CARDINGTON YUTAKA TECHNOLOGIES, INC.

WELFARE BENEFITS PLAN

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

EFFECTIVE AS OF APRIL 1, 2019

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Article 1.Definitions

Capitalized terms used in this document have the following meanings:

AD&D

"AD&D" means accidental death and dismemberment insurance.

"ADA" means Americans with Disabilities Act.

"ADA"

ADEA

"ADEA" means the Age Discrimination in Employment Act.

CHIPRA

"CHIPRA" means the Children's Health Insurance Program Reauthorization Act, as amended.

COBRA

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code

"Code" means the Internal Revenue Code of 1986, as amended.

Company or Employer

"Company" or "Employer" means Cardington Yutaka Technologies, Inc., or any successor thereto.

Cures Act

"Cures Act" means 21st Century Cures Act.

Effective Date

"Effective Date" means April 1, 2013. The effective date of this restatement is April 1, 2019.

Eligible Employee

"Eligible Employee" means an Employee who satisfies the eligibility provisions and who is not excluded from participation by the terms of an applicable component benefit program.

Employee

"Employee" means any common-law employee of the Company or related employer who has adopted the Plan who satisfies the eligibility provisions of Section 4 of this document and who is not excluded from participation by the terms of the component benefit program. "Related employer" means

any employer affiliated with Cardington Yutaka Technologies, Inc. that, under Code Sections 414(b), (c), or (m), is treated as a single employer with Cardington Yutaka Technologies, Inc. for purposes of Code Section 105.

ERISA

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

FMLA

"FMLA" means the Family and Medical Leave Act of 1993.

GINA

"GINA" means the Genetic Information Nondiscrimination Act of 2008.

Cafeteria Plan

The Cafeteria Plan (Premium Conversion Only Plan) is a component benefit program under the Plan. It allows Employees to use pre-tax dollars to pay for most medical and dental expenses not reimbursed under other programs.

HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

HITECH

"HITECH" means the Health Information Technology for Economic and Clinical Health Act.

MHPA

"MHPA" means the Mental Health Parity Act.

MHPAEA

"MHPAEA" means the Mental Health Parity Addiction Equity Act.

Michelle's Law

"Michelle's Law" means the law that requires group health plans to allow seriously ill or injured college students who are covered dependents to continue coverage for up to one year while on medically necessary leaves of absence.

NMHPA

"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

Participant

"Participant" means an Eligible Employee or the covered eligible dependent of an Eligible Employee.

Plan

"Plan" means the Cardington Yutaka Technologies, Inc. Welfare Benefits Plan.

Plan Administrator

"Plan Administrator" means Cardington Yutaka Technologies, Inc.

Plan Sponsor

"Plan Sponsor" means Cardington Yutaka Technologies, Inc.

PPACA

"PPACA" means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA).

USERRA

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994.

WHCRA

"WHCRA" means the Women's Health and Cancer Rights Act of 1998.

Within this document, "you" and "your" refer to the participants in the Plan, while references to "we," "us," and "our" refer to the Company or, in certain circumstances, its delegate or an insurer or third-party administrator of one of the component benefit programs of the Plan.

Article 2.Introduction

The Company maintains the Plan for the exclusive benefit of its eligible Employees and their eligible spouses and dependents. The Plan provides benefits through the component benefit programs listed in Appendix A.

The individual component benefit programs may require you to make an annual election to enroll for coverage. Each of the component benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description prepared specifically for that component benefit program, or another written governing document prepared by the Company (an "Attachment") and which is referenced in the Appendix. Copies of the relevant documents applicable to you are attached to this document in the Attachments noted above. To facilitate efficient operation of the Plan, and to the extent permitted by applicable law, the Plan may allow forms (including, for example, election forms and notices), whether required or permissive, to be sent and/or made by electronic means.

We are providing this document to give you an overview of the Plan and to address certain information that may not be addressed in the Attachments. This document and its Attachments constitute the plan document and summary plan description for the Plan. The applicable insurance companies or other providers may amend, modify, or completely restate the Attachments from time to time. Any such amendment, modification, or restatement that you receive constitutes an amendment of this document. You should keep any such amendment, modification, or restatement together with this document and its attachments. This document is not intended to give you any substantive rights to benefits that are not already provided by the Plan and the Attachments.

If the applicable certificates of coverage or other attachments listed in the Appendix are not attached, then this document is not complete and you should contact the Plan Administrator for a complete copy.

Article 3.General Information about the Plan

Facts

Plan Name:

Cardington Yutaka Technologies, Inc. Welfare Benefits Plan

Type of Plan:

Welfare plan providing group health and other welfare benefits.

Plan Year:

April 1 – March 31

Plan Number:

501

Effective Date:

April 1, 2013

Funding Medium and Type of Plan Administration:

The Appendix describes the component benefit programs and their funding. Generally, the Medical Coverage portion of the Plan and other health care benefits are self-insured. The Plan Administrator, or its delegate, shall cause the Plan to pay for covered expenses or coverage under any self-insured component benefit program(s). Other benefits are fully insured. With respect to benefits under such component benefit programs, the relevant insurance company, not the Company, is responsible for paying claims with respect to the program. Any fully-insured component benefit program shall be made available to you subject to the terms and conditions of the Plan, the applicable Attachments, and other governing documents for the component benefit program

Your Medical Coverage contributions and insurance premiums for your coverage (and coverage for your eligible dependents) may be paid in part by us out of the Company's general assets and part by you via payroll deductions. Payroll deductions for certain component benefit programs may be made on a pre-tax basis through the Premium Conversion Plan (Cafeteria Plan). For voluntary benefits, premiums may be wholly paid by participants. The Plan Administrator provides a schedule of the applicable premiums for the component benefit programs during the initial and subsequent open enrollment periods and upon request.

Plan Sponsor, Plan Administrator, Named Fiduciary and Agent for Service of Legal Process:

Cardington Yutaka Technologies, Inc.
575 W. Main St.
Cardington, OH 43315
(419) 864-8777

Plan Sponsor's Employer Identification Number:

31-1428274

Insurance Company (for fully-insured benefits):

See attached Appendix A

Named Fiduciary for Determination of Benefits and for Benefit Appeals:

See Appendices and attachments. The Company is the named fiduciary if the named fiduciary is not specified with respect to a particular benefit.

Important Disclaimer

Benefits hereunder are provided pursuant to one or more insurance contracts or other governing plan documents issued by the insurance companies, the Company, or other service providers. If the terms of this document conflict with the terms of such insurance contracts or other governing plan documents, then unless otherwise stated herein, the terms of the insurance contracts or other governing plan documents will control, rather than this document, unless superseded by applicable law.

Article 4.Eligibility and Participation Requirements

Eligibility and Participation

You are eligible to participate in the Plan if you are an eligible Employee. An eligible Employee with respect to the Plan will be any common law Employee who is eligible to participate in and receive benefits under one or more of the component benefit programs. To determine whether you or your dependents are eligible to participate in the component benefit programs, and for additional information concerning eligibility and enrollment, please read the eligibility information contained in Appendix A and the Attachments for the component benefit programs.

The component benefit programs may require that you make an initial election to enroll if you are a new Employee. New Employees must generally enroll within certain time periods after being hired, as

described in the Attachments. Thereafter, you may also be required to make an annual election to enroll for coverage during an open enrollment period, or the Plan may carry forward your prior election if you do not make an affirmative election during a subsequent open enrollment period. In certain circumstances and with respect to particular component benefit programs, enrollment may occur at times outside the open enrollment period, as explained in the Attachments.

Once you, as an eligible Employee, have completed the necessary enrollment process, your coverage under the Plan may begin. Requirements may vary depending on the component benefit program. For information about when coverage begins, please read the eligibility and participation information contained in the Attachments.

Termination of Participation

Your participation and the participation of your eligible dependents in any benefit program under the Plan will terminate as provided in Appendix A and the Attachments for the component benefit programs. Coverage also terminates if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you submit false claims, and for certain other reasons described in the Attachments.

Coverage for your spouse and dependents stops when your coverage stops and for other reasons specified in the Attachments (for example, divorce or a dependent's attaining age limit). Coverage also ceases for Employees, spouses, and dependents upon termination of the Plan.

Note that termination of coverage under a particular component benefit program does not necessarily mean your coverage under the Plan in general terminates. You may still have coverage under another component benefit program. You should consult the Attachments for specific termination events and information.

COBRA Rights

If group health plan coverage for you or your eligible family members ceases because of certain "qualifying events" specified in COBRA, then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time. COBRA rights are discussed in the health care benefit booklet(s).

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the Uniformed Services pursuant to the Uniformed Service Employment and Reemployment Rights Act of 1994, as amended. More information about coverage available pursuant to this Act is included in the Attachments.

Note also that state law may provide continuation and/or conversion coverage.

Article 5.Circumstances that May Affect Benefits

Qualified Medical Child Support Orders

With respect to a component benefit program that is a group health plan, the Plan will also provide benefits as required by any qualified medical child support order, or "QMCSO" (defined in ERISA § 609(a)), and will provide benefits to dependent children placed with participants or beneficiaries for

adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries, in accordance with ERISA § 609(c). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You can obtain, without charge, a copy of such procedures from the Plan Administrator.

Plan's Right to Recover

If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to you or one of your dependents, you (or your dependent) shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the insurance companies, third party administrators, Plan Administrator, or Company (or designee) may recover that incorrect payment, whether or not it was made due to the insurance companies', third party administrators', or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party. As may be permitted in the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods: (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurance companies or third party administrators. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Participant Responsibilities

You are responsible for providing the Plan Administrator and the Company and, if required by an insurance company or third party administrator, the insurance company or third party administrator with your current address. If required by the insurance company or third party administrator, you shall be responsible for providing the insurance company or third party administrator with the address of each of your covered eligible dependents. Any notices required or permitted to be given to a participant hereunder shall be deemed given if directed to the address most recently provided by the participant and mailed by first class United States mail. The insurance companies, the third party administrators, the Plan Administrator, and the Company shall have no obligation or duty to locate a participant.

Right to Information and Fraudulent Claims

Any person claiming benefits under the Plan must furnish the Plan Administrator or, with respect to a fully-insured benefit, the insurance company with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan.

The Plan Administrator (and, with respect to a fully-insured benefit, the insurance company) shall have the right and opportunity to have a participant examined when benefits are claimed, and when and so often as it may be required during the pendency of any claim under the Plan. The Plan Administrator and, with respect to a fully-insured benefit, the insurance company also shall have the right and opportunity to have an autopsy done in the case of death, where it is not forbidden by law.

If a person is found to have falsified any document in support of a claim for benefits or coverage under the Plan, or failed to have corrected information which such person knows or should have known to be incorrect, or failed to bring such misinformation to the attention of the Plan Administrator or the insurance company, the Plan Administrator may, without the consent of any person, terminate the person's Plan coverage, including retroactively. In addition, the Plan Administrator or insurance

company may refuse to honor any claim for benefits under the Plan for the participant related to the person submitting the falsified information. Such person shall be responsible to provide restitution, including monetary repayment to the Plan, with respect to any overpayment or ineligible payment of benefits.

Denial or Loss of Benefits

Your benefits (and the benefits of your eligible dependents) will cease when your participation in the Plan terminates. See Section 4 above.

Your benefits will also cease on termination of the Plan.

Depending on the reason that coverage was terminated, you and your covered spouse and dependents may have the right to continue coverage temporarily under COBRA and USERRA, to the extent these laws apply to a particular component benefit program.

Other circumstances can result in the termination, reduction, or denial of benefits. You should consult the Attachments for additional information.

Article 6.How the Plan Is Administered

Plan Administration and Discretion

The administration of the Plan is under the supervision of the Plan Administrator.

Except as specifically otherwise provided in the Attachments (such as an insurance company's or TPA's authority to determine eligibility for and the amount of any benefits payable under the applicable component benefit program), the Plan Administrator has the full and final discretionary authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including, without limitation, the construction of the language of the Plan and summary plan description. Any writing, decision, determination of benefit eligibility, or any other determination or instrument created by the Plan Administrator in connection with the operation of the Plan shall be binding upon all persons dealing with the Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in its sole discretion, that its original decision was in error, or to the extent such decision may be determined to be arbitrary or capricious by a court or other entity having jurisdiction over such matters.

Powers of the Administrator

The Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters hereunder, and all determinations of the Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this

Plan, except to the extent plan documents provide for an insurer or other service provider to have such authority;

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to enroll in and submit claims pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the Benefits under this Plan in such manner as the Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate;

(f) to receive, review, and keep on file such reports and information concerning the Benefits covered by this Plan as the Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

Reliance on Participant, Tables, etc.

The Administrator may rely upon the information submitted by a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Administrator.

Provisions for Third-Party Plan Service Providers

The Administrator, subject to the approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the

Fiduciary Liability

To the extent permitted by law, the Administrator shall not incur any liability for any acts or for failure to act except for the Administrator's own willful misconduct or willful breach of this Plan.

Compensation of Administrator

Unless otherwise determined by the Employer and permitted by law, any Administrator who is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of the Administrator's duties shall be paid by the Employer.

Bonding

The Administrator shall be bonded to the extent required by ERISA.

Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any Benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

Inability to Locate Payee

If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date that any such payment first became due.

Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee or the amount of Benefits paid or to be paid to a Participant or other person, the Administrator shall, to the extent that it deems administratively possible and otherwise permissible under applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the Benefits to which he or she is properly entitled under the Plan. Such action by the Administrator may include the withholding of any amounts due to the Plan or the Employer from compensation paid to the Participant by the Employer.

Power and Authority of Insurance Company or Third-Party Administrator

As provided in the Attachments, or unless otherwise provided, the applicable insurance company or (third-party administrator) TPA may be responsible for (1) determining eligibility for and the amount of any benefits payable under the component benefit program, and (2) prescribing claims procedures to be followed and the claims forms to be used by Employees pursuant to the component benefit program.

The insurance company or TPA, if applicable, is the Named Fiduciary for purposes of determining benefits and for purposes of benefit appeals. The applicable insurance company or TPA also has the authority to require eligible individuals to furnish it with such information as it determines is necessary for the proper administration of the applicable component benefit program.

Your Questions

If you have any general questions regarding the Plan (including, for example, whether you are eligible to participate in the Plan or a particular component benefit program offered through the Plan, or the amount of any benefit payable under the self-funded component benefit programs), please contact the Plan Administrator.

However, if you have any question regarding your claim for, or the amount of, any benefit payable under the component benefit programs, please contact the applicable insurance company or TPA.

Article 7.Amendment or Termination of the Plan

Amendment or Termination

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. For this purpose, amending the Plan includes making changes to a component benefit program. Terminating a component benefit program (including terminating an insurance contract through which such benefits are provided) is not a termination of the Plan. Rather, it is an amendment to the Plan.

An authorized officer or Employee of the Company may sign insurance contracts or other governing documents for this Plan on behalf of the Company, including amendments to those contracts or documents, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

Article 8.Miscellaneous Provisions

Governing Law

The Plan shall be construed, administered, and enforced according to the laws of the State of Ohio, to the extent not superseded or preempted by the Code, ERISA, or any other federal law.

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between the Company and you giving the right for you to be employed for any specific period of time.

Compliance with State and Federal Mandates

With respect to component benefit plans, the Plan will comply, to the extent applicable, with the requirements of all applicable federal and state laws (and regulations thereunder), such as ADA, ADEA, CHIPRA, COBRA, Code (including general tax and nondiscrimination requirements) ERISA, FMLA, GINA,

HIPAA nondiscrimination, portability and privacy and data security, HITECH, MHPH, MHPAEA, Michele's Law, NMHPA, PPACA, USERRA, WHCRA and Title VII of the Civil Rights Act.

In accordance with Title I of the Genetic Information Nondiscrimination Act of 2008, in no event shall the Plan or any of its insurers discriminate against you on the basis of genetic information with respect to eligibility, premiums, or contributions.

No Guarantee of Tax Consequences

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Administrator if the Participant has any reason to believe that such payment is not so excludable.

No Vesting of Participant Benefits

No Employee participating in the Plan shall have any vested or nonforfeitable right to any coverage under any component benefit program under the Plan by reason of participation herein.

Expenses

All reasonable expenses incurred in administering the Plan may be paid by the Employer, or may be paid from plan assets.

Indemnification of Employer

If any Participant receives one or more payments or reimbursements under the Plan on a tax-free basis and such payments or reimbursements do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

Non-Assignability of Rights

The right of any Participant to receive any payment or reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

Headings

The headings of the various Articles and Sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provisions.

Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of this Plan shall be given effect to the maximum extent possible.

Article 9.Claims Procedures

For purposes of the determination of the amount of, and entitlement to, benefits of the component benefit programs (other than the Group Medical Benefit), the insurer, TPA, or Plan Administrator (as applicable) is the Named Fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the insurance contract or other governing plan document.

To obtain benefits from the insurer, TPA, or Plan Administrator, you must follow the claims procedures under the insurance contract or other governing plan document, which may require you to complete, sign, and submit a written claim on the insurer's, TPA's, or Plan Administrator's form. In that case, the form is available from the Plan Administrator. All claims will be decided in accordance with reasonable claims procedures, as required by ERISA.

To the extent that any governing documents for such component benefit programs do not provide legally sufficient claims procedures, or in the event that any claims procedures of a component benefit program are contrary to applicable law under ERISA, then separate claims procedures will be provided to you. Please see the Plan Administrator for further details or if you have questions regarding the claims review procedures that apply to you.

Appendix C sets forth claims procedures for group health plan benefits, to the extent such procedures are not set forth in other plan documentation.

Limitation of Action

You cannot bring any legal action against the Company or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement and all required reviews of your claim have been completed. If you want to bring a legal action against the Company or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the Company or the Claims Administrator. You cannot bring any legal action against the Company or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process. After completing that process, if you want to bring a legal action against Company or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Company or the Claims Administrator.

Article 10.Statement of ERISA Rights

Your Rights

As a participant in the Plan, you are entitled to certain rights and protections under 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 worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, 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 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 Form 5500, if any is required by ERISA to be prepared, in which the Company, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights

Continue health care coverage for yourself, your spouse, or your 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 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 your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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. These people who operate your Plan, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignore 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 that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, 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 Company, as Plan Administrator, to provide the materials and pay you up to $110 per 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, and if you have exhausted the claims procedures available to you under the Plan (discussed in Section 9), 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 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 Administrator. If you have questions about this statement or about your ERISA rights, or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or contact them at http://www.dol.gov/ebsa/aboutebsa/org_chart.html or at 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 can call the Employee Benefits Security Administration (the EBSA) at (866) 444-3272; TTY/TDD users: (877) 889-5627. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. You may also obtain additional pension-related information at the Department of Labor's website at http://www.dol.gov/ebsa/publications/wyskapr.html where you can review a publication called "What You Should Know About Your Retirement Plan."

* * *

Cardington Yutaka Technologies, Inc. has caused this Plan to be executed in its name and on its behalf, on this ____ day of _____, 2019.

CARDINGTON TECHNOLOGIES, INC.

By:_____

Its:_____

CARDINGTON YUTAKA TECHNOLOGIES, INC.

WELFARE BENEFITS PLAN

APPENDIX A: COMPONENT BENEFIT PROGRAMS

Last updated effective April 1, 2019

List of Component Benefit Programs and Incorporated Documents

The Cardington Yutaka Technologies, Inc. Welfare Benefits Plan is comprised of the following component benefit programs which together with this wrap plan document and the various insurance policies, certificates of coverage, schedules of benefits and miscellaneous documents attached to this Appendix constitute the entire Plan. Claims can be submitted to the entities as indicated.

Benefit	Fully Insured/ Self-insured Employee Contribution Pre-tax or After-tax	Insurer/Claims Administrator	Document Names in Online Payroll System	Eligibility to Participate
Medical Coverage – Preferred Provider Organization (PPO) (includes Care 24 employee assistance)	Self Insured Pre-tax	United Healthcare P.O. Box 981502 El Paso, TX 79998-1502 866-270-5311	• SBC: PPO C Current • SPD: PPO C Current • Uniform Glossary of Terms Current	Non-exempt employees – 91st day after date of hire Exempt employees – first day of the month following date of hire
Medical Coverage – Health Reimbursement Arrangement (HRA) (includes Care 24 employee assistance)	Self Insured Pre-tax	United Healthcare P.O. Box 981502 El Paso, TX 79998-1502 866-270-5311	• SBC: HRA Current • SPD: HRA Current • Uniform Glossary of Terms Current	Non-exempt employees – 91st day after date of hire Exempt employees – first day of the month following date of hire
Dental Coverage	Fully Insured N/A (100% employer paid)	Delta Dental P.O. Box 9085 Farmington Hills, MI 48333-9085 800-524-0149	• Dental Summary Current • Dental Certificate of Coverage Current	Non-exempt employees – 91st day after date of hire Exempt employees – first day of the month following date of hire
Vision Coverage	Fully Insured	EyeMed (Fidelity	• Vision Summary	Non-exempt

Benefit	Fully Insured/ Self-insured Employee Contribution Pre-tax or After-tax	Insurer/Claims Administrator	Document Names in Online Payroll System	Eligibility to Participate
	N/A (100% employer paid)	Security Life Insurance Company) 3130 Broadway Kansas City, MO 64111-2406 800-648-8624	Current • Vision Certificate of Coverage Current	employees - 91st day after the date of hire Exempt employees - first day of the month following date of hire
Wellness Program	Self Insured N/A	DHS Group 3301 East Royalton Road, Broadview Heights, OH 44147 440-746-1234	• DHS Healthy Ways Wellness Program Summary Current • DHS Healthy Ways Wellness Program SPD Current	Non-exempt employees – 91st day after date of hire Exempt employees – first day of the month following date of hire
Employee Assistance Program (New Directions)	Fully Insured N/A	New Directions 1575 Marion Avenue Mansfield, OH 44906 888-805-1561		For those not covered by Medical Coverage. Non-exempt employees – 3 months after date of hire Exempt employees – first day of the month following date of hire
Onsite Medical Clinic	Self Insured N/A	Ohio Health c/o Cardington Yutaka Technologies 573 W Main St Cardington, OH 43315 419-864-0272		All full-time associates from date of hire. Spouse and dependents (age 2+) who are covered under Medical Coverage. Available to retirees for five years after date of retirement.
Health FSA	Self Insured	United Healthcare	• FSA SPD Current	One year after date of hire

Benefit	Fully Insured/ Self-insured Employee Contribution Pre-tax or After-tax	Insurer/Claims Administrator	Document Names in Online Payroll System	Eligibility to Participate
	Pre-Tax	United Healthcare 450 Columbus Boulevard Hartford, CT 06115-0450 866-633-2446		
Short Term Disability Insurance (including voluntary insurance)	Fully Insured Pre-Tax	Mutual of Omaha Life Insurance Company Mutual of Omaha Plaza Omaha, NE 68175 800-775-8805	• STD Group Certificate of Coverage Non-Exempt Current • STD Voluntary Certificate of Coverage Non-Exempt Current • STD Group Certificate of Coverage Technical Specialist Current • STD Group Summary Non-Exempt Current • STD Voluntary Summary Non-Exempt Current • STD Summary Technical Specialists Current	Non-exempt employees – 3 months after date of hire Exempt employees – first day of the month following date of hire
Group Term Life Insurance (including voluntary insurance)	Fully Insured N/A (100% employer paid); Voluntary is After-Tax	Mutual of Omaha Life Insurance Company Mutual of Omaha Plaza Omaha, NE 68175 800-775-8805	• Group Life Certificate of Coverage Non-Exempt Current • Group Life Certificate of Coverage Exempt Current • Group Life Summary of Coverage Non-	Non-exempt employees – 3 months after date of hire Exempt employees – first day of the month following date of hire

Benefit	Fully Insured/ Self-insured Employee Contribution Pre-tax or After-tax	Insurer/Claims Administrator	Document Names in Online Payroll System	Eligibility to Participate
			Exempt Current • Group Life Summary of Coverage Exempt Current • Voluntary Life Certificate of Coverage Non-Exempt Current • Voluntary Life Certificate of Coverage Exempt Current • Voluntary Life Summary of Coverage Non-Exempt Current • Voluntary Life Summary of Coverage Exempt Current	
Accidental Death and Dismemberment (AD&D) Insurance	Fully Insured N/A (100% employer paid)	Mutual of Omaha Life Insurance Company Mutual of Omaha Plaza Omaha, NE 68175 800-775-8805	• Group Life Certificate of Coverage Non-Exempt Current • Group Life Certificate of Coverage Exempt Current • Group Life Summary of Coverage Non-Exempt Current • Group Life Summary of Coverage Exempt Current	Non-exempt employees – 3 months after date of hire Exempt employees – first day of the month following date of hire
Long Term Disability	Fully Insured	Mutual of Omaha Life	• LTD Certificate of Coverage Non-	Non-exempt employees – 3 months

Benefit	Fully Insured/ Self-insured Employee Contribution Pre-tax or After-tax	Insurer/Claims Administrator	Document Names in Online Payroll System	Eligibility to Participate
Insurance	N/A (100% employer paid)	Insurance Company Mutual of Omaha Plaza Omaha, NE 68175 800-775-8805	Exempt Current • LTD Certificate of Coverage Exempt Current • LTD Summary of Coverage Non-Exempt Current • LTD Summary of Coverage Exempt Current	after date of hire Exempt employees – first day of the month following date of hire
Voluntary Group Accident Insurance	Fully Insured Pre-tax	AFLAC PO Box 427 Columbia, SC 29202 800-433-3036	• Plan Certificates are sent directly to enrolled Associtates homes.	Non-exempt employees – first day of the month following 90 days of employment. Exempt employees – first day of the month following date of hire
Voluntary Group Hospital Indemnity Insurance	Fully Insured Pre-tax	AFLAC PO Box 427 Columbia, SC 29202 800-433-3036	• Plan Certificates are sent directly to enrolled Associtates homes.	Non-exempt employees – first day of the month following 90 days of employment. Exempt employees – first day of the month following date of hire
Voluntary Group Critical Illness Insurance	Fully Insured After-tax	AFLAC PO Box 427 Columbia, SC 29202 800-433-3036	• Plan Certificates are sent directly to enrolled Associtates homes.	Non-exempt employees – first day of the month following 90 days of employment. Exempt employees – first day of the month following date of hire

Period of Coverage – The Period of Coverage for the benefits described above is April 1 through March 31 annually.

Coverage during a leave of absence will be maintained in accordance with the requirements of FMLA and USERRA as applicable. Coverage will be maintained for up to six months for a participant who is receiving disability benefits. If an Associate returns to work following a disability lasting longer than 6 months, the Associate will be treated as a, "New Hire" and will need to satisfy the "Eligibility to Participate*" periods noted for each benefit.

Unless the other benefit documentation sets for more specific provisions: medical, dental and vision coverage ends on the last day of the month in which an associate terminates employment; and group life, accidental death and dismemberment, voluntary life, and short-term and long-term disability coverage ends of the date an associate terminates employment.

Look-back Measurement Method for Eligibility Determinations for Purposes of the Patient Protection and Affordable Care Act. Effective April 1, 2015, the Company uses the look-back measurement method to determine who is a full-time employee for purposes of Plan coverage. The look-back measurement method is based on Internal Revenue Service (IRS) guidance under the Patient Protection and Affordable Care Act. Its purpose is to provide greater predictability for Plan coverage determinations.

The look-back measurement method applies to all Company employees.

The look-back measurement method involves three different periods:

- A *measurement period* for counting your hours of service. Different measurement periods apply to ongoing employees, new employees who are variable hour, seasonal or part-time, and new non-seasonal employees who are expected to work full-time.

    - If you are an ongoing employee, this measurement period is called the "standard measurement period." Your hours of service during the standard measurement period will determine your Plan eligibility for the stability period that follows the measurement period and any administrative period.

      The standard measurement period starts on February 1 and ends on January 31.

    - If you are a new employee who is variable hour, seasonal or part-time, this measurement period is called the "initial measurement period." Your hours of service during the initial measurement period will determine your Plan eligibility for the stability period that follows the measurement period and any administrative period.

      The initial measurement period starts on the first of the month following your date of hire and lasts for 12 months.

    - If you are a new non-seasonal employee who is expected to work full time, the Company will determine your status as a full-time employee who is eligible for Plan coverage based on your hours of service for each calendar month. Once you have been

employed for a certain length of time, the measurement rules for ongoing employees will apply to you.

- A *stability period* is a period that follows a measurement period. Your hours of service during the measurement period will determine whether you are a full-time employee who is eligible for coverage during the stability period. As a general rule, your status as a full-time employee or a non-full-time employee is "locked in" for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of the Company. There are exceptions to this general rule for employees who experience certain changes in employment status.

  The stability period lasts 12 months from the date you're offered coverage.

- An *administrative period* is a short period between the measurement period and the stability period when the Company performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment.

  The administrative period for new employees in their initial measurement period lasts one month following the conclusion of their initial measurement period. The administrative period for those employees in their standard measurement period lasts two months from February 1 to March 31 each year.

Special rules may apply in certain circumstances, such as when employees are rehired by the Company or return from an unpaid leave.

The rules for the look-back measurement method are very complex. Keep in mind that this information is just a summary of how the rules work. More complex rules may apply to your situation. The Company intends to follow applicable IRS guidance when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, please contact Human Resources.

CARDINGTON YUTAKA TECHNOLOGIES, INC.

WELFARE BENEFITS PLAN

APPENDIX B: ADDITIONAL BENEFIT PROGRAMS

1. Wellness Program

The Cardington Yutaka Technologies, Inc. Wellness Program: Healthy Ways (the "Wellness Program") is intended to provide nontaxable wellness benefits to Eligible Employees who participate in the Health Plan component of the Cardington Yutaka Technologies, Inc. Welfare Benefits Plan (the "Plan") and their Spouses, for the time period during which they are eligible to participate in the Health Plan. The Wellness Program is intended to provide nontaxable employer-provided health coverage under Code Sections 105 and 106 and the regulations issued thereunder, and shall be interpreted to accomplish that objective. The Benefits provided under the Wellness Program are intended to be eligible for exclusion from Participants' gross income under Code Section 105(b).

The Employer shall have the option to provide rewards for participation in this program. Any reward will be in the form and amount selected by the Employer. The form of reward can include, but is not limited to, gift cards, Health Plan premium discounts, reductions in a deductible or copayment under the Health Plan, cash payments, or contributions to another arrangement (such as a health reimbursement arrangement or health flexible spending account sponsored by the Employer).

Benefits provided under this Wellness Program shall be provided solely from the Employer's general assets. The Employer may take all necessary actions to address the taxation of a reward, including but not limited to treating the amounts as taxable income on reports and, to the extent consistent with other applicable laws, withholding amounts from an employee's wages to pay for taxes owed by the employee with respect to the rewards. The Employer may withhold or modify rewards, alter the requirements for obtaining a reward, and take whatever other steps it deems reasonably necessary to ensure that the rewards are provided in accordance with all applicable laws.

2. Employee Assistance Program – New Directions

Medical Coverage includes an employee assistance program for participants and beneficiaries who participate in Medical Coverage.

The Company also provides an employee assistance program, New Directions, for employees who do not participate in Medical Coverage. The provisions of the program are set forth in separate materials.

3. On-Site Health Clinic

The Company provides an on-site health clinic, currently operated by OhioHealth. The clinic is free of charge and staffed by a Certified Nurse Practitioner and Medical Assistant. It is suited to treat acute health concerns such as upper respiratory infections, sinus infections, sore throats, sprains, earaches, flu shots (age 16+) and minor cuts or bruises. Walk-ins are permitted, but appointments are recommended.

The Company provides a nearby fitness facility for employees. Retirees are also eligible to use the fitness facility for five years after their retirement date. This facility is not intended to be part of the ERISA Plan.

The Company maintains a Premium Conversion Plan, which is not an ERISA benefit, to allow participants to make pre-tax contributions for certain employee benefits coverages. Associates are eligible on the date they are eligible to make elections under benefit programs.