you want to invest in particular funds.

Account Information

Fidelity gives you immediate access to your Plan account by two different routes:

- By logging on to the Fidelity NetBenefits website at 401k.com and
- By calling Fidelity at 800-835-5095).

These resources also enable you to monitor fund performance regularly and direct your investments more strategically.

Your statements will be available on-line. You may also request paper copies on the Fidelity NetBenefits website at 401k.com. With the on-line option, statements can be printed at any time and for any period within the previous 24 months.

Note that all assets are valued daily at 4:00 p.m. of each business day when the New York Stock Exchange (NYSE) is in session. If you request any changes after 4:00 p.m. or on a day that is not a business day when the NYSE is in session, the change will become effective on the next such business day.

Reach Fidelity through the Fidelity NetBenefits website at 401k.com or by calling 800-835-5095 to:

- Enroll in the Plan;
- Find out your account balance;
- Change your payroll deduction amount;
- Change your investment mix;
- Make an exchange;
- Request a loan or withdrawal; or
- Speak to a service representative for information about the Plan

Both the Fidelity NetBenefits website at 401k.com and the Fidelity call-in line are available virtually 24 hours a day, 7 days a week. Service representatives are available Monday through Friday from 8:30 a.m. to 8:00 p.m. in your local time zone.

Your Password and Security

Your Plan information is personal and confidential. Your username and password give you access to your personalized benefits information through Fidelity.

You have a role in ensuring that your Plan information remains confidential. To protect the security of your Plan account, it is critical that you establish a unique username and password. Do not share your password with anyone or leave it in places where it can easily be found. You should change your password regularly. In addition, when you are logged on to the Fidelity website, be sure to log out before leaving your computer unattended.

Using Your Money Before Retirement

The Plan is designed to encourage long-term savings, especially to add to your retirement income. Because of the tax breaks provided by the Plan, the IRS has some restrictions on taking money from your account before you reach retirement age. However, the Plan includes loan and withdrawal features that may let you access your savings when special needs arise.

Loans from Contributions

Loans allow you to borrow against your Plan account. You repay loans, with interest, through automatic payroll deductions or through an Electronic Loan Payment service (see below for guidelines). All of your payments, including interest, are credited back to your account.

Loans may be taken for any purpose, and the loan amount is taken pro-rata from all of your accounts. You may only initiate one loan in any 12-month period. You may have up to four loans (only one can be a loan for a principle residence) outstanding at any time, up to a total defined maximum. That maximum is generally the lesser of (1) 50% of your vested account value or (2) the sum of $50,000 minus the highest outstanding loan balance from the past 12 months. The minimum loan amount is $1,000. If you have four loans outstanding, you must wait 30 days after the date on which the final payment on one of the outstanding loans is made before applying for a new loan.

To pay back a loan, the money is deducted in equal installments from your paychecks. The minimum payment amount, which includes all payments being made on previous loans, is $50 per month. Most loans must be repaid within five years, although a loan used to buy a primary residence for your own use may be repaid over a longer period of time. You may repay a loan at any time without penalty. A partial repayment will be applied to reduce the outstanding principal balance and the remaining amount will be paid under terms consistent with Plan and loan document provisions.

Electronic Loan Payments

Current and former employees have the option of making loan payments electronically through the Electronic Loan Payment service. Active participants (current employees) may use this option to pay their outstanding loan in full or by making partial payments. Former employees (inactive participants) can use the Electronic Loan Payment service to process both recurring and one-time payments (*i.e.*, partial payments, full payoffs, or payments of past due amounts). To use electronic payment, you must provide payment instructions and authorization to Fidelity, permitting Fidelity to debit loan payment amounts directly from your bank account. To use this service, you will need to provide your bank account information (account name, type, routing number, account number, and payment amount, for one-time loan payments) to Fidelity through the Fidelity NetBenefits website at 401k.com or by calling Fidelity at 800-835-5095.

If a loan has not been repaid in full at the time you retire, leave the Company, or for other reasons become eligible for a distribution from the Plan, the outstanding balance will be deducted from your account before a distribution is made unless you choose one of the following options:

- You pay your outstanding loan in full;

- You arrange to continue making loan payments to your Plan account through Fidelity. Under this arrangement, you will not be able to take a distribution from your account until the loan is paid in full;
- You roll over your account balance from this Plan to a savings or retirement plan with a new employer and continue paying off the loan through payroll deductions under your new employer's plan. This option is available only if that plan will accept a loan as part of a rollover; or
- You cease further payments on the loan and have the outstanding balance treated as a distribution.

Withdrawals from Employee Contributions

Two types of withdrawals from your own contributions, plus any net earnings on them, may be available before you retire or terminate employment to help meet your immediate financial needs—non-hardship withdrawals and hardship withdrawals.

Non-Hardship Withdrawals

You can take a non-hardship withdrawal from any After-Tax Contributions or Rollover Contributions you have in your account, plus their net investment earnings. If you are age 59½ or older, you also may take a non-hardship withdrawal from amounts in your account that are attributable to your Before-Tax or Roth Contributions.

A request for a withdrawal is considered in relation to any outstanding loan(s) you have. You cannot withdraw an amount that would result in your outstanding loan balance being higher than the maximum loan balance allowed under the Plan.

Hardship Withdrawals

You may be able to make a hardship withdrawal from your Before-Tax or Roth Contributions to meet an immediate and heavy financial need, as defined by the IRS. Hardship withdrawals may be permitted to:

- Cover unreimbursed medical expenses incurred by you, a spouse or a dependent;
- Purchase your primary residence (not including mortgage payments);
- Pay tuition fees for the next 12 months for education beyond high school for you, a spouse, children, or other dependents; or
- Prevent eviction from, or a mortgage foreclosure on, your primary residence.

Before a hardship withdrawal may be taken, you must first access all funds available to you from the Plan non-hardship withdrawals. The withdrawal cannot include any outstanding loan balance. Also, the amount withdrawn cannot be more than the amount of the specific financial need. Because the money you receive will become taxable income, the withdrawal may include an amount needed to pay Federal, state or local income taxes or penalties you expect to owe as a direct result of the distribution.

CARES Act Distributions (January 1 to December 30, 2020)

For the period from January 1 to December 30, 2020, Participants who were Qualified Individuals (generally Participants who were diagnosed with COVID, or whose family members were so diagnosed, or whose family members had adverse COVID-related financial consequences) were able to elect to receive in-service CARES Act distributions of their vested account balances of up to $100,000, without regard to the restrictions of Section 401(k) of the Internal Revenue Code distribution rules. The Plan will accept a rollover contribution of a CARES Act distribution made in accordance with the rules for such a distribution from an Active Participant if it made within the three-year period beginning on the day after the date of the distribution.

Electronic Funds Transfer Option for Loans and Withdrawals

The Electronic Funds Transfer (EFT) service gives you the option of taking a loan or withdrawal from your Plan account by having the money wired directly into your bank account rather than receiving the payment via a paper check. In order to participate in this "paperless" service, you must provide bank information (account name, type, routing and account number) and authorization to Fidelity at least six business days before requesting the loan or withdrawal.

You can set up the EFT service by logging on to the Fidelity NetBenefits website at 401k.com or by calling Fidelity at 800-835-5095.

When Benefits Are Paid

You may receive the full value of your vested Plan account, including Company contributions as well as your own, if you:

- Leave employment with the Company; or
- Become permanently disabled.

The Plan also pays death benefits to your beneficiary in the event of your death.

Leaving the Company

You are entitled to a distribution of your vested account balance following your termination of employment.

If You Become Disabled

If your employment ends because you become disabled, you may request an immediate distribution of your account. Under this Plan, you are considered "disabled" if you will be receiving benefits under the terms of the Company's group long-term disability contract. Medical proof may be required to verify disability.

Death Benefits

If you die with a Plan account balance, your benefit will be paid to your spouse or to a designated beneficiary if you have no spouse or you named a designated beneficiary with your spouse's consent. If you have not named a beneficiary, or if your spouse or other beneficiary

does not survive you, death benefits are automatically paid to any surviving children or, if you have no children, to your estate. A spouse is someone to whom you have been married for one year on the date of the participant's death. To be spouse for this purpose, you have to have been married throughout the one-year period ending on the date of the participant's death. However, the Plan will pay death benefits to a former spouse or certain other beneficiaries, e.g., children, even if not designated by you to be the beneficiary, if that is required by a Qualified Domestic Relations Order ("QDRO").

Taxes

The timing and form of your vested account distributions have important tax consequences, as well as other personal considerations. Federal and state tax laws are complex, change frequently and vary according to your individual situation.

You (or your beneficiary) may wish to consider consulting a legal, financial or tax adviser to determine how current tax laws and regulations affect your specific situation before making any final decisions concerning your distribution.

If you elect to have a distribution that is eligible for rollover distributed to you, instead of rolling it over, it will be subject to a mandatory 20% federal income tax withholding, and applicable state and local withholding, if any, in the year it is distributed. The Plan will automatically withhold the 20% federal income tax withholding and mandatory state tax withholding from distributions made in cash (instead of, e.g., shares of stock). You cannot decrease, but may elect to increase, the amount of federal income tax withheld. Any remaining taxes on the distribution will be due when you file your income tax return for the year of distribution.

If you get a distribution before you attain age 59½, generally, the federal government will impose an additional 10% federal early distribution tax on the taxable amount of your distribution. You pay your 10% federal early distribution tax when you file your income tax return for the year of distribution. The 10% federal early distribution tax will not apply in certain situations, such as:

- The distribution made is due to disability, death or termination of employment after age 55; or
- The distribution is made to an alternate payee under a qualified domestic relations order (a court order issued in connection with a divorce or certain other family matters).

Loans from your account are not taxable when paid to you and throughout the time you continue working for the Company. If you have an outstanding loan at the time your employment ends and you do not pay the balance within a short grace period, the unpaid loan amount will be treated as a distribution from the Plan and treated like other distributions for tax purposes. Also, if you have not attained age 59½, the 10% federal early distribution tax may apply. To avoid paying taxes and penalty, you can choose to continue paying the loan directly to Fidelity, but to do so, you must leave your own contributions in the Plan.

If you get a "qualifying" distribution of Roth Contributions and earnings, the earnings are not subject to federal income tax (and the Roth Contributions were already taxed). A qualifying distribution is one made after your Roth account has been open for at least five years (starting with the year when you made the first contribution to your Roth account, even if you made it part way through that year), and if you are either age 59½ at the time of the distribution, or the

distribution is made to you when you are disabled in accordance with IRS definitions, or the distribution is made to your beneficiary after your death.

You will not owe taxes on your After-Tax Contributions, but earnings on those contributions are taxable.

How Benefits Are Paid

Payment Method

The Plan pays benefits in a lump-sum cash payment or in monthly, quarterly or annual installments over any specified period of years (not to exceed your life expectancy). If you are receiving installment payments, you can elect to change these payments or receive a lump sum distribution of your entire vested account balance at any time. Please contact Fidelity at 800-835-5095 for more information.

Please note that Fidelity deducts a withdrawal fee from every withdrawal you take, including required withdrawals. For additional information about this and other fees and expenses, as well as other plan information, please review the Required Disclosure Information document provided by Fidelity on an annual basis.

If your account balance is $1,000 or less, your account will be paid out in a lump sum when you leave the Company. If you have not contacted Fidelity by the end of the year to request payment, your account will be paid out to you automatically after year-end.

If your account balance is over $1,000, your account will remain in the Plan until you request a distribution and will continue to earn dividends, interest and gains or losses based upon the investment performance of the funds in which they are invested.

When Plan benefits are payable to a beneficiary, notification of payment availability will be made as soon as practicable following receipt of notice of the participant's death. Any beneficiary may choose to receive a lump sum payment or by direct rollover to an eligible retirement plan. In cases of an eligible rollover distribution to a surviving spouse, an eligible retirement plan would include another qualified plan, any type of individual retirement arrangement, a 403(b) plan or a 457(b) plan sponsored by a state or local government that agrees to account for such rollovers separately. In the case of any other beneficiary, an eligible retirement plan is an individual retirement account or an individual retirement annuity that is designated an "inherited IRA" or a Roth IRA.

The rules governing the Required Beginning Date and Required Minimum Distributions were changed by Congress at the end of 2019 in two major ways, described generally below.

For Participants born before July 1, 1949, the Required Beginning Date age remains April 1 of the calendar year following the calendar year in which the Participant attains age 70½. For Participants born on or after July 1, 1949, the Required Beginning Date is now determined by substituting age 72 in the prior sentence.

The other change was to the rules governing beneficiary payments. In the past, beneficiaries had to receive all payments in 5 years (starting with the year of the Participant's death) unless

the beneficiary started payments over life expectancy by the end of the year following death. In the case of a surviving spouse, payments did not have to commence, if taken over life expectancy, until the Participant would have been age 70½.

The new rules substitute 10 years for 5 years for most beneficiaries (other than estates or certain trusts) and limit who can receive payments over life expectancy. Life expectancy payments are only available to Eligible Designated Beneficiaries, which is defined as a surviving spouse, a beneficiary who is no more than 10 years younger than the Participant, and certain disabled and chronically ill beneficiaries. There is a special rule for minor children. In addition, the spousal rule allows commencement to be delayed to when the Participant would have been 72 (for Participants born on or after July 1, 1949).

If payments to the Participant had started before the Participant's death, then payments to the beneficiary will be continued based on the form of benefit elected by the Participant as long as that form satisfied the required minimum distribution rules when selected.

Assignment of Benefits

In general, you cannot assign, transfer, or pledge any benefits to which you are entitled under the Plan. However, the Company will honor certain court or administrative orders requiring that part or all of your benefits be paid to a spouse or former spouse (whose status is recognized under U.S. law) or child. By Federal law, the Plan Administrator must determine that the order is a Qualified Domestic Relations Order ("QDRO") as defined under the Internal Revenue Code. You will be notified if the Plan receives any such order. A copy of the Plan's QDRO procedures is available to you, without charge, on request to the Plan Administrator. The Plan also may be required to pay out your benefits to satisfy a lien for delinquent taxes.

Your Rights As A Plan Participant

ERISA Protections

As a Participant in The Segal Group Profit Sharing Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). You have the right to:

- **Receive** information about your Plan and benefits.
- **Examine**, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- **Obtain**, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

- **Receive** a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary annual report.
- **Obtain** a statement free of charge, once a calendar quarter, which tells the value of your account in the Plan, the investments in your account and the extent to which your account is vested.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Members, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension 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 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.

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. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities

under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Claims for Benefits

If you have a question about your Plan benefits, you can contact the Human Resources Department and a representative will respond to your informal inquiry. If you are not satisfied with the response to your informal inquiry, you have the option of writing it up to begin the formal claims process. The filing of a formal written claim with the Human Resources Department initiates the Plan's Claims and Appeals Procedure, which is set forth below. You are required to exhaust the Plan's Claims and Appeals Procedure before you may file a lawsuit.

Denial of Claims

If you (or your beneficiary) files a written claim for benefits under the Plan, and the Trustees determine that the claim should be denied in whole or in part, the Trustees will notify you in writing, within 90 days of its receipt of the claim, that the claim has been denied. The Trustees can extend this time by up to an additional 90 days if special circumstances require this. If so, the Trustees, before the end of the initial 90-day period, will send you a notice of the extension, indicating what the special circumstances are and setting forth the date by which a final decision is expected to be made.

Notice of Denial

The notice of denial will:

- Explain why the claim was denied;
- Cite the Plan provisions on which the denial is based;
- Describe any additional material or information necessary for you to perfect the claim and explain why this material or information is needed;
- Explain what steps need to be taken to appeal the claim's denial; and
- Explain your right to sue under Section 502(a) of ERISA following an adverse ruling on appeal (as discussed below).

Right to Authorized Representative

You can appoint an authorized representative to act on your behalf in filing a claim and seeking a review of a denied claim. You, however, must notify the Trustees in advance in writing of the name, address, and phone number of the authorized representative.

Right to Appeal

Within 60 days after receiving of notice of denial, you or your authorized representative can request, by mailing or delivering written notice to the Trustees, a review of the decision denying the claim. The request for review and/or hearing should state in clear and concise terms the reason(s) for disputing the denial and also should include any additional information and documents that would help support your claim. Upon request and free of charge, you or your duly authorized representative will be allowed to review relevant documents and submit issues and comments to the Trustees in writing.

Notification of Decision on Appeal

After the review, the Trustees will determine whether the denial of the claim was correct and will notify you in writing of its determination within a reasonable period of time, but no later than 60 days after the request for review was first received. The Trustees may extend the time for response for up to another 60 days if special circumstances require. Notice of any extension, indicating what special circumstances exist and the date by which a final decision is expected, will be furnished to you before the end of the initial 60-day period.

Content of Notice of Decision on Appeal

The Trustees will inform you of their decision on the appeal in writing. The written decision will include specific reasons for the decision and will cite the Plan provisions on which the Trustees relied in making their decision. The Trustees also will give you a statement indicating that you or your authorized representative is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits and a statement explaining your right to bring a civil lawsuit under ERISA following an adverse benefit determination upon your appeal.

Pension Benefit Guaranty Corporation (PBGC)

The Plan is a defined contribution profit-sharing plan, which means that contributions are made in specific — or defined — amounts, but you are not guaranteed a specific amount of benefit when you leave covered employment. Because of this, your Plan Account is not insured under the plan termination insurance of the PBGC.

Plan Directory

Here is some information about the Plan and the people who are responsible for its operation.

Plan Name

The Segal Group Profit Sharing Plan

Plan Sponsor

The Sponsor of the Plan is:

The Segal Group, Inc.
66 Hudson Blvd. East, 20th Floor
New York, NY 10001

Plan Administrator

The Plan is administered by:

The Trustees of The Segal Group Profit Sharing Plan
The Segal Company

66 Hudson Blvd. East, 20th Floor

New York, NY 10001
212.251.5000

The Plan is administered by the Plan Administrator. The Plan Administrator may delegate its authority to any individual or committee. The Plan Administrator has the complete discretion and authority to interpret the terms of the Plan, to determine all claims, demands and actions arising under the Plan and to determine the rights and benefits of any participant, beneficiary or other person having or claiming to have any interest under the Plan, including the authority to make factual determinations under the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its sole discretion that the participant or beneficiary is entitled to them. Such interpretation and decision is final, conclusive and binding on all participants and any person claiming under or through any participant, in the absence of clear and convincing evidence that the Plan Administrator acted arbitrarily and capriciously. When making a determination or calculation, the Plan Administrator may rely on information furnished by the participant, beneficiary, the Company or the Trustee.

Plan Number

The Plan Number, as assigned by the Plan Sponsor, is 004.

Plan Trust Fund

The trust fund holds the assets of the Plan. It exists for the exclusive benefit of employees participating in the Plan and their beneficiaries and cannot revert to the Company. All contributions to the Plan are managed by the Plan trustees or their designees.

Cost of the Plan

The Plan is funded through Participant and employer contributions, although the Company may pay certain expenses related to administering the Plan. To the extent that the administrative costs of the Plan are not paid by the Company, they will be paid out of the Plan's trust fund.

Employer Identification Number

The Internal Revenue Service has assigned the Employer Identification Number 06-0839113 to the Company. If you need to correspond with a government agency about the Plan, use this number along with the Plan name and the Company's name and address.

Plan Year

The Plan year runs from January 1 to December 31.

Agent for Service of Legal Process

Legal process against the Plan can be served on The Trustees of The Segal Group Profit Sharing Plan c/o Segal, 66 Hudson Blvd. East, 20th Floor, New York, NY, 10001. Effective March 2025, the new business address will be The Segal Group, Inc., 66 Hudson Blvd., 20th

Floor, New York, NY 10001. Service of legal process may be made upon a Plan Trustee or the Plan Administrator in addition to the agent for service of legal process.

The Trustees of the Plan as of January 1, 2020 are:

Ms. Jennifer Benz

Ms. Eileen M. Flick

Mr. Daniel Fries

Mr. Robert D. Krinsky

Mr. Joseph A. LoCicero

All can be reached at

66 Hudson Blvd. East, 20th Floor

New York, NY 10001

About The Plan

This Summary Plan Description describes the main features of The Segal Group Profit Sharing Plan in easy-to-understand terms. A complete description of all details and provisions of the Plan is provided in the legal Plan document. If any questions arise that are not covered in this Summary Plan Description, or if this Summary Plan Description appears to conflict with the Plan documents, the text of the Plan documents will govern.

If a clerical error or other mistake occurs, that error does not create a right to benefits. These errors include, but are not limited to, providing misinformation on eligibility or benefits. The terms of the Plan may not be amended by oral statements by the Company, the Plan administrator or any other person. In the event an oral statement conflicts with any term of the Plan, the Plan's terms will control. It is your responsibility to confirm the accuracy of statements made by the Company or its designees, including the Plan Administrator, in accordance with the terms of this Summary Plan Description and other Plan documents.

Participation in the Plan does not give any employee the right to continued employment and will not interfere with the right of the Company to discharge any employee.

The Plan is intended to constitute a plan described in Section 404(c) of the Employee Retirement Income Security Act of 1974 (ERISA). Consequently, the fiduciaries of the Plan may be relieved of liability for any losses that are the direct and necessary result of investment instructions given by a participant or his or her beneficiary(ies) hereunder or the direct and necessary result of the failure to provide such instructions, when such opportunity was provided.

Although it is hoped that the Plan will continue indefinitely, The Segal Group, Inc. (by action of its Board of Directors) reserves the right to modify, suspend, or terminate the Plan, in whole or in part, at any time, but not to reduce any benefits already earned. No additional benefits will be earned under the Plan after its termination date.