HITACHI VANTARA LLC

SELF-INSURED SHORT TERM DISABILITY BENEFIT PLAN

The provisions of this restatement of the Plan apply to periods of Disability or Paid Family Leave beginning on or after January 1, 2025.

Plan Number 504

HITACHI VANTARA LLC

SELF-INSURED SHORT TERM DISABILITY BENEFIT PLAN

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HITACHI VANTARA LLC

SELF-INSURED TEMPORARY DISABILITY BENEFIT PLAN

The provisions of this Plan restatement apply to periods of Disability or Paid Family Leave beginning on or after January 1, 2025.

I. DEFINITIONS

A. *Active Employment* "Active Employment" means performance by the Employee of the regular duties of his or her work on any day that is one of the Company's scheduled work days. A period of Active Employment will also include (i) day(s) of vacation that have been scheduled by an Employee and (ii) days which are not the Company's scheduled work days provided the Employee is in Active Employment on the preceding scheduled work day.

B. *Care Provider* "Care Provider" means either (i) the Participant who is providing the required care for a Serious Health Condition, (ii) the Participant who is Bonding with the New Child, or (iii) the Participant who is participating in a Qualifying Exigency.

C. *Care Recipient* "Care Recipient" means either (i) the Family Member who is receiving care for a Serious Health Condition, (ii) the New Child with whom the Participant is Bonding, or (iii) the Family Member who is receiving assistance or the Participant who is participating in a Qualifying Exigency.

D. *Child* "Child" means a biological, adopted, or foster child, a stepchild, a legal ward, a son or daughter of a Domestic Partner, or a son or daughter of a Participant who stands in loco parentis to that child.

E. *Claims Administrator* "Claims Administrator" means the entity appointed by the Company for the purposes of processing and adjudicating claims and making determinations on review of denied claims under the Plan in accordance with the terms of the Plan and the Department of Labor claims procedure regulations.

F. *Company* "Company" means Hitachi Vantara LLC and any successor thereto. In addition, for the purpose of determining eligibility to participate in the Plan, "Company" also means any subsidiary or sister company of Hitachi Vantara LLC that the officers of Hitachi Vantara LLC, in their sole discretion, authorize to participate in the Plan.

G. *Disability* "Disability" means any physical or mental condition arising from an illness, pregnancy or injury which renders a Participant incapable of performing the material duties of his or her regular occupation or any reasonably related occupation on any day or portion of a day. A Participant will also be considered to have sustained a Disability if:

1. he or she is ordered not to work by written order from a State or local health officer because he or she is infected with, or suspected of being infected with, a communicable disease;

2. he or she has been referred or recommended by a Physician or Practitioner to participate in either a residential or outpatient program for the treatment of alcohol or drug abuse. If the Participant is in an outpatient patient program, he or she must attend a minimum of five (5) days a week, six (6) hours per day; however, such Disability will be considered to continue only during the first ninety (90) days while the Participant is receiving treatment for alcohol or drug abuse in a residential facility; or

3. he or she has a Terminal Illness as certified by a Physician or Practitioner.

A Participant will not be considered disabled if (i) he or she is performing work of any kind for remuneration or profit unless with the prior approval of the Plan Administrator, or (ii) he or she declines alternative employment by the Company that is within the Participant's capabilities and, as determined solely by the Company, has status and compensation comparable to the Participant's previous occupation.

H. *Domestic Partner* "Domestic Partner" means a Participant's domestic partner as defined in Hitachi Vantara LLC's group health plan.

I. *Earnings* "Earnings" means gross base pay in effect or, with respect to select sales employees, Benefit Target Compensation immediately preceding the onset Disability or PFL.

"Earnings," with respect to a Participant who sustains a Disability or files a PFL claim while on an approved leave under the federal Family and Medical Leave Act (FMLA) and/or state or local laws with provisions similar to FMLA or as may be allowed while on an approved unpaid leave in accordance with the Company's leave policies means gross base pay in effect or, if applicable, Benefit Target Compensation on the date immediately preceding the start of the leave.

An increase in Earnings during a period of Disability of PFL will not increase the benefit amount.

J. *Effective Date* "Effective Date" of the Plan means May 1, 1989. The "Effective Date" of this restatement of the Plan is January 1, 2025.

K. *Employee* "Employee" means any employee of the Company attached to a geographic location within the United States of America and California employees of Hitachi Vantara Federal Corporation, Hitachi Digital LLC, and Hitachi Digital Services LLC, and. "Employee" does not include Interns or a person who is performing services for the Company through an employment or leasing agency or as an independent contractor or consultant.

L. *ERISA* "ERISA" means the Employee Retirement Income Security Act of 1974, as amended, or as it may be amended from time to time, and the rules and regulations promulgated thereunder.

M. *Family Member* "Family Member" means Child, Parent, Parent-in-law, Grandparent, Grandchild, Sibling, Spouse, or Domestic Partner as defined in this section. For Qualifying Exigency, "Family Member" means a Spouse, Domestic

Partner, Child, or Parent who is a member of the regular Armed Forces of the United States or a member of the reserve components of the Armed Forces of the United States.

N. *Grandchild* "Grandchild" means a Child of the employee's Child.

O. *Grandparent* "Grandparent" means a Parent of the employee's Parent or Parent-in-law.

P. *Hospital* "Hospital" means an institution with organized facilities for diagnosis and surgery, and twenty-four (24) hour nursing services for the care and treatment of sick or injured persons. Such institution must be licensed as a hospital pursuant to the statutes or laws of the state or foreign country in which it operates unless such state or foreign country does not have statutes or laws concerning requirements for licensing hospitals.

Q. *Hospital Confinement* "Hospital Confinement" means confinement as a registered bed patient in a Hospital for a twenty-four (24) hour period, or any part thereof, for which the employee is charged a full day's rate for room and board.

R. *Intern* "Intern" means an individual, generally a college student receiving college credit for participating in an established internship program, performing work for a specified period of time (e.g., during the summer, typically three (3) months).

S. *New Child* "New Child" means a minor child for whom leave is taken for the purposes of bonding within one year of the child's birth or placement with the Participant or the Participant's Spouse or Domestic Partner.

T. *Objective Medical Evidence* "Objective Medical Evidence" means a measurable abnormality which is evidenced by one or more standard medical diagnostic procedures including laboratory tests, physical examination findings, x-rays, MRIs, EEGs, ECGs, CAT scans or similar tests that support the presence of a Disability or indicate a functional limitation. Objective Medical Evidence does not include Physician's or Practitioner's opinions based solely on the acceptance of subjective complaints (e.g. headache, fatigue, pain, and nausea), age, transportation, local labor market and other non-medical factors. To be considered an abnormality, the test result must be clearly recognizable as out of the range of normal for a healthy population; the significance of the abnormality must be understood and accepted in the medical community.

U. *Paid Family Leave or PFL* "Paid Family Leave or PFL" means a Participant is not working on any given day because he or she (i) must provide care to a sick or injured Family Member, (ii) is bonding with a New Child, or (iii) is participating in a Qualifying Exigency.

V. *Parent* "Parent" means a biological, foster or adoptive parent, a Stepparent, a legal guardian, or other person who stood in loco parentis to the Participant when the Participant was a Child.

W. *Parent-in-law* "Parent-in-law" means the Parent of the employee's Spouse or Domestic Partner.

X. *Participant* "Participant" means an Employee who satisfies the requirements for participation in the Plan as hereinafter specified.

Y. *Physician* "Physician" means a physician or surgeon holding an MD or DO degree, Psychologist, optometrist, dentist, podiatrist, or chiropractic practitioner duly licensed or certified in the state or foreign country in which he or she practices and acting within the scope of his or her practice. "Psychologist" means a licensed psychologist with a doctoral degree in psychology and who either (i) has at least two years clinical experience in a recognized health setting, or (ii) has met the standards of the National Register of the Health Service Providers in Psychology.

Z. *Plan* "Plan" means the Hitachi Vantara LLC Self-Insured Short Term Disability Benefit Plan, as herein set forth and as it may be amended from time to time.

AA. *Plan Administrator* "Plan Administrator" means the Company or person or persons designated by the Company to carry out the duties and responsibilities associated with the Plan. The Plan Administrator will also serve as the "named fiduciary" as required by ERISA. The Plan Administrator will serve without compensation.

BB. *Plan Year* "Plan Year" means the twelve (12) month period ending December 31.

CC. *Practitioner* "Practitioner" means a Nurse Practitioner or physician assistant (provided the physician assistant has performed a physical examination and collaborated with a Physician or surgeon) duly licensed or certified by the state or foreign country in which he or she practices and acting within the scope of his or her license or certification. With regard to Disability resulting from pregnancy, childbirth, or postpartum conditions, Practitioner will also include a midwife, Nurse Practitioner, or nurse midwife acting within the scope of his or her license. "Nurse Practitioner" means a licensed Nurse Practitioner who has completed a transition to practice in their licensed state of a minimum of three (3) full-time equivalent years of practice or 4,600 hours.

DD. *Qualifying Exigency* "Qualifying Exigency" means time off to assist a Family Member deployed to a foreign country on active military service for reasons including, but not limited to, the following: short-notice deployment; attendance in an official ceremony; attendance in a family support program sponsored by the military; arranging or providing childcare; transferring a Child to a new school; making or updating financial or legal arrangements; attending counseling; accompanying the Family Member while he or she is on short-term rest and recuperation leave; or, attending arrival ceremonies.

EE. *Serious Health Condition* "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice, or residential health care facility, or continuing supervision by a Physician or Practitioner, as defined in Section 825.113 of the federal Family and Medical Leave Act.

FF. *Sibling* "Sibling" means a person related to the employee by blood, adoption, or affinity through a common legal or biological Parent.

GG. *Spouse* "Spouse" means a partner to lawful marriage.

HH. *Surgical Clinic* "Surgical Clinic" means a clinic that (i) is not a part of and not operating under the license of a hospital, (ii) is licensed by the state in which it operates, (iii) provides treatment for patients who remain fewer than 24 hours. A "Surgical Clinic" does not include the office of a private Physician.

II. *Surgical Unit* "Surgical Unit" means a unit, located in or operating under the license of a hospital, that provides treatment for patients who remain fewer than 24 hours. A "Surgical Unit" does not include emergency room facilities.

JJ. *Terminal Illness* "Terminal Illness" means an illness or end-stage disease that cannot be cured or adequately treated and is expected to result in death within 6 months or less.

KK. *Trust* "Trust" means the trust created pursuant to the Trust Agreement.

LL. *Trust Agreement* "Trust Agreement" means the Hitachi Vantara LLC Self-Insured Temporary Disability Plan Trust Agreement by and between Hitachi Vantara LLC and the trustee(s), as stated effective May 1, 1989, or as it may be amended from time to time.

MM. *Twelve-Month Period* "Twelve-Month Period" means the 365 consecutive days that begins with the first day a Participant first establishes a valid claim for Paid Family Leave.

II. PARTICIPATION

A. *Eligibility for Participation* A person who is an Employee on the Effective Date of the Plan is eligible to participate on such Effective Date. A person who becomes an Employee after the Effective Date of the Plan is eligible to participate on the date on which he or she becomes an Employee.

B. *Effective Date of Participation* An eligible Employee becomes a Participant on the date he or she becomes eligible, provided, however, that if an Employee is not in Active Employment on the date that his or her participation would otherwise become effective, his or her participation will be deferred until the date on which he or she returns to Active Employment.

Any Employee who has rejected coverage, or has withdrawn from the Plan, may become a Participant by filing a notice of election during a period designated by the Plan Administrator as an open enrollment period, on the date determined by and announced by the Plan Administrator.

C. *Cessation of Participation* A Participant will automatically cease to participate on the earliest of the following:

1. the date on which the Participant ceases to be an Employee;

2. the date on which the Participant commences a leave of absence without pay. (This provision does not apply if the Participant is on an approved leave under the federal Family and Medical Leave Act or similar state- or local-mandated leave law);

3. the date on which the Participant is placed on layoff status;

4. the date on which the Plan terminates;

5. the date the Participant waives coverage as a new employee; or

6. the first day of the new Plan year after the Participant elects to waive enrollment for the following Plan year during the annual open enrollment period as designated by the Plan Administrator.

III. ELIGIBILITY FOR DISABILITY BENEFITS

A. *Elimination Period* A Participant who sustains a Disability will, subject to the provisions of the Plan, become eligible to receive benefits on the earliest of:

1. the eighth (8th) consecutive day of Disability, provided the Participant has (i) been examined by a Physician or Practitioner during some portion of that eight-day period, and (ii) has been continuously Disabled during the first (7) consecutive days;

2. the first (1st) day of Hospital Confinement; or

3. the first (1st) day of treatment in a Surgical Clinic or surgical unit of a hospital provided the employee is disabled for at least eight (8) days as a result of the condition requiring treatment.

Successive periods of Disability separated by sixty (60) or fewer calendar days of continuous Active Employment at the Participant's normal work schedule will be considered one period of Disability, unless the subsequent Disability is due to an illness or injury found by the Claims Administrator to be entirely unrelated to the cause of the previous Disability and commences after return to Active Employment with the Institute for at least one (1) day.

B. *Disability Determination* The Claims Administrator will determine whether a Disability exists with respect to a Participant on the basis of (i) Objective Medical Evidence), (ii) a certificate from the Participant's Physician or Practitioner, and (iii) any such other information which the Claims Administrator, in its sole discretion, deems relevant to such determination.

Certificates from the Participant's Physician or Practitioner must contain (i) a diagnosis and diagnostic code prescribed in the International Classification of Diseases, or, where no diagnosis has yet been obtained, a detailed statement of symptoms, (ii) a statement of the medical facts within the Physician's or Practitioner's knowledge, based on a physical examination and documented medical history of the Participant by the Physician or Practitioner, (iii) the Physician's or Practitioner's conclusion as to the Participant's disability, and (iv) a statement of the Physician's or Practitioner's opinion as to the expected duration of the disability.

C. *Exclusions* No Participant will be entitled to a benefit under this Plan if:

1. his or her Disability arises out of, relates to, is caused by or results from an intentionally self-inflicted illness or injury unless the Participant's underlying injury or illness is otherwise covered by the plan and results from a documented medical condition (such as depression or mental illness);

2. his or her Disability arises out of, relates to, is caused by or results from an illness or injury to which the contributing cause was the Participant's commission or attempted commission of a felony, or the Participant's engagement in an illegal occupation;

3. his or her Disability arises out of, relates to, is caused by or results from an illness or injury due to war or any act of war, declared or undeclared, insurrection, rebellion, participation in a riot, or service in the armed forces of any country or international authority;

4. the participant is not under the regular and continuous care and treatment of a Physician or Practitioner, unless the Claims Administrator determines that such regular and continuous care and treatment are not medically indicated given the nature of the Disability;

5. the Participant is incarcerated in any federal, state or municipal penal institution, jail, medical facility, hospital (public or private) or in any other place because of a criminal conviction under federal, state or municipal law or ordinance;

6. his or her Disability arises out of, relates to, is caused by or results from an illness or injury due to dipsomania, drug addiction or sexual psychopathy; provided, however, that this exclusion will apply only to periods during which the Participant is confined by court order or certification as a result of such condition or conditions;

7. the period of Disability begins when the Employee is not a Participant in the Plan;

8. the Participant is receiving unemployment compensation under any federal or state program;

9. the Participant is receiving Company-paid sick leave, PTO used as sick leave or salary continuation during his or her period of Disability, except that a benefit will be payable which, when added to such Company-paid sick leave or salary continuation, does not exceed the Participant's weekly Earnings;

10. his or her Disability is caused by or results from gainful self-employment or employment elsewhere. or

11. the Participant is receiving pay under the Worker Adjustment and Retraining Notification (WARN) Act or in-lieu-of-notice pay.

IV. ELIGIBILITY FOR PAID FAMILY LEAVE BENEFITS

A. *Elimination Period* Paid Family Leave benefits are payable as of the first (1st) day of a valid leave.

The PFL period will be deemed continuous if the Participant needs to provide care with the same Care Recipient within a Twelve-Month Period.

B. *Paid Family Leave Determination*

1. For the purpose of providing care to a sick or injured Family Member, a Participant will be considered to have a valid claim for Paid Family Leave if he or she files a certificate from a Physician or Practitioner that establishes medical eligibility of the Serious Health Condition of the Family Member that warrants the care of the Participant. The information provided must be within the Physician’s or Practitioner's knowledge and must be based on a physical examination and documented medical history of the Family Member requiring care. The certificate must contain but is not limited to:

   a. the name and date of birth of the Family Member requiring the Participant's care;

   b. diagnosis and diagnostic code prescribed in the International Classification of Diseases, or where no diagnosis has been obtained, a detailed statement of symptoms;

   c. the date, if known, on which the condition commenced;

   d. the probable duration of the condition;

   e. an estimate of the amount of time (day or days) that the Physician or Practitioner believes the Participant is needed to care for the Family Member; and

   f. statement that the Serious Health Condition warrants the participation of the Participant to provide care for his or her Family Member. "Warrants the participation of the Participant" includes, but is not limited to, providing psychological comfort, and arranging "third party" care for the Family Member, as well as directly providing, or participating in, medical care.

The Participant (Care Provider) must provide information about himself or herself and the Care Recipient. This information includes but is not limited to (i) the Participant's authorization for the Plan Administrator or the Plan Administrator’s authorized claims administrator to disclose the Participant’s information to the Care Recipient's treating Physician or Practitioner or the Care Recipient, and (ii) the Care Recipient's or authorized representative's signature authorizing the treating Physician or Practitioner to release protected health information to the Participant (Care Provider), the Plan Administrator or the Plan Administrator’s authorized claims administrator.

2. For the purpose of bonding with a New Child, a Participant will be considered to have a valid claim for Paid Family Leave if he or she files a claim and supporting documentation which provides satisfactory evidence of (i) the birth, adoption or foster care placement of the child and (ii) the relationship between the Participant and the child. The supporting documentation must contain but is not limited to:

    a. the child's full name, date of birth and gender;

    b. any of the following to verify the birth of a child: (i) a photocopy of the child's certified birth certificate, (ii) a photocopy of the completed hospital or birthing center documents attesting to the birth of the child, or (iii) a letter from the birthing center's or hospital's Director of Medical Records or their designate containing all the information in subparagraph a above plus the full name of the mother, the full name of father, if known, or registered Domestic Partner, and a dated signature of the treating Physician, Practitioner, or midwife, or Director of Medical Records or their designate as appropriate;

    c. for paternal, non-spouse bonding claims (where the Participant is not named on one of the documents listed in the paragraph immediately above), a photocopy of the document providing proof of paternity as issued from the appropriate state or county child support services department;

    d. any of the following to verify adoption: (i) a photocopy of a court order for placement for adoption issued within the United States or the equivalent state department of social services notice of placement, (ii) a copy of the child's passport clearly showing an Immigration and Naturalization Services (INS) stamp, or (iii) a copy of the child's adoption certificate from the country's competent local authority with a notarized English translation; and

    e. for verification of foster care placement, a statement on letterhead from the county department of social services, or equivalent government entity, stating all the information in subparagraph a above, resident address where the child is placed, date of foster care placement including the length of time of the placement if duration has been established, full name(s) of person(s) with whom the foster care placement is made, including such person's residence address and date of birth. The statement must also include a dated signature of the social worker, the social worker's typewritten name and the social worker's direct telephone number.

PFL eligibility is limited to the first year after the birth, adoption, or foster care placement of the New Child.

3. For the purpose of leave related to a Qualifying Exigency, an employee will be considered to have a valid claim for Paid Family Leave if he or she files a claim and supporting documentation which provides sufficient evidence of (i) the appropriate facts regarding the Qualifying Exigency; (ii) start and end dates of the requested leave period (including frequency and duration for intermittent leave); (iii) if meeting with a third party, contact information for the individual or

entity; and, (iv) a copy of the rest and recuperation orders, if applicable. The supporting documentation includes but is not limited to:

a. a notification of an impending call or order to covered active duty of a military member; a copy of the military member's active duty orders or other documentation issued by the military; a statement or description, signed by the employee, of appropriate facts related to the Qualifying Exigency; a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming an appointment with a counselor or school official; or, a copy of a bill for services for the handling of legal or financial affairs.

C. *Exclusions* No Participant will be entitled to a PFL benefit under this Plan:

1. if the PFL begins when the Employee is not a Participant in the Plan;

2. for any day the Participant receives or is entitled to receive temporary disability payments (whether total or partial) or vocational rehabilitation payments under any workers' compensation law, occupational disease law, or any other legislation or law of similar purpose;

3. for any day the Participant receives or is entitled to receive disability payments under this Plan or under any state disability benefit act or a Company plan established in lieu thereof;

4. for any day for which another Family Member is ready, willing, able and available for the same period of time that the Participant is providing the required care.

5. for any day the Participant is receiving unemployment compensation under any federal or state program;

6. for any day the Participant is incarcerated in any federal, state or municipal penal institution, jail, medical facility, hospital (public or private) or in any other place because of a criminal conviction under federal, state or municipal law or ordinance;

7. the Participant is receiving Company-paid sick leave, PTO used as sick leave pay or salary continuation during his or her period of PFL, except that a benefit will be payable which, when added to such Company-paid sick leave, PTO or salary continuation, does not exceed the Participant's weekly Earnings; or

8. the Participant is receiving pay under the Worker Adjustment and Retraining Notification (WARN) Act or in-lieu-of-notice pay.

V. DISABILITY BENEFITS

A. *Amount of Benefit* Subject to reduction as hereinafter provided, the amount of weekly benefit for which a Participant is covered under the Plan will be equal to eighty (80%) of weekly Earnings subject to a maximum benefit of $4,077. Except that such benefit will be equal to sixty (60%) of weekly Earnings subject to a maximum of $1,620 if the period of Disability begins during the first ninety (90) days of the Participant's employment with the Company.

For each day of any period of Disability for which benefits are payable and which is less than a full week, the amount of benefit payable will be 1/7th of the amount of the weekly benefit.

B. *Benefits During Partial Disability* A Participant who has returned to work for the Company on a part-time basis, and who is working fewer hours than he or she is regularly scheduled to work, may, with the approval of the Plan Administrator, receive benefits under the Plan. Such benefits will be reduced by 80% of the income derived from such part-time employment and are subject to reduction as hereinafter provided.

C. *Redirection of Benefits* A Participant eligible to receive benefits under this Plan may choose to redirect a portion of his or her benefit to cover all or part of the cost of employee-paid benefits under the Company's group health coverage plans or policies. To execute this option, the employee must designate in writing on a form available from the Company the semi-monthly amount to be redirected. This redirection may be initiated at any time while receiving Plan benefits. The employee may terminate or change the terms of the redirection at any time while receiving Plan benefits.

D. *Reductions to the Amount of Benefit* The Disability benefit will be reduced by any of the following which are available to the Participant, or the Participant's spouse or child(ren) if applicable, for the same period for which the Disability benefit is payable hereunder:

1. primary and dependent disability or retirement benefits under the Federal Social Security Act, or any similar plan or act; provided, however, that any cost-of-living increases in such benefits, effective after the initial reduction in the Plan benefit, will not serve to further reduce the Plan benefit;

2. temporary and permanent disability payments (whether total or partial) and vocational rehabilitation payments under any workers' compensation law, occupational disease law, or any other legislation or law of similar purpose. Any amount awarded or paid in a lump sum which represents payment for a specified period will be prorated over that period. If the amount awarded or paid in a lump sum does not represent payment for a specified period, or if such a specified period cannot be determined, the lump sum will be prorated over a period of fifty-two (52) weeks;

3. benefits under any plan, fund or other arrangement, by whatever name called, providing disability benefits pursuant to any compulsory benefit act or law of any government; and

4. benefits under a State disability or PFL plan or a Company plan established in lieu thereof except for Company-paid sick leave or PTO, if a Participant is or might be entitled to any of the above-itemized benefits, the full Plan benefit will be paid upon receipt by the Claims Administrator of (i) evidence that the Participant has applied for such benefits and (ii) an executed agreement to reimburse the Plan, up to the amount of payments made, immediately upon receipt of such benefits.

   Except for Company-paid sick leave or PTO, if the Participant fails to apply for any of the above-itemized benefits to which he or she might be entitled, the Plan benefit will be reduced by the amount of the benefit that the Participant would have received had application been made. Determination of the amount of such benefit will be made by the Claims Administrator.

E. *Acts of Third Parties* In the event that a Participant is injured through the acts or omissions of another person or organization, benefits under the Plan will be provided only on condition that the Participant agree in writing to the following:

1. to reimburse the Plan, for the full amount of payments made under the terms of the Plan, immediately upon receipt of the proceeds of any settlement of, or judgement in, an action at law, arbitration, claim, or other proceeding to determine his or her rights of recovery arising out of his or her injury, net of his or her reasonable expenses in collecting such a mount including reasonable attorney's fees, and net of any amounts which are allocated by terms of any judgement for the payment of unreimbursed medical expenses; he or she will execute and deliver instruments and papers and do whatever else is reasonably necessary to secure the rights of the Plan to reimbursement out of such proceeds, and he or she will do nothing to prejudice such rights;
2. to provide the Plan with a lien on the proceeds described in the preceding paragraph, to the extent of the full amount of payments made under the terms of the Plan; and
3. to provide the Plan with credit against payments to be made in the future under the Plan equal to the proceeds described above, less any amount paid to the Plan by way of reimbursement.

F. *Commencement and Duration of Benefits* Benefits will be payable as of the first day that a Participant becomes eligible to receive benefits and applies therefor. Thereafter, benefits will be payable periodically so long as such eligibility continues.

Eligibility for benefits will terminate on the earliest of the following:

1. the date following a period of fifty-two weeks of Disability;

2. the date of the Participant's death; or

3. the date the Disability ceases to exist.

With respect to a Disability that commenced while the Participant was covered under this Plan, benefits will not terminate solely because the Participant ceased to be employed by the Company.

G. *Discontinuance and Resumption of Benefits* Benefits will be discontinued on the date, as determined by the Claims Administrator, that any of the following has occurred:

1. the participant has refused to undergo a medical examination; failure by the Participant to undergo a scheduled medical examination following a written request by the Claims Administrator to do so will be considered a refusal;

2. the Participant has refused to provide information requested in writing by the Claims Administrator for the purpose of determining whether the Participant is entitled to benefits under the Plan; failure to furnish such information within thirty (30) days after such information has been requested will be considered a refusal;

3. the Participant has refused to follow or has rejected the treatment plan recommended by his or her Physician or Practitioner, unless the Participant disputes such treatment plan in good faith and on the advice of another Physician or Practitioner; or

4. the Participant is no longer under the regular and continuous care and treatment of a Physician or Practitioner, unless such regular and continuous care and treatment are not medically indicated, given the nature of the Disability.

Benefits that have been discontinued in accordance with the above may resume if the reason for discontinuance ceases to apply. In no event, however, will benefits be paid for the period during which the Participant was not in compliance with the Plan unless the Claims Administrator determines that the Participant's failure to comply was due to reasonable cause.

The Participant will not be required to reimburse the Plan for benefits which may have already been paid between the date on which the reason for discontinuance occurred and the date of the Claims Administrator's determination.

H. *Suspension and Reinstatement of Benefits* Benefits will be suspended as of the date of any medical examination conducted pursuant to Section VII. G.1. If the Claims Administrator, on the basis of the results of such examination, determines that eligibility for benefits continues, benefits will be reinstated as of the date of the medical examination.

VI. PAID FAMILY LEAVE BENEFITS

A. *Amount of Benefit* Subject to reduction as hereinafter provided, the amount of weekly benefit for which a Participant is covered under the Plan will be equal to 80% of weekly Earnings but not more than $4,077. Except that such benefit will be equal to sixty (60%) of weekly Earnings subject to a maximum of $1,620 if the period of PFL begins during the first ninety (90) days of the Participant's employment with the Company.

The amount of PFL benefit payable for each calendar day will be one-seventh (1/7th) of the amount of the weekly benefit.

B. *Benefits During Intermittent or Reduced Schedule PFL* A Participant who claims PFL on an intermittent or reduced schedule basis will receive eighty percent (80%) of the difference between Earnings and income from employment, subject to a maximum weekly benefit of $4,077.

C. *Redirection of Benefits* A Participant eligible to receive benefits under this Plan may choose to redirect a portion of his or her benefit to cover all or part of the cost of employee-paid benefits under the Company's group health coverage plans or policies. To execute this option, the Participant must designate in writing on a form available from the Company the weekly or semi-monthly amount to be redirected. This redirection may be initiated at any time while receiving Plan benefits. The Participant may terminate or change the terms of the redirection at any time while receiving Plan benefits.

D. *Commencement and Duration of Benefits* Benefits will be payable as of the first (1st) day of PFL. Thereafter, benefits will be payable until the earliest of the following:

1. the date following the date on which PFL benefits have been paid for eighty-four (84) calendar days;

2. the date the Care Recipient dies; or

3. the date the Care Recipient no longer requires the Participant's care.

A Participant is not entitled to a PFL benefit for more than eighty-four (84) calendar days in any Twelve-Month Period.

With respect to a PFL that commenced while the Participant was covered under this Plan, benefits will not terminate solely because the Participant ceased to be employed by the Company.

E. *Reductions to the Amount of Benefit* The PFL benefit will be reduced by the following which are available to the Participant, for the same period for which the PFL benefit is payable hereunder:

1. company-paid sick leave, PTO used as sick leave pay or salary continuation; provided, however, if a Participant receives Company-paid sick leave, PTO or salary continuation the Plan benefit will be reduced only to the extent that the

sum of the Company-paid sick leave, PTO or salary continuation and the Plan benefit exceeds the Participant's Earnings; and

2. benefits under a State PFL plan or an Institute Plan established in lieu thereof; and

If a Participant fails to apply for any of the above-itemized benefits to which he or she might be entitled, the Plan benefit will be reduced by the amount of the benefit which the Participant would have received had application been made. Determination of the amount of such benefit will be made by the Claims Administrator.

F. *Suspension and Reinstatement of Benefits* Benefits will be suspended as of the date of any medical examination conducted pursuant to Section VII. G. 2. If the Claims Administrator, on the basis of the results of such examination, determines that eligibility for benefits continues, benefits will be reinstated as of the date of the medical examination.

VII. PAYMENT OF BENEFITS

A. *Application for Benefits* To be entitled to any benefits under the Plan, a Participant must comply with such procedures and requirements as the Claims Administrator may have prescribed with respect to the completion and filing of an application for such benefits and submission of evidence that the Participant is entitled to such benefits. The Claims Administrator may require information with respect to the Participant's age, address, marital status, dependents, employment record, medical history and evidence that the Participant has applied for any benefits which would serve to reduce benefits under this Plan.

The Claims Administrator may require any other information reasonably relevant to a determination of whether the Participant is eligible to receive benefits and may also require written authorization to obtain:

1. information from the Participant's Physician(s) or Practitioner(s) with respect to his or her physical condition, diagnosis, prognosis, date of expected return to work and related matters;

2. information from the Family Member's Physician(s) or Practitioner(s) with respect to the Serious Health Condition of the Participant's Family Member requiring the Participant's care;

3. relevant medical records on file in any hospital, Physician's or Practitioner's or government office; and

4. such other records from any company having information reasonably relevant to a determination.

B. *Time Limit for Application for Benefits* An application for benefits must be filed no later than forty-five (45) days after the date benefits may become payable under the Plan unless it is not reasonably possible for the Participant or his or her representative to do so. In no event will an application be accepted by the Claims Administrator if such application is filed more than six (6) months after the date benefits become payable.

C. *Claim Processing* Upon receipt of the Participant's application, the Claims Administrator will make a determination as to the eligibility of the Participant for benefits not later than forty-five (45) days after receipt of the claim. If, due to circumstances beyond the Claims Administrator's control, a decision cannot be made within that period, the Claims Administrator may extend that period up to sixty (60) additional days (in thirty (30) day increments) provided the Claims Administrator notifies the Participant, in writing:

1. of the delay prior to the expiration of the deadline(s) (e.g., prior to the expiration of the first forty-five (45) days, or the first thirty (30) day extension period);

2. of the date by which it intends to make a decision;

3. of the circumstances that caused the delay;

4. of the standards on which entitlement is based;

5. of the unresolved issues and the additional information needed to resolve those issues; and

6. that the Participant is entitled to at least forty-five (45) days within which to provide additional information needed to resolve the issues.

If the time for making a decision is extended due to a Participant's failure to submit information necessary to decide the claim, the time for making a decision will be tolled from the date notification of an extension is sent to the Participant until the Participant provides the required information.

D. *Notification of Benefit Determination* If the Claims Administrator determines that a Participant is not eligible for benefits, the Participant will be notified, in writing, of the adverse benefit determination (denial). The notification will be written in a culturally and linguistically appropriate manner designed to be understood by the Participant, and it will set forth the following:

1. the specific reason or reasons for the denial;

2. reference to the specific Plan provisions on which the denial is based;

3. a description of any additional material or information necessary for the Participant to perfect the claim and an explanation as to why such material or information is necessary;

4. a description of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of the Participant's right to bring a civil action following an adverse benefit determination on review;

5. the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the decision or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist;

6. if the decision is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment used in making the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such an explanation is available, on request, free of charge;

7. if a discussion of the decision, including (if applicable) an explanation of the basis for disagreeing with or not following:

   a. the views presented by the Participant or health care professionals treating the Participant and vocational professionals who evaluated the Participant;

b. the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse decision, without regard to whether the advice was relied upon in making the benefit decision; or

c. a disability determination made by the Social Security Administration regarding the Participant and presented to the Plan by the Participant; and

8. 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.

E. *Claim Review Procedure* The claims procedures set forth in this section will provide all Participants with a full and fair opportunity for review of any claim that is denied. Each Participant will have the right to appoint a representative to pursue any claim or appeal on the Participant's behalf. Such request must:

1. be in writing;

2. be filed with the Plan Administrator within one hundred eighty (180) days after receipt of the written decision;

3. set forth all the grounds upon which the request for review is based and any facts, documents, records or any other information in support thereof; and

4. set forth any issues or comments that the Participant deems relevant to his or her claim.

Any Participant or representative of the Participant whose claim has been denied will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Upon receipt of the request for review of the decision, the Plan Administrator will consider the request and provide the Participant with a written decision, written in a culturally and linguistically appropriate manner, within forty-five (45) days after receipt of the request for review. This review: (i) will not afford deference to the initial adverse benefits determination, (ii) will include a review of the entire file, including any new materials and arguments submitted since the initial adverse benefits determination, (iii) will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or other person making the benefit determination in connection with the claim as soon as possible and sufficiently in advance of end of the aforementioned forty-five (45) day period, (iv) will be rendered by an appropriately named individual or individuals who neither made the adverse benefits determination that is subject of the appeal, nor is a subordinate of that individual, and (v) will be rendered with the consultation of a health care professional (who has appropriate training and experience in the field of medicine involved with the particulars of the claim under review) who was not the health care professional consulted during the adverse benefit determination that is the subject of the appeal, nor the subordinate of that health care

professional, if the initial adverse benefit determination was made in consultation with a health care professional or was based in whole or in part on a medical judgment.

If, for reasons beyond the Plan Administrator's control, additional time is required in which to review the Participant's request, the Participant will be notified, in writing, on or before the date the forty-five (45) day period expires. The notice of extension will include the reason for the delay and the date that the Plan Administrator expects to render a decision; however, in no event, will the written decision be issued more than ninety (90) days after the request for review is received.

If, after rendering an adverse determination, the Plan Administrator receives new or additional evidence that is considered, relied upon, or generated in connection with the claim, the Participant will be provided, free of charge, with the new or additional evidence as soon as possible and sufficiently in advance of the date on which the notification of benefit determination on review is due, and the Participant will be afforded an opportunity to respond.

F. *Notification of Benefit Determination on Review* If, on review, the Plan Administrator determines that a Participant is not eligible for benefits, the Participant will be notified, in writing of the adverse benefit determination (denial). The notification will be written in a culturally and linguistically manner designed to be understood by the Participant and will set forth the following:

1. the specific reason or reasons for the denial;

2. reference to the specific 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 claim;

4. a statement of the Participant's right to bring a civil action no later than six (6) months after the date on which notification of the final determination is made, including the calendar date on which the six (6) month period will expire;

5. the rule, guideline, protocol or similar criterion on which the denial was based and a statement that a copy of such is available, on request, free of charge, or, if the denial was not based on a rule, guideline, protocol or similar criterion, a statement that these were not used;

6. if the decision is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment used in making the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such an explanation is available, on request, free of charge;

7. if applicable, the identity of any medical or vocational expert(s) whose advice was obtained on behalf of the Plan Administrator in connection with the

adverse benefit determination, whether or not the advice was relied upon in making the determination;

8. a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

   a. the views presented by the Participant to the Plan Administrator of the Physician(s) or Practitioner(s) treating the Participant and vocational professionals who evaluated the Participant;

   b. the views of medical or vocational experts whose advice was obtained on behalf of the Plan Administrator 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 regarding the Participant presented by him or her to the Plan made by the Social Security Administration.

If an adverse benefit determination on review is based on a new or additional rationale, the Plan Administrator will provide the Participant, free of charge, with the rationale. To allow the Participant a reasonable opportunity to respond, the rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required.

G. *Medical Examinations*

1. Disability The Claims Administrator may require that a Participant applying for benefits submit to an examination by a Physician or Practitioner designated by the Claims Administrator, for his or her medical opinion as to whether the Participant is disabled so as to meet the eligibility requirements under the Plan for benefits. Reexaminations of a Participant receiving benefits may be directed by the Claims Administrator from time to time for the purpose of assisting the Claims Administrator in determining whether continued eligibility for such benefits exists. The fees of such Physician or Practitioner and the expenses of such examination will be paid by the Plan.

2. Paid Family Leave The Claims Administrator may require that the Participant's Family Member requiring the Participant's care be examined by a Physician or Practitioner designated by the Claims Administrator, for his or her opinion as to whether a Serious Health Condition exists and/or the Participant's care is warranted. This may be done as often as may be reasonably required during the period benefit payments may be due under this Plan. The fees of such Physician or Practitioner and the expenses of such examination will be paid by the Plan.

H. *Non-Alienation of Benefits* To the extent permitted by law, no benefit payable at any time under the Plan will be assigned or transferable, or subject to any lien, in whole or in part, either directly or by operation of law or otherwise, including, but not limited to, execution, levy, garnishment, attachment, pledge, bankruptcy, or in any other manner. Other than the Redirection of Benefits option contained in this Plan Document, no benefit payable under the Plan will be liable for, or be subject to, any obligation or liability of any Participant.

I. *Payment to Representative* In the event that a guardian, conservator, committee or other legal representative has been duly appointed for a Participant entitled to any payment under the Plan, any such payment due may be made to the legal representative making claim therefor. Any such payment so made will be in complete discharge of the liabilities of the Plan therefor, and the obligations of the Plan Administrator and the Company.

J. *Payment In the Event of Death* In the event of the death of the Participant, any payment due under this Plan as a result of the Participant's Disability will be made to his or her beneficiary as noted in the Participant's group life insurance policy or, if no such policy exists, to the Participant's spouse. If payments cannot be made under either of the above methods, payment will be made to the Participant's estate.

VIII. PLAN FINANCING

A. *Trust Fund* All Participant and Company contributions will be deposited into a trust fund from which all Plan benefits and expenses will be paid. The Company has entered into a trust agreement with a trustee to hold, manage and invest the trust fund in accordance with the provisions of the agreement.

B. *Participant Contributions* Participants will make contributions in such amounts as the Plan Administrator may from time to time determine. The Plan Administrator will establish employee contributions at such amount as will, in the Plan Administrator's sole discretion, be sufficient to fund the benefits provided by the Plan. With respect to a Participant required to contribute to a state-mandated plan or program (or Company plan established in lieu thereof), the amount of contributions required under this Plan will be credited by the amount of contributions made to the state-mandated plan or program (or Company plan established in lieu thereof).

C. *Company Contributions* In the event that the Participant contributions deposited into the trust are insufficient to meet the liabilities of the Plan, the Company may, from time to time, contribute to the trust fund amounts which are determined necessary to properly maintain and operate the Plan.

D. *Company Loans* As an alternative to contributions, the Company may make interest-free, unsecured loans to the Plan to the extent permitted by ERISA. Any such loan may be made by depositing funds in the Trust for the purpose of the payment of ordinary operating expenses of the Plan, including the payment of benefits, or by the Company's advancing such expenses on behalf of the Trust.

E. *Irrevocability of Company Contributions* All contributions, but not loans, made by the Company to the trust fund will be irrevocably appropriated for the exclusive benefit of Participants as provided in the Plan, and no part of the trust fund will revert to the Company or be used for or diverted to, purposes other than the exclusive benefit of such Participants prior to the satisfaction of all liabilities of the Plan, except to the extent that ERISA permits repayment by the Plan of Company loans.

F. *Limitations of Liability* The payment of benefits under the Plan will be made only from the trust fund. No liability for the payment of benefits under the Plan will be imposed upon the Company or its officers, directors or stockholders. Should the Plan terminate, the Company will not be liable for any benefits under this Plan.

IX. ADMINISTRATION AND RESPONSIBILITY

A. *Duties of the Plan Administrator* The Plan Administrator will have discretionary and exclusive authority and responsibility for all matters in connection with the operation and administration of the Plan. Specifically, the Plan Administrator will:

1. be responsible for the compilation and maintenance of all records necessary in connection with the Plan;

2. determine eligibility for benefits under the Plan, and compute and authorize the payments of such benefits as they become payable;

3. decide questions relating to the eligibility of Employees to become Participants;

4. engage such legal, actuarial, accounting and other professional and clerical services as may be necessary or proper; and

5. interpret this document and make and publish such uniform and non-discriminatory rules for administration of the Plan as are not inconsistent with the provisions of this document.

B. *Delegation of Duties* The Plan Administrator may, from time to time, delegate any rights, powers, and duties of the Plan Administrator (including fiduciary responsibilities) with respect to the operation and administration of the Plan to one or more committees, individuals or entities. If the Plan Administrator delegates any rights, powers or duties to any person, such person may from time to time further delegate such rights, powers and duties to another person. If any right, power or duty is delegated to more than one person, such persons may from time to time allocate among themselves any such right, power or duty. Any allocation or delegation of fiduciary responsibility under the Plan will be terminable upon such notice as the Plan Administrator, in its sole discretion, deems reasonable and prudent.

C. *Decisions and Rules* The decisions of the Plan Administrator made in good faith upon any matter within the scope of its authority will be final, but the Plan Administrator at all times in carrying out its decisions will act in a uniform and nondiscriminatory manner.

D. *Fiduciary Duties* In performing its duties, the Plan Administrator will act solely in the interest of the Participants:

1. for the exclusive purpose of providing benefits to Participants and defraying reasonable expenses of administering the Plan;

2. with care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

3. in accordance with the documents and instruments governing the Plan, insofar as such documents and instruments are consistent with the provisions of ERISA.

E. *Liability; Indemnification* The Plan Administrator will not be liable for any act, omission, determination, or construction made by itself or by its delegated counsel, agents, or other employees, except for willful misconduct. Nothing herein, however, will be construed as purporting to relieve the Plan Administrator or any other fiduciary under the Plan, or any officers or directors of the Company, or any other agent thereof, from responsibility or liability for any responsibility, obligation, or duty imposed by ERISA. The Company will indemnify and hold harmless any person to whom any fiduciary duty is delegated from and against any and all liabilities, claims, demands, costs and expenses (including attorneys' fees) arising out of an alleged breach in the performance of its fiduciary duties under the Plan, other than such liabilities, claims, demands, costs and expenses as may result from gross negligence or willful misconduct of such person. The Company will have the right, but not the obligation, to conduct the defense of such person in any proceeding to which the Section applies.

X. MISCELLANEOUS

A. *Permanence of the Plan* The Company intends to continue the Plan indefinitely, but will not be under any obligation or liability whatsoever to continue to maintain the Plan for any given length of time. The Company may, in its sole discretion, terminate the Plan any time without any liability whatsoever for such action. If the Plan is terminated, the termination will not affect the rights of any Participant to claim benefits with respect to a Disability or PFL incurred prior to such termination.

B. *Right to Amend* The Company reserves the power and right, at any time or times to amend any or all of the provisions of the Plan to any extent and in any manner it will deem advisable.

C. *Nonguarantee of Employment* The adoption and maintenance of the Plan will not be considered to be a contract between the Company and any Employee. Therefore, no provision of the Plan will give any Employee the right to be retained in the employ of the Company or to interfere with the right of the Company to discharge any Employee at any time, irrespective of the effect such discharge may have upon an Employee as a Participant or prospective Participant under the Plan. In addition, no provision of the Plan will be considered to give the Company the right to require any Employee to remain in its employ, or to interfere with any Employee's right to terminate his or her employment at any time.

D. *Titles* Titles are for reference only. In the event of a conflict between a title and the content of a Section, the content will control.

E. *Governing Law* The Plan will be construed, administered and governed in all respects in accordance with ERISA and other pertinent federal laws and in accordance with the laws of the State of California to the extent not preempted by ERISA. If any provision of this Plan will be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions of the Plan will continue to be fully effective.

F. *Gender and Number* Wherever used in the Plan, the masculine gender will include the feminine gender and the singular will include the plural, unless the context indicates otherwise.

G. *Overpayments* In the event the Participant has been paid benefits by the Plan in excess of those to which he or she is entitled, the Plan has a right to recover the overpayment. The Claims Administrator will make reasonable arrangements with the Participants or his or her legal representative(s) for the repayment to the Plan. The Plan will not recover more money than the amount paid to the Participant.