GENESYS CLOUD SERVICES, INC. HEALTH & WELFARE PLAN

WRAP PLAN DOCUMENT

Established as of January 1, 1996
Amended and Restated as of January 1, 2022

GENESYS CLOUD SERVICES, INC. HEALTH & WELFARE PLAN

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ARTICLE 1 - VARIABLE PROVISIONS/DEFINITIONS

Section 1.01 PLAN QUALIFICATION

This Plan is intended to qualify as a welfare benefit plan of Genesys Cloud Services, Inc. (the "Company") under ERISA. The components covered by this Plan, which is to be treated as a single plan for purposes of ERISA, are: Medical/Prescription Drug, Dental, Vision, Health/Limited Purpose Flexible Spending Accounts, Employee Assistance Program, Severance Plan, Life/Accidental Death & Dismemberment, Short-Term Disability, Long-Term Disability, Wellness Program, Business Travel Accident, Hawaii Temporary Disability Insurance Program (TDI), NY state-mandated disability, Legal Plan, Health Savings Account, and Dependent Care Flexible Spending Account. The inclusion of non-ERISA benefits (Health Savings Account, Dependent Care Flexible Spending Account, Commuter Benefit Plan, state mandated disability coverage) in this Plan Document, and the inclusion of any other benefit that is not otherwise subject to ERISA shall not subject such benefit to ERISA.

Section 1.02 PLAN SPONSOR

Name of adopting employer (Plan Sponsor): Genesys Cloud Services, Inc. The Plan Sponsor was previously known as Genesys Telecommunications Laboratories, Inc. prior to March 15, 2021.

EIN of Plan Sponsor: 94-3120525

"Company" means the Plan Sponsor and any other entity that adopts the Plan with the consent of the Plan Sponsor.

Section 1.03 GENERAL PLAN INFORMATION

Plan name: Genesys Cloud Services, Inc. Health & Welfare Plan. The Plan name was previously known as Genesys Telecommunications, Inc. Laboratories, Inc. Health & Welfare – Plan #502.

Plan number: 502

Effective Date: January 1, 2022. This is a restatement of a prior plan document. The original effective date of Plan is: January 1, 1996.

"Plan Year" means each 12-consecutive month period ending on: December 31.

Section 1.04 COMPONENT BENEFIT PROGRAMS

"Component Benefit Program" means any agreement, writing, contract, plan or arrangement between the Company and a welfare benefit provider where the benefits provided are subject to ERISA.

In addition, any statements of coverage provided by the Plan Administrator setting forth a description of the scope of coverage under the Plan as well as the options, terms, conditions and limitations related thereto are herein incorporated as part of the Component Benefit Programs.

Section 1.05 ELIGIBILITY/ENROLLMENT

An eligible employee with respect to the programs described in this document is any individual who is designated as eligible to participate in and receive benefits under one or more of the component benefit programs described herein. The eligibility and participation requirements may vary depending on the particular Component Benefit Program. An employee must satisfy the eligibility requirements under a particular Component Benefit Program in order to receive benefits under that program. Certain individuals related to the employee, such as a spouse (or domestic Partner) or dependents, may be eligible for coverage under certain Component Benefit Programs. To determine whether an employee's family members are eligible to participate in a Component Benefit Program, the employee should read the eligibility information contained in the SPD and governing documents for the applicable Component Benefit Programs.

a) In accordance with the Company enrollment information, Benefit Eligible Employees are defined as follows:

    i) Employees who work 20 hours or more per week are eligible to participate in benefits; provided, however, that interns shall only be considered Benefit Eligible Employees with respect to the following Component Benefit Programs: Medical, Prescription Drug, Dental, and Vision

    ii) Participation may begin immediately upon date of hire.

b) Eligibility and special enrollment for benefits under the Component Benefit Programs shall be determined by the Component Benefit Programs.

c) "Participant" means an employee of the Company that participates in one or more Component Benefit Programs.

Section 1.06 PLAN OPERATIONS

The Plan Administrator shall be the Plan Sponsor. The Plan Administrator shall also be the named fiduciary within the meaning of ERISA section 402.

Section 1.07 INDEMNIFICATION

To the extent permitted by law, the Company shall indemnify and hold harmless the members of the Board of Directors, the Plan Administrator (and/or its delegate), and any other Employee to whom any fiduciary responsibility with respect to the Plan is allocated or delegated, from and against any and all liabilities, costs, and expenses, including reasonable attorney's fees and expenses, incurred by any such person in connection with the duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan or ERISA.

Section 1.08 PARTICIPANT'S RESPONSIBILITIES

It is the Participants responsibility to notify the Plan Administrator and the Company (and an insurance company with respect to a fully insured benefit) of his or her current address and the address of any other individual covered through the employee. Any notices required or permitted to be given to a Participant or Beneficiary with respect to the Plan shall be deemed given if directed to the address most recently provided by first-class U.S. mail or by electronic transmission to the email address provided. The insurance companies, the Plan Administrator, and the Company shall have no duty to locate a Participant or Beneficiary.

ARTICLE 2 - BENEFITS

Section 2.01 INCORPORATION BY REFERENCE

The actual terms and conditions of the Component Benefit Programs offered under this Plan (as described in Section 1.01 hereof) are contained in separate, written documents governing each respective benefit, and shall govern in the event of a conflict between the individual plan document and this Plan. To that end, each such separate Component Benefit Program, as amended or subsequently replaced, is hereby incorporated by reference and should be attached herein.

Section 2.02 COORDINATION OF BENEFITS

Benefits provided under this Plan shall be coordinated with benefits provided under other plans as provided in the applicable Component Benefit Program.

ARTICLE 3 - PLAN ADMINISTRATION

Section 3.01 PLAN ADMINISTRATOR

a) Certain other third parties may exercise plan administrator functions with respect to the Plan.

b) The company may appoint a person, entity or committee to serve as Plan Administrator. In the absence of such appointment, the Employer shall be the Plan Administrator. The Plan Administrator shall be the "named fiduciary" for purposes of ERISA. When the Plan is silent as to that designation, ERISA provides that the Plan Sponsor is the "Plan Administrator" under ERISA.

c) **Authority and Responsibility of the Plan Administrator.** The Plan Administrator shall be the Plan "administrator" as such term is defined in section 3(16) of ERISA, and as such shall have total and complete discretionary power and authority:

i) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;

ii) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits in accordance with Article 5;

iii) to determine the amount and manner of any allocations hereunder;

iv) to maintain and preserve records relating to the Plan;

v) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;

vi) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all, reports and other information required under law to be so filed or published;

vii) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;

viii) to determine all questions of the eligibility of employees and of the status of rights of Participants under the Plan;

ix) to determine the validity of any judicial order;

x) to retain records on elections and waivers by Participants;

xi) to supply such information to any person as may be required;

xii) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

d) **Procedures.** The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

e) **Allocation of Duties and Responsibilities.** The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.

f) **Compensation.** The Plan Administrator shall serve without compensation for its services.

g) **Expenses.** All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the Company.

h) **Allocation of Fiduciary Duties.** A Plan fiduciary shall have only those specific powers, duties, responsibilities and obligations as are explicitly given him under the Plan. It is intended that each fiduciary shall not be responsible for any act or failure to act of another fiduciary. A fiduciary may serve in more than one fiduciary capacity with respect to the Plan.

Section 3.02 MEDICAL CHILD SUPPORT ORDERS

In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA section 609(a)(2)(B)), the Plan Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA section 609(a)(2)(A)). Within a reasonable period, the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

Section 3.03 FMLA/USERRA

To the extent the Plan is subject to the Family Medical Leave Act (FMLA), the Plan Administrator shall permit a Participant taking unpaid leave under the FMLA to continue medical benefits under such applicable law. Non-medical benefits shall be continued according

to the established Company policy. Participants continuing participation pursuant to the foregoing shall pay for such coverage (on a pre-tax or after-tax basis) under a method as determined by the Plan Administrator satisfying Treas. Reg. 1.125-3 Q&A-3. Any Participant on FMLA leave who revoked coverage shall be reinstated to the extent required by Treas. Reg. 1.125-3. If the Participant's coverage under the Plan terminates while the Participant is on FMLA leave, the Participant is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. Upon reinstatement into the Plan upon return from FMLA leave, the Participant has the right to (i) resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments, or (ii) resume coverage at a level that is reduced by the amount of unpaid premiums and resume premium payments at the level in effect before the FMLA leave. The Plan Administrator shall also permit Participants to continue benefit elections as required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) and shall provide such reinstatement rights as required by such law. The Plan Administrator shall also permit Participants to continue benefit elections as required under any other applicable state law to the extent that such law is not pre-empted by federal law.

Section 3.04 COBRA

To the extent the Plan is subject to COBRA (Code section 4980B and other applicable state law), a Participant shall be entitled to continuation coverage with respect to his or her health benefits as prescribed in Code section 4980B (and the regulations thereunder) or such applicable state statutes.

Section 3.05 THIRD PARTY RECOVERY/REIMBURSEMENT

a) The Plan Administrator may, but is not required to, utilize the provisions of this subsection to the extent not inconsistent with the provisions of any applicable Component Benefit Program, in which case the provisions of the Component Benefit Program shall control.

b) **In General.** When a Participant or covered dependent receives Plan benefits 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, the Participant shall reimburse the Plan for the related Plan benefits received out of any funds or monies the Participant recovers from any third party.

c) **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 a Participant or covered dependent may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if

the Participant or covered dependent has not been paid or fully reimbursed for all of their damages or expenses.

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

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

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

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

Once a Participant or covered dependent has any reason to believe that the Plan may be entitled to recovery from any third party, the Participant must notify the Plan. And, at that time, the Participant (and the Participant'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 the Participant or covered dependent to any payment, amount or recovery from a third party.

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

right to subrogation or reimbursement.

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

Section 3.06 HIPAA PORTABILITY, PRIVACY AND SECURITY RULES

a) **HIPAA Portability Rules:** To the extent the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules, the Plan shall comply with the requirements of Code section 9801 et. seq. including the requirement to cover children until the attainment of at least age 26 if the Plan makes dependent coverage of children available.

b) **HIPAA Privacy Rules**: The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information and sets limits and conditions on the uses and disclosures that may be made of such information without participant authorization. The Rule also gives participants' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

c) **HIPAA Security Rules**: The HIPAA Security Rule establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.

ARTICLE 4 - FUNDING

Section 4.01 NO FUNDING REQUIRED

Except as otherwise required by law:

a) Any amount contributed by a Participant and/or the Company to provide benefits hereunder shall remain part of the general assets of the Company and all payments of benefits under the Plan shall be made out of the general assets of the Company or the Component Benefit Programs.

b) The Company shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the Company may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.

c) No person shall have any rights to, or interest in, any account other than as expressly authorized in the Plan.

Section 4.02 FUNDING POLICY

The Company shall have the right to enter into a contract with one or more Component Benefit Program providers for the purposes of providing any benefits under the Plan and to replace any of such Component Benefit Programs. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such Component Benefit Program shall not be assets of the Plan but shall be the property of and shall be retained by the Company. The Company will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this Plan. Such limitation shall include, but not be limited to, losses or obligations that pertain to the following:

a) Once a Component Benefit Program is applied for or obtained, the Company will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Company;

b) To the extent premium notices are received by the Company, the Company's liability for the payment of such premiums will be limited to such premiums and will not include liability for any other loss which result from such failure;

c) When employment ends, the Company will have no liability to take any step to maintain any policy in force except as may be specifically required otherwise in this Plan and the Company will not be liable for or responsible to see to the payment of any premium with respect to periods after employment ends.

Section 4.03 REFUND POLICY

Whenever a payment has been made under any benefit plan in a total amount, at any time, in excess of the maximum amount payable under the plan's provisions ("Overpayment"), the entity for whom the payment was made must refund the applicable Overpayment to the plan and/or help the plan obtain the refund of the Overpayment from another entity. This includes any Overpayments resulting from retroactive awards received from any source, fraud, or any error made in processing the claim.

In case of a recovery from a source other than the plan, Overpayment recovery will not be more than the amount of the payment. An Overpayment also occurs when payment is made from the plan that should have been made under another group plan. In that case, the plan may recover the payment from one or more of the following: any other insurance company, any other organization, or any person to or for whom payment was made.

The plan may, at its option, recover the Overpayment by reducing or offsetting against any future benefits payable to the employee and/or family members; stopping future benefit payments that would otherwise be due under the plan (payments may continue when the Overpayment has been recovered); or demanding an immediate refund of the Overpayment from any entity for whom the payment was made.

ARTICLE 5 - CLAIMS PROCEDURES

Section 5.01 CLAIMS PROCEDURES

This Section 5.01 shall apply for any claim for benefits under a Component Benefit Program that is subject to ERISA unless the Component Benefit Program has a claims procedure that is compliant with ERISA section 503. If the Component Benefit Program has a claims procedure that is compliant withERISA section 503, the claims procedure of the Component Benefit Program shall apply.

A request for benefits is a "claim" subject to these procedures only if it is filed by the Participant or the Participant's authorized representative in accordance with the Component Benefit Program's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable Component Benefit Program provider. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that the inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information.

Participants may designate an authorized representative by providing to the Plan Administrator or its delegate written notice of such designation and identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of the Participant's medical condition may act as an authorized representative with or without prior notice. A "health care professional" is a physician or other health care professional licensed, accredited, or certified to perform specified health services, consistent with state law.

(a) Timing of Notice of Claim. The Plan Administrator will notify the Claimant of an adverse benefit determination within a reasonable period of time, but not later than the time frame below, depending on the type of benefit being provided under the Component Benefit Program under which the claim for benefits arises. An "adverse benefit determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan, and including, with respect to a group health plan, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(1) In General. The Plan Administrator (or its delegate) will provide notice of an adverse benefit determination within 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that

the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(2) Group Health Plan Claims.

(A) Urgent Care Claims. An "urgent care" claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function, or, in the opinion of a physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an "urgent care" claim is determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the Participant's medical condition determines is an "urgent care" claim will be treated as an "urgent care" claim by the Plan.

If the Participant or the Participant's authorized representative fails to follow the Plan's procedures for filing an urgent care claim, the Plan Administrator (or its delegate) will notify the Participant of the failure as soon as possible, but not later than 24 hours following the failure and of the proper procedures to be followed in filing a claim for benefits. Notification may be oral, unless written notification is requested by the Participant or authorized representative. This paragraph (A) applies only to a communication by a Participant or an authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific Participant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Plan Administrator will notify the Participant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Participant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the plan administrator will notify the Participant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Participant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified

information, or (2) the end of the period afforded the Participant to provide the specified additional information.

(B) Pre-Service Claims. A "pre-service" claim is any claim for a benefit under a group health plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. If the Participant or the Participant's authorized representative fails to follow the Plan's procedures for filing a pre-service claim, the Plan Administrator (or its delegate) will notify the Participant of the failure as soon as possible, but not later than 5 days following the failure and of the proper procedures to be followed in filing a claim for benefits. Notification may be oral, unless written notification is requested by the Participant or authorized representative. This paragraph (B) applies only to a communication by a Participant or an authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific Participant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Plan Administrator will notify the Participant of the Plan's determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Participant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Participant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(C) Post-Service Claims. A post-service claim is any claim for a benefit under the plan that is not a pre-service claim. In the case of a post-service claim, the Plan Administrator will notify the Participant of the Plan's adverse benefit determination within a reasonable period of time, but no later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Participant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information,

and the Participant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(D) Concurrent Care Claims. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. The Plan Administrator will notify the Participant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Any request by a Participant to extend the course of treatment beyond the period of time or number of treatments that is an urgent care claim will be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator will notify the Participant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Notwithstanding anything herein to the contrary, the timeframe for benefit determinations under group health plans will be determined as provided under DOL Reg. section 2560.503-1(f)(2). For purposes of this Section 5.01, group health plan means a group health plan as defined in DOL Reg. section 2560.503-1(m)(6).

(3) Disability Benefit Claims. The Plan Administrator will provide notice of an adverse benefits determination to the Participant within 45 days after receipt of the claim. This period may be extended by the Plan for up to 30 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The period for making the determination may be extended for up to an additional 30 days if Plan Administrator notifies the Participant prior to the expiration of the first 30-day extension period the circumstances of the extension and the date by which the Plan expects to render a decision. Any notice extension under this section will explain the standards on which the entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Participant will be afforded at least 45 days within which to provide the specified information.

(c) Content of Notice of Adverse Benefit Determination.

(1) If a claim is wholly or partially denied, the Plan Administrator will provide the Participant with a written notice identifying (1) the reason or reasons for such denial; (2) the pertinent Plan provisions on which the denial is based; (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary; and (4) an explanation of the steps that the Participant must take if he wishes to appeal the denial including a statement that the Participant may bring a civil action under ERISA.

(2) In addition, if the wholly or partially denied claim is for a group health plan or disability benefit under the Plan, the following information must also be included in the written notice: (1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request; or (2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(3) If the denied claim is for a disability benefit under the Plan, the Plan Administrator will also provide the Participant the following information in the written notice: (1) a discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination made by the Social Security Administration regarding the Participant presented by the Participant to the Plan; (2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request; (3) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and (4) a statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for disability benefits.

(4) In the case of a wholly or partially denied urgent care claim by a group health plan under the Plan, the notice must include a description of the expedited

review process applicable to such claims. In addition, the information described in this Section 5.01(c) may be provided orally within the timeframe required under Section 5.01(b) provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

(d) Appeal of Adverse Benefit Determination.

(1) A Participant may appeal the denial of a claim by filing a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied (the 180th day for claims involving a group health plan or disability benefits). If the denial involves a claim for disability benefits, a denial includes a cancellation or discontinuance of coverage that has retroactive effect (unless it is due to the Participant's failure to pay required premiums). The written appeal will identify both the grounds and specific Plan provisions upon which the appeal is based. The Participant will lose the right to appeal if the appeal is not timely made.

The Plan will provide the Participant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefit. The Participant may submit written comments, documents, records, and other information relating to the claim for benefits. The Plan will take into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Plan Administrator will consider the merits of the Participant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant.

(2) If the claim is for group health plan or disability benefits, the following will apply:

(A) the review will not afford deference to the initial adverse benefit determination. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(B) in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the adverse

benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

(C) the Plan will identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Participant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(D) in the case of an urgent care claim, the Plan will expedite review of the claim such that a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Participant and all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Participant by telephone, facsimile, or other available similarly expeditious method.

(3) If the claim is for disability benefits under the Plan, the following will also apply:

(A) Before the Plan issues any adverse benefit determination, the Plan Administrator will provide the Participant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan) in connection with the claim, and any new or additional rationale must be provided to the Participant as soon as possible and sufficiently in advance of the date on which the Plan must provide the Participant with the notice of final adverse benefit determination so that the Participant has a reasonable opportunity to respond prior to that date.

(B) If the determination is based on a new or additional rationale, the Participant will be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is required to be provided to give the Participant a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it in time for the Participant to have a reasonable opportunity to respond, the Plan's deadline for providing a notice of final adverse benefit determination will be delayed until the Participant has had reasonable opportunity to respond. After the Participant responds, or has a reasonable opportunity to respond but fails to do so, the Plan Administrator will notify the Participant of the Plan's benefit determination as soon as a Plan Administrator acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.

(4) The Plan Administrator will ordinarily rule on an appeal of an adverse benefit determination within 60 days following receipt of the claim. However, if special circumstances require an extension and the Plan Administrator furnishes the Participant with a written extension notice during the initial

period, the Plan Administrator may extend this period of time by 60 days if written notice of the extension is furnished to the Participant prior to the termination of the initial 60-day period.

If a Committee designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, the Committee will instead make a benefit determination no later than the date of the meeting of the Committee that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination will be rendered not later than the third meeting of the Committee following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator will provide the Participant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator will notify the Participant of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(5) If the claim is for group health plan benefits, the Plan Administrator will notify the Participant of the Plan's benefit determination on review as follows:

(A) Urgent Care Claims. The Plan Administrator will notify the Participant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Participant's request for review of an adverse benefit determination by the Plan.

(B) Pre-Service Claims. The plan administrator will notify the Participant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt by the Plan of the Participant's request for review of an adverse benefit determination.

(C) Post-Service Claims. The Plan Administrator will notify the Participant of the Plan's benefit determination on review within a reasonable period of time, but no later than 60 days after receipt by the Plan of the Participant's request for review of an adverse benefit determination.

(6) If the claim is for disability benefits, the Plan Administrator will ordinarily rule on an appeal of a claim denial within 45 days following receipt of the claim. However, if special circumstances require an extension and the Plan Administrator furnishes the Participant with a written extension notice during the initial period, the Plan Administrator may extend this period of time by 45 days if written notice of the extension is furnished prior to the termination of the initial 45-day period.

(7) The period of time within which a benefit determination on review is required to be made will begin at the time an appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended due to a Participant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review will be tolled from the date on which the notification of the extension is sent to the Participant until the date on which the Participant responds to the request for additional information.

(8) All claims and appeals involving disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will be made based upon the likelihood that the individual will support the denial of benefits.

(e) Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator will provide the Participant with a notice identifying (1) the reason or reasons for such denial; (2) the Plan provisions on which the denial is based; (3) a statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits; and (4) a statement describing the Participant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator will be binding upon all parties.

(1) In the case of a group health plan or a plan providing disability benefits, the notice will also include:

(A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Participant upon request;

(B) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(C) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(2) In the case of a claim involving disability benefits, the notice will also include:

(A) any applicable contractual limitations period that applies to the Participant's right to bring an action under section 502(a) of ERISA, including the calendar date that the contractual limitations period expires for the claim;

(B) a discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Participant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination made by the Social Security Administration regarding the Participant presented by the Participant to the Plan;

(C) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(D) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

(f) Exhaustion of Remedies. A Participant must exhaust all internal remedies before a claim or lawsuit can be filed in court.

(g) Additional Claims Processes.

(1) Applicability. This Subsection will apply to benefit under (1) a plan that constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the plan is subject to HIPAA portability rules, and (2) the plan is not a grandfathered health plan under the Patient Protection and Affordable Care Act.

(2) Internal Claims Process. The claims requirements set forth in Section 5.01 above will apply as the internal claims process, except that

(A) an "adverse benefit determination" will also include any cancellation or discontinuance of coverage under the applicable plan that has retroactive effect;

(B) the Plan will provide the Participant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence

must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to the Participant to give the Participant a reasonable opportunity to respond prior to that date;

(C) before the Plan can issue a final internal adverse benefit determination based on a new or additional rationale, the Participant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the Participant a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it to the Participant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the Participant has a reasonable opportunity to respond. After the Participant responds, or has a reasonable opportunity to respond but fails to do so, the Plan Administrator will notify the Participant of the Plan's benefit determination as soon as a Plan Administrator acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies;

(D) the Plan must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits;

(E) the Plan must provide notice to Participants, in a culturally and linguistically appropriate manner;

(F) the Plan must ensure that any notice of adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

(G) the Plan must provide to Participants, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination. The Plan must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review;

(H) the Plan must ensure that the reason or reasons for the adverse benefit determination includes the denial code and its corresponding meaning,

as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision;

(I) the Plan must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(J) the Plan must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist Participant's with the internal claims and appeals and external review processes; and

(K) the Plan will continue to provide continued coverage under the Plan as required by DOL Reg. section 2590.715-2719(b)(2)(iii) pending the outcome of an appeal.

(h) External Claims Process.

(1) State Process. To the extent the Plan is required pursuant to DOL Reg. section 2590.715-2719(c)(1) to comply with a State external claims process that includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the Plan will comply with the state external claims process of DOL Reg. section 2590.715-2719(c).

(2) Federal Process. To the extent the Plan is not required pursuant to DOL Reg. section 2590.715-2719(c)(1) to comply with the State external claims process, then the Plan will comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d).

Section 5.02 MINOR OR LEGALLY INCOMPETENT PAYEE

If a distribution is to be made to an individual who is either a minor or legally incompetent, the Plan Administrator may direct that such distribution be paid to the legal guardian. If a distribution is to be made to a minor and there is no legal guardian, payment may be made to a parent of such minor or a responsible adult with whom the minor maintains his residence, or to the custodian for such minor under the Uniform Transfer to Minors Act, if such is permitted by the laws of the state in which such minor resides. Such payment shall fully discharge the Plan Administrator and the Company from further liability on account thereof.

Section 5.03 MISSING PAYEE

If the Plan 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 Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.

Section 5.04 RIGHT TO INFORMATION AND FRAUDULENT CLAIMS

Any person claiming benefits under the Plan shall furnish the Plan Administrator (and with respect to a fully insured Component Benefit Program, the insurance company) with such information and documentation as may be necessary to verify eligibility for or entitlement to benefits under the Plan.

The Plan Administrator (and, with respect to a fully insured Component Benefit Program, the insurance company) shall have the right and the opportunity to have a Participant or Beneficiary examined when benefits are claimed, and when and as often as 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 consent of any person and to the fullest extent permitted by applicable law, terminate the individual's coverage under the Plan or a Component Benefit Program. A Participant or Beneficiary submitting false information shall be responsible to provide restitution, including, but not limited to monetary repayment, to the Plan with respect to an overpayment or any amount paid from the Plan for a benefit for which the Participant or Beneficiary was not eligible.

Section 5.05 STATUTE OF LIMITATIONS/FORUM SELECTION

Any legal action brought against the Plan must be filed no later than the earlier of (i) one year from the date theParticipant (or his/her covered dependent) exhausted the claims procedures described above inSection 5.01, (ii) the date specified in the Component Benefit Program plan document, or (iii) the date the applicable California statute of limitations has or will run. No action at law or in equity shall be brought in connection with the Plan except in the United States District Court for the Northern District of California.

ARTICLE 6 - AMENDMENT OR TERMINATION OF PLAN

Section 6.01 AMENDMENT

The provisions of the Plan may be amended in writing at any time and from time to time by the Plan Sponsor. In addition, any amendment to the Plan that is required by applicable law or does not materially increase the benefits provided under the Plan or the costs of administering the Plan may be made by the Company's Chief People Officer.

Section 6.02 TERMINATION

It is the intention of the Plan Sponsor that this Plan will be permanent. However, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason.

Each entity constituting the Company reserves the right to terminate its participation in this Plan. In addition, each such entity constituting the Company shall be deemed to terminate its participation in the Plan if: (i) it is a party to a merger in which it is not the surviving entity and the surviving entity is not an affiliate of another entity constituting the Company, or (ii) it sells all or substantially all of its assets to an entity that is not an affiliate of another entity constituting the Company.

Upon termination, any assets remaining in the Plan shall be used to pay outstanding benefit claims. To the extent permitted by the Component Benefit Programs and to the extent the assets do not revert to the Company, any remaining assets shall be refunded to Participants.

ARTICLE 7 - GENERAL PROVISIONS

Section 7.01 NONALIENATION OF BENEFITS

No Participant or Beneficiary shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he may expect to receive, contingently or otherwise, under the Plan except as required by law, or, in the case of assignments, as permitted under the terms of the Component Benefit Programs.

Section 7.02 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the Company and the Participant, or as a right of any employee to continue in the employment of the Company, or as a limitation of the right of the Company to discharge any of its employees, with or without cause.

Section 7.03 GOVERNING LAW

The Plan shall be construed in accordance with and governed by the laws of the State of California or commonwealth of organization of the Plan Sponsor to the extent not preempted by Federal law.

The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

Section 7.04 TAX EFFECT

The Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. A Participant should consult with professional tax advisors to determine the tax consequences of his or her participation.

Section 7.05 SEVERABILITY OF PROVISIONS

If any provision of the Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and the Plan shall be construed and enforced as if such provisions had not been included.

Section 7.06 HEADINGS AND CAPTIONS

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

Section 7.07 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.

Section 7.08 EFFECT OF MISTAKE

In the event of a mistake as to the eligibility or participation of an employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due the Plan or the Company from compensation paid by the Company.

ARTICLE 8 - HIPAA

The components of the Plan that are considered Group Health Benefits will comply with the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") as set forth below.

Section 8.01 HIPAA COMPLIANCE FOR FULLY INSURED GROUP HEALTH BENEFITS

Notwithstanding the foregoing, to the extent any of the Plan's Group Health Benefits are fully insured, the Plan Sponsor has adopted a policy of not receiving, disclosing or using Personal Health Information (PHI) or Summary Health Information regarding insured benefits for any purpose permitted under HIPAA, unless authorized by the Individual, when appropriate.

Section 8.02 DEFINITIONS

For purposes of this Article 8, the following terms have the following meanings:

a) "Business Associate" means any outside vendor who performs a function or activity on behalf the Plan which involves the creation, use or disclosure of PHI, and includes any subcontractor to whom a Business Associate delegates its obligations.

b) "Group Health Benefits" means the medical, dental, vision, life, disability and, if applicable, employee assistance program benefits offered under the Plan.

c) "Individual" means the Participant or the Participant's covered dependents enrolled in any of the Group Health Benefits under the Plan.

d) "Notice of Privacy Practices" means a notice explaining the uses and disclosures of PHI that may be made by the Plan, the covered Individuals' rights under the Plan with respect to PHI, and the Plan's legal duties with respect to PHI.

e) "Plan Administration Functions" means the administration functions performed by the Plan Sponsor on behalf of the Plan. Plan Administration Functions do not include functions performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor.

f) "Protected Health Information ("PHI")" means information about an Individual, including genetic information, (whether oral or recorded in any form or medium) that:

    i) is created or received by the Plan or the Plan Sponsor;

    ii) relates to the past, present or future physical or mental health or condition of the Individual, the provision of health care to the Individual, or the past, present or future payment for the provision of health care to the Individual; and

iii) identifies the Individual or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual.

PHI includes Protected Health Information that is transmitted by or maintained in electronic media.

g) "Summary Health Information" means information summarizing the claims history, claims expenses, or types of claims experienced by an Individual, and from which the following information has been removed:

i) names;

ii) any geographic information which is more specific than a five-digit zip code;

iii) all elements of dates relating to a covered Individual (e.g., birth date) or any medical treatment (e.g., admission date) except the year; all ages for a covered Individual if the Individual is over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);

iv) other identifying numbers, such as, Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;

v) facial photographs or biometric identifiers (e.g., fingerprints); and

vi) any other unique identifying number, characteristic, or code.

Section 8.03 HIPAA PRIVACY COMPLIANCE

The Plan's HIPAA privacy compliance rules ("Privacy Rule") are as follows:

a) **Permitted Use or Disclosure of PHI by Plan Sponsor.** Any disclosure to and use by the Plan Sponsor of any PHI will be subject to and consistent with this Section.

i) The Plan and health insurance issuer, HMO, or Business Associate servicing the Plan may disclose PHI to the Plan Sponsor to permit the Plan Sponsor to carry out Plan Administration Functions, including but not limited to the following purposes:

(1) to provide and conduct Plan Administrative Functions related to payment and health care operations for and on behalf of the Plan;

(2) for auditing claims payments made by the Plan;

(3) to request proposals for services to be provided to or on behalf of the Plan; and

(4) to investigate fraud or other unlawful acts related to the Plan and committed or reasonably suspected of having been committed by a Plan participant.

ii) The uses described above in (i) are permissible only if the Notice of Privacy Practices distributed to covered Individuals in accordance with the Privacy Rule states that PHI may be disclosed to the Plan Sponsor.

iii) The Plan or a health insurance issuer or HMO may disclose to the Plan Sponsor information regarding whether an Individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

b) **Restrictions on Plan Sponsor's Use and Disclosure of PHI.**

i) The Plan Sponsor will not use or further disclose PHI, except as permitted or required by the Plan or as required by law.

ii) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides PHI agrees to the restrictions and conditions of this Section.

iii) The Plan Sponsor will not permit a health insurance issuer or HMO to use or disclose PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

iv) The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.

v) The Plan Sponsor will make a covered Individual's PHI available to the covered Individual in accordance with the Privacy Rule.

vi) The Plan Sponsor will make PHI available for amendment and will, upon notice, amend PHI in accordance with the Privacy Rule.

vii) The Plan Sponsor will track certain PHI disclosures it makes so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rule.

viii) The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of PHI received from the Plan to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with the Privacy Rule.

ix) The Plan Sponsor will, if feasible, return or destroy all PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control) received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Individual who is the subject of the PHI, when that PHI is no longer needed for the Plan Administration Functions for which the disclosure was made. If it is not feasible to return or destroy all such PHI, the Plan Sponsor will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

x) When using or disclosing PHI or when requesting PHI from another party, the Plan sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.

xi) The Plan Sponsor will not use any genetic information for any underwriting purposes.

c) **Adequate Separation between the Plan Sponsor and the Plan**.

i) Only those employees of the Plan Sponsor, as outlined in the Plan's HIPAA Policies and Procedures, may be given access to PHI received from the Plan or a health insurance issuer, HMO or Business Associate servicing the Plan.

ii) The members of the classes of employees identified in the Plan's HIPAA Policies and Procedures will have access to PHI only to perform the Plan Administration Functions that the Plan Sponsor provides for the Plan.

iii) The Plan Sponsor will promptly report to the Plan any use or disclosure of PHI in breach, violation of, or noncompliance with, the provisions of this Section of the Plan, as required under this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, will impose appropriate disciplinary action or sanctions, including termination of employment, on each employee who is responsible for the breach, violation or noncompliance, and will mitigate any deleterious effect of the breach, violation or noncompliance on any Individual covered under the Plan, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. Regardless of whether a person is disciplined or terminated pursuant to this section, the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor shall, modify or revoke any person's access to or use of PHI.

d) **Purpose of Disclosure of Summary Health Information to Plan Sponsor.**

i) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan.

ii) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

e) **Plan Sponsor Certification.** The Plan Sponsor will provide the Plan with a certification stating that the Plan has been amended to incorporate the terms of this Article and that the Plan Sponsor agrees to abide by these terms. The Plan Sponsor will also provide the certification upon request to its health insurance issuers, HMOs and Business Associates of the Plan.

f) **Rights of Individuals.**

i) **Notice of Privacy Practices.** The Plan Sponsor will provide a Notice of Privacy Practices to the Participant in accordance with HIPAA.

ii) **Right to Request Restrictions.** Each Individual has the right to request that the Plan restrict its uses and disclosures of the Individual's PHI.

iii) **Right to Access.** Each Individual has the right to obtain and inspect its PHI held by the Plan.

iv) **Right to Amend.** Each Individual has the right to ask the Plan to amend its PHI.

v) **Right to an Accounting.** Each Individual has the right to request an accounting of disclosures of PHI made by the Plan for purposes other than treatment, payment or health care operations.

Section 8.04 HIPAA SECURITY COMPLIANCE

To ensure the Plan's compliance with HIPAA's privacy compliance rules ("Security Rule"), the Plan Sponsor will:

a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

b) Ensure that the adequate separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;

c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

d) Report to the Plan any security incident of which it becomes aware.

[Signature Page Follows]

The Plan Sponsor caused this Plan to be executed this 10th day of May 2022.

GENESYS CLOUD SERVICES, INC.:

DocuSigned by:
Eva Majercsik
91E5C5E9D8BA46B...

Eva Majercsik
Chief People Officer