

BREMER WHYTE BROWN AND O'MEARA LLP

HEALTH REIMBURSEMENT ARRANGEMENT

SUMMARY PLAN DESCRIPTION

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RESTATED EFFECTIVE JANUARY 1, 2024

PLAN PURPOSE

The Bremer Whyte Brown and O'Meara LLP ("Employer") Health Reimbursement Arrangement ("HRA") ("Plan") is a benefit program that allows you to receive reimbursement for qualifying expenses incurred by you, your spouse, and dependents, if any, when enrolled in our High Deductible Medical PPO plan. If there is a conflict between this Summary Plan Description and your group health plan, the Company's group health plan will prevail.

The purpose of this Plan is to reimburse qualified medical expenses that apply to your deductible under our High Deductible Medical PPO plan only. Expenses that don't qualify as applying to your medical plan deductible are not eligible for reimbursement under our HRA Plan.

SCHEDULE OF HEALTH REIMBURSEMENT ARRANGEMENT

Upon eligibility, the Plan Administrator will establish a health reimbursement account in your name. The plan allows you to be reimbursed by the Employer for any qualified expenses that apply to your medical plan deductible patient responsibilities for which you are liable under our group medical plan for yourself or your dependents.

The maximum allowed each year is as follows:

- | | |
|-------------------------------------|------------|
| - Participant: | \$2,000.00 |
| - Participant + one Covered Person: | \$5,000.00 |
| - Participant and Covered Family: | \$5,000.00 |

This amount is available as of the effective date of the High Deductible Health Plan and the amount is not prorated or reduced if the effective date of coverage occurs after January 1 of the calendar year.

Expenses are considered "incurred" when the service is performed. Any amounts reimbursed to you under the Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage.

HOW TO BE REIMBURSED

Deadlines

You must submit claims for reimbursement no later than June 30th for prior calendar year. However, if you terminate employment, you must submit claims for reimbursement within 90 days after your date of termination.

Debit Card

The Company will provide you with a debit card for purposes of making purchases that may be reimbursed from your health reimbursement account.

Documentation of Claims

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

Method and Timing of Payment

To the extent that the Plan Administrator approves a claim, the Company may either (i) reimburse you, or (ii) pay the service provider directly. The Plan Administrator will pay claims at least once per year. The entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

WHAT ARE QUALIFYING EXPENSES?

Qualifying Expenses are expenses that apply toward your deductible of our High Deductible Health Plan. Some examples are doctor office visits, lab work, outpatient services, inpatient hospitalization and pharmacy services.

SPENDING ACCOUNTS – OTHER FACTS TO CONSIDER

To allow this unique opportunity to reduce your taxable income, the IRS has placed some restrictions on health reimbursement accounts:

- HRA funds are in effect for the entire year unless you have a change in status as listed under “Election Changes” in this SPD.
- At the end of the Plan Year any unused funds in your spending account will be forfeited; the balances will not be carried over into the next year or converted to cash.
- You may request statements periodically to remind you how much money is left in your account. This money must be used for expenses incurred before the end of the Plan Year or be forfeited. You may continue to submit claims until June 30th after the calendar year ends for prior year’s expenses. Employees who terminate employment during the Plan Year will be given 90 days from their date of termination in which to submit expenses incurred prior to their termination for remaining HRA benefits.

MEDICAL CARE EXPENSES THAT MAY BE REIMBURSED FROM THE HRA

For HRAs, “Medical Care Expense” means expenses incurred by you, your Spouse, or your Dependents for medical care as defined in the Internal Revenue Code §213(d) if enrolled in our High Deductible Medical PPO plan.

The following list specifies certain expenses that are not reimbursable, even if they meet the definition of “Medical Care” under the Internal Revenue Code §213(d). Note that many expenses that are not on the list of exclusions below will still not be reimbursable if such expenses do not meet the definition of Medical Care under the Internal Revenue Code §213(d) and other requirements for reimbursement under this HRA.

EXCLUSIONS

- Health insurance premiums for any other plan (including premiums for a plan sponsored by the Employer, such as the Medical Insurance Plan);

- Long-term care services;
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. “Cosmetic Surgery” means any procedure that is directed at improving the patient’s appearance and that does not meaningfully promote the proper function of the body or prevent or treat illness or disease;
- The salary expenses of a nurse to care for a healthy newborn at home;
- Funeral and burial expenses;
- Household and domestic help (even if recommended by a qualified physician due to an Employee’s or Dependent’s inability to perform physical housework);
- Custodial care;
- Costs for sending a child to a special school for behavioral benefits that the child may receive from the course of study and disciplinary methods;
- Social activities, such as dance lessons, regardless of recommendation by a physician;
- Bottled water;
- Cosmetics, toiletries, toothpaste, etc.;
- Uniforms or special clothing, such as maternity clothing;
- Automobile insurance premiums;
- Marijuana and other controlled substances that are in violation of federal law, even if prescribed by a physician;
- Any item that doesn’t constitute “Medical Care” under the Internal Revenue Code §213(d); and
- Any item that isn’t reimbursable under applicable regulations.

For more information about what items are-and are not-Medical Care Expenses, consult IRS Publication 502. Also, ask the Plan Administrator if you need further information about which expenses are-and are not reimbursable.

LOSS OF BENEFITS

You may lose all or part of your account if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you.

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan.

NO CARRYOVER

No, HRA funds from the prior coverage period may not be used to cover prior Coverage Period expenses. You may file claims until June 30th for qualified expenses that were incurred in the prior calendar year.

FMLA LEAVES OF ABSENCE

If you go on a qualifying leave under the federal Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your Medical Insurance Benefits, HRA benefits, and HRA benefits on the same terms and conditions as if you were still active. Your Employer may require you to continue all Medical Insurance Benefits and HRA benefits coverage while you are on paid leave (so long as Employees on non-FMLA paid leave are required to continue coverage). You will pay

your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary reduction basis.)

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

If you go on an unpaid leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA Leave”), you may revoke your election to participate under any benefit offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator. Upon your return from USERRA leave, you may be reinstated in the Plan, on the same terms that applied to you prior to your USERRA Leave, and with such other rights to make enrollment changes as are provided to other Employees under the Plan. Notwithstanding the foregoing, you shall have no greater rights to benefits while on USERRA Leave as other Employees.

ABOUT TAXES

The Company intends that all benefits provided under the HRA will not be taxable to you under federal law. The Company does not represent or guarantee that any federal, state, or local income, payroll, personal property of other tax consequence will result from participation in this Plan.

FUTURE OF THE HRA / PLAN ADMINISTRATOR’S DISCRETIONARY AUTHORITY

The HRA is based on the Employers’ understanding of the current provisions of the Internal Revenue Code. The Plan Administrator reserves the right to amend or discontinue the Plan if regulations or changes in the tax law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which you were entitled before the date of the amendment or termination.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of a Qualified Medical Child Support Order (“QMCSO”). A QMCSO is a court-ordered judgment, decree, order, or property settlement agreement in connection with state domestic relations law which either (a) creates or extends the rights of an “alternate recipient” to participate in a group health plan, including this Plan, or (b) enforces certain laws relating to medical child support. An “alternate recipient” is any child of an Employee who is recognized by a medical child support order as having a right to enrollment under an Employee’s group health plan.

A medical child support order will outline certain specific conditions to be qualified. The Plan Administrator will notify you if it receives a medical child support order that applies to you.

MATERNITY AND NEWBORN COVERAGE

Since this Plan offers maternity and newborn coverage under the employer-sponsored group health plan and one or more of the Medical Insurance Benefits, you are advised that under federal law, this Plan and the insurers may not restrict benefits (or fail to provide reimbursement) for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require authorization from this Plan for prescribing a length of stay not in excess of the above periods.

MICHELLE'S LAW AND ITS EFFECT ON YOUR HRA ACCOUNT

Michelle's Law provides that a group health plan may not terminate the coverage of a dependent child who is covered as a full-time student at a post-secondary educational institution because of that individual ceasing to meet the definition of a full-time student due to a medically necessary leave of absence (or other change of enrollment, if medically necessary). In such a situation, the plan is required to continue the individual's coverage for up to a year while he or she is on a medically necessary leave of absence (unless coverage would otherwise terminate sooner under the terms of the plan). The student must be full-time until the first day of the leave and must be medically certified by a treating physician. To be eligible, the treating physician must certify that the student's medical leave of absence (or change in enrollment) is medically necessary.

Michelle's Law amends ERISA, so it applies to any group health plan subject to ERISA. Because Michele's Law did not amend Internal Revenue Code §152, reimbursements for eligible expenses of Dependents covered under Michelle's Law that do not meet the definition of Dependent under Internal Revenue Code §152 may be subject to tax.

COORDINATION WITH OTHER PLANS

All claims for benefits must first be coordinated by other health benefits and or insurance prior to submission to the Company for payment by the HRA.

YOUR PRIVACY RIGHTS UNDER HIPAA

Introduction

This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to Your protected health information.

Your Health Information Rights

Although your health record is the physical property of the health provider, the information belongs to You. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

The Plan Sponsor is required to:

- Maintain the privacy of your health information,
- Provide You with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify You if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We will not use or disclose your health information without your authorization submitted to Your health care provider, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If You have questions and would like additional information, You may contact the Plan Administrator's Privacy Officer, at 20320 S.W. Birch Street, Newport Beach, CA 92660.

If You believe Your privacy rights have been violated, You can file a complaint with the Plan Sponsor's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Business associates: There are some services provided in our organization through contacts with business associates. Examples include, but are not limited to, medical review and case management. When these services are contracted, we may disclose your health information to our business associate. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Any legal action where you or your provider is a party will result in providing identifying health information. The retaining of legal counsel will include the confidentiality of this information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your health care benefit plan if you have signed an authorization disclosure form.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in Your care or payment related to Your care.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

HIPAA SECURITY RULE

The HIPAA Security Rule requires that reasonable and appropriate technical, physical, and administrative safeguards be taken with electronic individually identifiable health information. Specifically, the Plan ensures the confidentiality, integrity, and availability of all electronic protected health information it creates, receives, maintains, or transmits.

COBRA CONTINUATION COVERAGE

Eligibility for Coverage under COBRA

If you, your Spouse, or your Dependent(s) coverage under this Plan terminates because of a Qualifying Event, and you, your Spouse, or your Dependent(s) were covered under the Plan on the day before the Qualifying Event, the Plan will offer the opportunity to continue coverage as a Qualified Beneficiary in compliance with Consolidated Omnibus Reconciliation Act of 1986, as amended (COBRA).

A “Qualified Beneficiary” is an Employee, Spouse and/or Dependent Child who were covered under this Plan on the day before a Qualifying Event, and who loses coverage as a result of the Qualifying Event.

A “Qualifying Event” is any of the following, which results in a loss of coverage for that you, your Spouse, or your Dependent(s):

1. The Employee’s death; or
2. A termination of the Employee’s employment (for reasons other than gross misconduct) or reduction in the Employee’s hours of employment; or
3. A Dependent Child no longer satisfies the Plan’s definition of a Dependent Child; or
4. Divorce or legal separation of the Employee from the Employee’s Spouse; or
5. Your Employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act.

Coverage under COBRA will be identical to coverage offered under the Plan to similarly situated Employees. You will also be entitled, while receiving continuation coverage, to the same benefits, choices, and services that a similarly situated Participant is currently receiving under the Plan, such as the right during Open Enrollment to choose among available coverage options. You will also be subject to the same rules and limits that would apply to a similarly situated Participant, such as Copayments, Deductibles, and coverage limits. The Plan’s rules for filing benefit claims and appealing any claim denials also apply.

Any changes made to the Plan’s terms that apply to similarly situated Employees and their Dependents will also apply to Qualified Beneficiaries receiving COBRA continuation coverage. Each Qualified Beneficiary under COBRA shall have all of the rights of an Employee under the Plan, including the right to enroll Dependents, if such right is given to Employees; however, other than a child born to the Employee or placed for adoption with the Employee during a period of COBRA continuation coverage, any such Dependent so enrolled, who was not covered under the Plan on the day prior to the initial Qualifying Event, although eligible for coverage under COBRA, shall not have the status of Qualifying Beneficiary.

Initial Notification of a Qualifying Event

If the Qualifying Event is a divorce or legal separation, or a Dependent child no longer satisfying the Plan’s definition of a “Dependent Child”, the Qualified Beneficiary eligible for COBRA as a result of such Qualifying

Event must notify the Plan Administrator, in writing, of the Qualifying Event within sixty (60) days of (a) the Qualifying Event, or (b) the date on which coverage is lost as a result of the Qualifying Event, whichever is later. If the Plan Administrator is not so notified, the Qualified Beneficiary may not enroll in COBRA. In the event of a divorce or legal separation, notice sent to the Plan Administrator by any one of the Participants for whom the divorce or legal separation constitutes a Qualifying Event will be considered notice sent on behalf of all such Participants.

For all other Qualifying Events, the Employer will notify the Plan Administrator of a Qualified Beneficiary's Qualifying Event within thirty (30) days of such event. The Plan Administrator will then notify all Qualified Beneficiaries, in writing, of their rights to continue coverage under COBRA, within fourteen (14) days following the thirty (30) day period specified above in this paragraph.

Electing COBRA

If a Qualified Beneficiary wishes to enroll in COBRA, he must so notify the Plan Administrator, in writing, within sixty (60) days of the date the Plan Administrator mails written notification of the right to continue coverage, except that if the loss of coverage occurs after the date of the Qualifying Event, the sixty (60) days shall be counted from the date coverage is lost. An election is made on the date it is mailed to the Plan Administrator.

If notice of election is not sent to the Plan Administrator within the period specified in the paragraph immediately above, the Qualified Beneficiary may not enroll in COBRA.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage will be provided retroactively (that is, from the date of the loss of coverage). When coverage is provided retroactively the Qualified Beneficiary will be required to pay contributions retroactive to the effective date of coverage. Waivers and revocations of waivers are made on the date they are sent to the Employer or Plan Administrator.

Payment for COBRA

The cost to a qualified beneficiary for COBRA coverage shall be 102% of the Employer's cost or 150% of the Employer's cost during a month extension for disability, for such coverage.

A Qualified Beneficiary's first payment for COBRA is due forty-five (45) days after the date of his election. For Your first (1st) payment You must enclose payment for each month retroactive to the first month after Your coverage was terminated. Your health coverage is a pre-paid health plan and it is Your responsibility to ensure that Your payment is received by the Company by the first (1st) of the coverage month. This applies regardless of whether You receive an invoice from the Company. Failure to make a timely payment will result in the suspension of certain medical benefits, including prescription drug card coverage. Failure to make the required monthly payment by the end of the coverage month will result in a loss of coverage with no reinstatement allowed. Payment is made on the date on which it is sent (postmarked) to the Plan.

Failure to pay any contributions within the timeframes specified herein will result in cancellation of COBRA coverage, such cancellation to be effective as of the end of the last day for which coverage has been paid. COBRA does not require that the Qualified Beneficiary be notified in the event cancellation of COBRA coverage has occurred.

Maximum Coverage Periods – The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

- If the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is eighteen (18) months after the Qualifying Event. With a disability extension (see “Disability Extension” information below), the eighteen (18) months is extended to twenty-nine (29) months;
- If the Qualifying Event occurs to a Dependent due to Employee’s enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is thirty-six (36) months from the date the Employee is enrolled in Medicare;
- For any other Qualifying Event, the maximum coverage period ends thirty-six (36) months after the Qualifying Event.

If a Qualifying Event occurs that provides an eighteen (18) month or twenty-nine (29) month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to thirty-six (36) months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than thirty-six (36) months after the date of the first Qualifying Event.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) – USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

Disability Extension – An eleven (11) month disability extension (an extension from a maximum eighteen (18) months of COBRA continuation coverage to a maximum twenty-nine (29) months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first sixty (60) days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration’s disability determination date that falls within the allowable periods described. The notice must be provided within sixty (60) days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family must notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the eleven (11) month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the twenty-nine (29) month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself.

Termination of Continuation Coverage – COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

- The last day of the applicable maximum coverage period – see “Maximum Coverage Periods” above;
- The date on which the Employer ceases to provide any group health plan to any Employee;
- The date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any pre-existing condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;
- The date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, “entitled” means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect;
- In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - Twenty-nine (29) months after the date of the Qualifying Event, or the first day of the month that is more than thirty (30) days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary’s entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;
- The end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than thirty (30) days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary’s right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly situated non-COBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person’s relationship to a Qualified Beneficiary (i.e., a newborn or adopted child added during an Employee’s COBRA coverage period), the Plan’s obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

COMPLIANCE WITH THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The information furnished herein constitutes the Summary Plan Description required by federal law. Dependent Care Assistance Plans and Health Savings Accounts are not covered under ERISA.

ERISA Rights Statement

ERISA was enacted to help assure that all employer-sponsored group health benefit programs conform to standards set by Congress. You are entitled to certain rights and protections under ERISA, which provides that you be entitled to: (1) examine, without charge, at the Plan Administrator’s office and at other appropriate locations, all Plan documents and copies of documents filed with the U.S. Department of Labor,

such as copies of the latest annual reports (Form 5500), (2) obtain copies, upon written request to the Plan Administrator copies of all Plan documents and other Plan information governing the operation of the Plan, including copies of the latest annual report (Form 5500) and updated summary plan description, subject to a reasonable charge for the copies; and (3) receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for you, ERISA imposes duties upon those responsible for the operation of the Plan who are called "fiduciaries" and who have a duty to operate the Plan prudently and in the interest of participants and beneficiaries. If a claim for a benefit under the Plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the claim reviewed and reconsidered. Please see your Medical Insurance Benefits document for further information.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request material and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the company to provide the materials and pay the person up to \$110 a day until the person receives the materials, unless the materials were not sent because of reasons beyond the Employer's control.

If 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 may file suit in a federal court. The court will decide who should pay court costs and legal fees.

If you have any questions about your Plan, you should contact the Plan Sponsor. If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefit Security, 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.

The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend, or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Plan.

Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation, or application of the Plan by the Plan Administrator is final, conclusive, and binding.

Not a Contract of Employment

No provision of the Plan is to be considered a contract of employment between you and the Company or its affiliates. The Company's rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

Plan Definition and Funding

This is a Section 105 Health Reimbursement Arrangement, classified by the U.S. Department of Labor as a "welfare" plan. The Plan is funded by the employer.

GENERAL INFORMATION

- Plan Sponsor/Plan Administrator: Bremer Whyte Brown and O'Meara
- Plan Number: 505
- Effective Date: October 1, 2014; amended and restated January 1, 2024
- Plan Year: January 1 to December 31

Type(s) of Plans

Health Reimbursement Arrangement

Participants

The Plan provides benefits for all employees of Bremer Whyte Brown and O'Meara who meet the eligibility requirements described herein.

Employer/Plan Sponsor/Plan Administrator Information

Bremer Whyte Brown and O'Meara
20320 S.W. Birch Street
Newport Beach, CA 92660
(949) 275-1602

Employer Identification Number (EIN): 33-0747275

Agent for Service of Legal Process

Bremer Whyte Brown and O'Meara
20320 S.W. Birch Street
Newport Beach, CA 92660

Any legal papers should be delivered to one of the member or manager's. Service may also be made upon the Plan Administrator or a Trustee, if any.

Plan Year End: December 31 of each year.