AMENDMENT NO. 1
FOR
WENTE FAMILY ESTATE
HEALTH REIMBURSEMENT ARRANGEMENT PLAN

The following term as used in this Amendment shall have the following meaning:

"**Outbreak Period**" means the period beginning March 1, 2020 and ending sixty (60) days after the announced end of the National Emergency or such other date announced by the U.S. Department of Labor and Department of the Treasury. The Outbreak Period may not exceed a period of one (1) year.

I. The Outbreak Period will be disregarded when applying the sixty (60) day time frame in which to elect continued coverage in the section, "**CONTINUATION OF COVERAGE**", subsection, "***NOTIFICATION REQUIREMENTS***".

II. The Outbreak Period will be disregarded when applying the forty-five (45) day time frame for the initial payment of continuation coverage, and when applying the time frame for monthly payments due on the first day of each month, in the section, "**CONTINUATION OF COVERAGE**", subsection, "***NOTIFICATION REQUIREMENTS***".

III. The Outbreak Period will be disregarded when applying the sixty (60) day time frame to provide notice of a qualifying event resulting from divorce or legal separation from the employee or the child's loss of dependent status in the section, "**CONTINUATION OF COVERAGE**", subsection, "***NOTIFICATION REQUIREMENTS"***.

IV. The Outbreak Period will be disregarded when applying the time frame for submitting a claim in the section, "**CLAIMS PROCEDURE AND PAYMENT**", subsection, "***FILING A CLAIM***".

V. The Outbreak Period will be disregarded when applying the one hundred eighty (180) calendar day time frame to request a review of a denied claim in the section, "**CLAIMS PROCEDURE AND PAYMENT**", subsection, "***APPEALING A DENIED HRA CLAIM***".

VI. The Outbreak Period will be disregarded when applying the four (4) month time frame to request a review of a denied appeal in the section, "**CLAIMS PROCEDURE AND PAYMENT**", subsection "***EXTERNAL APPEAL***".

VII. The Outbreak Period will be disregarded when applying the time frame in which to perfect a request for an external review in the section, "**CLAIMS PROCEDURE AND PAYMENT**", subsection, "***NOTICE OF RIGHT TO EXTERNAL APPEAL***".

This amendment is effective January 1, 2021
Received and accepted for Wente Family Estates Health Reimbursement Arrangement (HRA) Plan

By: _____

Title: _____

Date: _____

WENTE FAMILY ESTATES

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN

PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

Effective Date: January 1, 2021

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INTRODUCTION

CREATION AND TITLE

Wente Family Estates hereby establishes this ***Plan*** under the terms and conditions set forth in this document. The ***Plan*** is to be known as Wente Family Estates Health Reimbursement Arrangement Plan.

EFFECTIVE DATE

The provisions of the ***Plan*** shall be effective as of January 1, 2021.

PURPOSE

The purpose of the ***Plan*** is to allow participating employees to receive reimbursements for eligible out-of-pocket health care expenses ***incurred*** by them (and/or their ***spouse, domestic partner*** or eligible ***dependents***) for expenses eligible for reimbursement. The ***employer*** intends that the ***Plan*** qualify as a health reimbursement arrangement as described in IRS Notice 2002-45 and as a nondiscriminatory accident and health plan under section 105(e) of the ***code***.

DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in ***bold and italics*** throughout the document.

Balance Rollover

Any ***benefits account*** balance that is carried forward from one plan year to the immediately following plan year in accordance with the *Benefits* section of the ***Plan***.

Benefits Account

The administrative account established by the ***plan administrator*** under the ***Plan*** for each ***participant***, reflecting the current amount that may be available to the ***participant*** for reimbursement of ***qualified expenses***.

Claims Processor

Evolution Healthcare

Code

The Internal Revenue Code of 1986, as amended from time to time.

Covered Person

A person who has coverage under this ***Plan***.

Dependent

An individual who is a dependent within the meaning of the ***Medical Plan***.

Domestic Partner

The term "***domestic partner***" means that the ***dependent***:

a. Is the opposite or same sex as the ***employee***; and

b. Is at least eighteen (18) years of age and competent to enter into a contract; and

c. Is not legally married or the domestic partner of another individual; and

d. Is not related to the ***employee*** by blood closer that which would bar marriage in the Domicile State; and

e. Has allowed at least six (6) months to pass since the termination of any previous domestic partnership; and

f. Has lived together as a couple with the ***employee*** in a shared residence for at least six (6) consecutive months; and

g. Partnership must be registered by your City, County Clerk or State.

Effective Date

January 1, 2021.

Eligible Employee

An ***employee*** who has met the eligibility requirements of the ***Plan*** as set forth herein.

Employee

An individual currently employed by the ***employer***. For purposes of this ***Plan***, "employee" does not include a self-employed individual as defined in section 410(c) of the ***code***.

Employer

Wente Family Estates or any successor by merger, consolidation, or purchase of substantially all of its assets and shall also include any of its affiliates, successors or assignors which adopt the ***Plan*** with the approval of Wente Family Estates.

Employer Contribution

The amount by which a ***participant's benefits account*** balance may be increased from time to time.

Incurred or Incurred Date

For purposes of the ***Plan,*** an expense is incurred on the date when the underlying services or products giving rise to the expense are performed or supplied and not on the date that the services or products are billed by the provider or paid by the ***participant***.

Medical Plan

Wente Family Estates PPO Medical Plan with Health Reimbursement Account Plan, as established and maintained by the ***employer***.

Participant

Any ***employee*** who has met the eligibility requirements of the ***Plan.***

Plan

Wente Family Estates Health Reimbursement Arrangement Plan.

Plan Administrator

The ***employer*** or such other person or committee as may be appointed by the ***employer*** to administer the ***Plan***.

Plan Sponsor

Wente Family Estates

Plan Year

The twelve (12) consecutive month period beginning January 1st and ends on December 31st.

Privacy Rule

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulation concerning privacy of individually identifiable health information, as published in 65 Fed. Reg. 82461 (Dec. 28, 2000) and as modified and published in 67 Fed. Reg. 53181 (Aug. 14, 2002).

Qualified Expenses

Expenses to the extent all of the following requirements are met: (i) the expenses are ***incurred*** by a ***participant,*** the ***participant's spouse, domestic partner,*** or the ***participant's dependents***, (ii) the expenses would have been paid under the ***Medical Plan*** but for the deductible requirements under the ***Medical Plan,*** and (iii) such expenses are not eligible to be reimbursed from another plan or arrangement except for any "flexible spending arrangement" (within the meaning of section 125 of the ***code***) sponsored by the ***employer***. Notwithstanding the foregoing, ***qualified expenses*** must qualify as "medical care" expenses within the meaning of section 213(d) of the ***code***. ***Qualified expenses*** do not include (A) any expenses incurred as a result of co-payment requirements, benefit maximum restrictions, or any other exclusions or limitations other than deductibles requirements under the ***Medical Plan*** or any other plan or program and (B) any medical care expense that is attributable to an individual tax deduction allowed under section 213 of the ***code*** for any prior year.

Required by Law

The same meaning as the term "required by law" as defined in 45 CFR 164.501, to the extent not preempted by ERISA or other Federal law.

Spouse

An individual who is considered the spouse or ***domestic partner*** of a ***participant*** for purposes of the ***Medical Plan***.

SUMMARY PLAN DESCRIPTION

Name of Plan:

Wente Family Estates Health Reimbursement Arrangement Plan

Name, Address and Phone Number of Employer/Plan Sponsor:

Wente Family Estates
5565 Tesla Road
Livermore, CA 94550
925-456-2300

Employer Identification Number:

94-1051349

Plan Number:

501

Group Number:

WV

Type of Plan:

The ***Plan*** is a health reimbursement account as described in IRS Notice 2002-45. The ***Plan*** is also an accident and health plan under section 105(e) of the ***code***.

Type of Administration:

Contract administration: The processing of claims for benefits under the terms of the ***Plan*** is provided through a company contracted by the ***employer*** and shall herein be referred to as the ***claims processor***.

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent For Service of Legal Process:

Wente Family Estates
5565 Tesla Road
Livermore, CA 94550
925-456-2300

Legal process may be served upon the ***plan administrator***.

Eligibility Requirements:

For detailed information regarding a person's eligibility to participate in the ***Plan*** and the events and circumstances upon which participation terminates**,** refer to the *Participation* section of the ***Plan***.

Source of Plan Contributions:

Contributions for ***Plan*** expenses are funded entirely by the ***employer***.

Funding Method:

The ***Plan*** benefits and administration expenses are paid solely by the employer directly from its general assets. ***Participants***, ***spouses, domestic partners*** and ***dependents*** shall have no legal or equitable rights, claims or interests in any specific property or assets of the ***employer*** in connection with the ***Plan***. No assets of the ***employer*** shall be held in any way as collateral security or otherwise dedicated for payment of benefits under this ***Plan***. In respect of this ***Plan***, any and all of the ***employer's*** assets shall be, and remain, the general unpledged, unrestricted assets of the ***employer***. The ***employer's*** obligation under the ***Plan*** shall be that of an unfunded and unsecured promise of the ***employer*** to meet the ***Plan's*** obligations. No ***Plan*** provision concerning allocation or accounting of credits shall be construed as requiring any separate funding.

Ending Date of Plan Year:

December 31st.

Procedures for Filing Claims:

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, *Claims Procedure and Payment*.

The designated ***claims processor*** is:

Evolution Healthcare
Attn: Benefit Spending Accounts
PO BOX 2968
Clinton, IA 52733

Statement of ERISA Rights:

Participants in the ***Plan*** are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all ***participants*** shall be entitled to:

1. Examine, without charge, at the ***plan administrator's*** office and at other specified locations, such as worksites and union halls, all documents governing the ***Plan***, including any collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the ***Plan*** with the U.S. Department of Labor.

2. Obtain, upon written request to the ***plan administrator***, copies of documents governing the operation of the ***Plan***, including any collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The ***plan administrator*** may make a reasonable charge for the copies.

3. Receive a summary of the ***Plan's*** annual financial report. The ***plan administrator*** is required by law to furnish each participant with a copy of this summary annual report.

4. Continue health care coverage for the ***participant spouse, domestic partner*** or ***dependents*** if there is a loss of coverage under the ***Plan*** as the result of a qualifying event. The ***participant spouse, domestic partner*** or ***dependent*** may have to pay for such coverage. Review this summary plan description and the documents governing the ***Plan*** on the rules governing COBRA continuation coverage rights.

In addition to creating rights for ***Plan participants***, ERISA imposes obligations upon the people who are responsible for the operation of the ***Plan***. The people who operate the ***Plan***, called "fiduciaries" of the ***Plan***, have a duty to do so prudently and in the interest of all ***Plan*** participants.

No one, including the ***employer***, a union, or any other person, may fire an ***employee*** or discriminate against an ***employee*** to prevent the ***employee*** from obtaining any benefit under the ***Plan*** or exercising the rights under ERISA.

If claims for benefits under the ***Plan*** are denied, in whole or in part, the ***participant*** must receive a written explanation of the reason for the denial. The ***participant*** has the right to have the ***Plan*** review and reconsider the claim.

Under ERISA, there are steps ***participants*** can take to enforce the rights. For instance, if material is requested from the ***Plan*** and the material is not received within thirty (30) days, the ***participant*** may file suit in a federal court. In such case, the court may require the ***plan administrator*** to provide the materials and pay the ***participant*** up to $110 a day until the materials are received, unless the materials were not provided for reasons beyond the control of the ***plan administrator***. If a claim for benefits is denied or ignored in whole or in part and after exhaustion of all administrative remedies, the ***participant*** may file suit in a state or federal court.

If it should happen that ***Plan*** fiduciaries misuse the ***Plan's*** money, or if ***participants*** are discriminated against for asserting their rights, ***participants*** may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who will pay the costs and legal fees. If the ***participant*** is successful, the court may order the person who is sued to pay these costs and fees. If the ***participant*** loses, the court may order the participant to pay the costs and fees; for example, if it finds the ***participant's*** claim frivolous.

Participants should contact the ***plan administrator*** for questions about the ***Plan***. For questions about this statement or about rights under ERISA, ***participants*** should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Participants may also obtain certain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PARTICIPATION

ELIGIBILITY AND PARTICIPATION

Participation in this ***Plan*** shall be available only to those ***employees*** who have coverage under the ***Medical Plan***. Each such ***eligible employee*** automatically becomes a ***participant*** in the ***Plan*** upon the later of (i) the ***effective date*** of the ***Plan*** and (ii) the ***eligible employee's*** first day of coverage under the ***Medical Plan***.

TERM OF PARTICIPATION

A ***participant*** shall cease to be a ***participant*** in the ***Plan*** on the earliest of:

1. the end of the month the ***participant*** ceases to be an ***employee*** for any reason;

2. the date the ***participant*** loses coverage under the ***Medical Plan*** for any reason or otherwise loses eligibility to participate in this ***Plan***; or

3. the date the ***Plan*** terminates.

BENEFITS

BENEFITS ACCOUNTS

The ***plan administrator*** shall establish a separate ***benefits account*** for each ***participant*** to reflect the amount of benefits available under the ***Plan***. For each ***plan year***, the ***benefits account*** balance of each ***participant*** shall be (i) increased by ***employer contributions*** and any ***balance rollovers*** and (ii) decreased by reimbursements made for ***qualified expenses*** and any applicable administrative expenses.

EMPLOYER CONTRIBUTIONS

Benefits under the ***Plan*** are paid solely by the ***employer*** in accordance with amounts available under the ***participants' benefits accounts***. Generally, the amount of ***employer contributions*** to be credited to the ***participants' benefits accounts*** for a ***plan year*** is determined by the ***employer*** in its sole discretion and announced prior to the beginning of that ***plan year***. The amount of ***employer contributions*** is subject, at the ***employer's*** discretion, to adjustment for any mid-plan year change in the ***participant's*** elected coverage under the ***Medical Plan*** (e.g., employee-only coverage, employee and spouse or ***domestic partner*** coverage, or family coverage). The ***employer contribution*** amount credited under this ***Plan*** may be prospectively increased or decreased at any time and to any extent at the sole discretion of the ***employer***.

AVAILABLE BENEFITS AND AMOUNT

Benefits under the ***Plan*** shall take the form of reimbursement of ***qualified expenses*** to the extent ***incurred*** by a ***participant***, the ***participant's spouse, domestic partner*** and/or ***dependents*** during the ***participant's*** participation in the ***Plan*** and have not been reimbursed by any other plan or program. A ***participant*** shall be entitled to benefits under the ***Plan*** in an amount that does not exceed the then current balance of his or her ***benefits account***. The ***plan administrator*** may also establish a minimum reimbursement amount below which requests for reimbursement shall not be made until the end of the ***plan year*** or, if earlier, until the last day of participation in the ***Plan***. *Notwithstanding any provision of this **Plan** to the contrary, no individual shall have the right, whether currently or in the future, to receive cash or any other taxable or non-taxable benefit under this **Plan** other than the reimbursement of **qualified expenses**.*

BALANCE ROLLOVER AND FORFEITURE

At the end of each ***plan year***, up to but not more than the Maximum Rollover amount listed below:

Maximum Rollover:	
Employee Only	$1,500
Employee & Spouse, or Domestic Partner	$3,000
Employee & Child(ren)	$3,000
Employee & Family	$3,000

shall be carried forward to that ***participant's benefits account*** for the immediately following ***plan year***, provided that the ***participant*** continues to participate in the ***Plan***. Except as may otherwise be required by applicable law, in the event an ***employee's*** participation in the ***Plan*** ceases for any reason, any balance in his or her ***benefits account*** shall be forfeited in its entirety upon the expiration of 365 days of the close of the ***plan year*** in which any relevant expense was ***incurred***. Notwithstanding the foregoing, in the event the ***Plan*** is terminated, any balance in his or her ***benefits account*** shall be forfeited in its entirety upon the expiration of 90 days after the date of termination of the ***Plan***. In no event shall any forfeitures be subject to the claim

of any current or former ***employee***, ***spouse, domestic partner*** or ***dependent*** or any of their successors or assigns.

LEAVE OF ABSENCE

Eligible Leave

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***Employees*** and/or ***Dependents***, when the ***Employee*** is on an authorized Leave of Absence from the ***Employer***. For additional information on Wente Family Estate's leave policy contact the Human Resources Department.

FAMILY AND MEDICAL LEAVE ACT

For any leave, and solely to the extent the provisions of the Family and Medical Leave Act of 1993 ("FMLA") apply and such leave qualifies as a FMLA leave, the ***participant*** may remain a ***participant*** and shall be entitled to receive the same benefits as before the start of the FMLA leave, subject to the ***participant's*** continued participation in the ***Medical Plan***. Solely to the extent required under FMLA, a ***participant*** whose participation in the ***Plan*** has been suspended or terminated while on an FMLA leave may have such participation reinstated on return from the FMLA leave on the same terms as prior to taking the FMLA leave, subject to any changes in benefit levels that may have taken place during the period of FMLA leave.

NONDISCRIMINATORY BENEFITS

The ***Plan***, in accordance with applicable provisions of the ***code***, is intended to not discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and/or benefits. The ***plan administrator*** may take such actions as it deems appropriate or necessary to ensure that the ***Plan*** is not deemed a discriminatory plan under applicable provisions of the ***code***, which actions may include excluding certain highly compensated individuals from participation in the ***Plan***.

CLAIMS PROCEDURE AND PAYMENT

FILING A CLAIM

Generally, the ***plan administrator*** will receive information regarding such ***qualified expenses*** directly from the ***Medical Plan's*** records [and/or through an automatic debit card system] so that the ***participant*** shall not be required to separately file a claim for reimbursement or supporting evidence for such expense. In certain instances, however, the ***plan administrator*** may require proper evidence of any or all of the following from the ***participant*** in order to complete its determination of whether, and to what extent, a ***qualified expense*** subject to reimbursement has been ***incurred***:

1. the name of the person or persons for whom the expenses have been ***incurred***;

2. the nature of the expenses ***incurred***;

3. the ***incurred date***;

4. the amount of the requested reimbursement; and/or

5. that the expenses have not been otherwise paid or reimbursed from another source.

Any requested information must be submitted to the ***claims processor*** at the following address:

Trustmark Health Benefits, Inc.
Trustmark Companies' Healthy Foundations
8324 South Avenue
Boardman, Ohio 44512

Any and all information submitted for purposes of receiving benefits under this ***Plan*** must be submitted on an approved form and include such evidence as the ***claims processor*** may deem reasonably necessary to administer the claim, including such evidence that substantiates the nature, the amount, and timeliness of any expenses that may be reimbursed.

Claims for benefits under this ***Plan*** must be received by the ***claims processor*** within 12 months of the close of the ***plan year*** in which the relevant expense was ***incurred***. Notwithstanding the foregoing, in the event the ***Plan*** is terminated, all claims for reimbursement of expenses ***incurred*** must be received by the ***claims processor*** not later than 90 days after the date of termination of the ***Plan***. All claims that are not timely received shall be denied.

NOTICE OF AUTHORIZED REPRESENTATIVE

A ***participant***, ***spouse, domestic partner*** or ***dependent*** may provide the ***claims processor*** with a written authorization that (i) designates and authorizes another person or entity to act on his or her behalf and (ii) consents to the communication of information related to him or her to the authorized representative with respect to a claim for benefits or an appeal of a denied claim. Authorization forms may be obtained from the [Human Resources Department].

BENEFIT DETERMINATION

After receipt by the ***claims processor*** of a completed claim for benefits under this ***Plan,*** the ***claims processor*** shall complete its determination of the claim within thirty (30) days unless an extension is necessary due to circumstances beyond the ***Plan's*** control. If additional information is needed for determination of the claim,

the ***claims processor*** shall provide the claimant (or authorized representative) with a notice detailing the information needed. The notice shall be provided within thirty (30) days of receipt of the completed claim and shall state the date as of which the ***Plan*** expects to make a decision. The claimant shall have forty-five (45) days to provide the information requested, and the ***claims processor*** shall complete its determination of the claim within fifteen (15) days of receipt of the requested information. Failure to respond in a timely and complete manner shall result in the denial of benefit payment.

If a claim for benefits under this ***Plan*** is denied, the ***claims processor*** shall provide the claimant (or authorized representative) with a written notice of benefits denial within the time frame for determination as described in this section.

The ***plan administrator*** has the discretionary authority and responsibility to determine whether or not an expense constitutes a ***qualified expense***.

PAYMENT OF BENEFITS

If the ***plan administrator*** determines that an expense is a ***qualified expense*** subject to reimbursement, the ***plan administrator*** shall reimburse the ***participant*** for the ***qualified expense*** within a reasonable time or, if applicable, provide such amount directly to a third party on behalf of the ***participant***. The ***plan administrator*** shall be the sole arbiter of what constitutes a ***qualified expense*** subject to reimbursement under the ***Plan.***

In the event of the death of the ***participant*** after a ***qualified expense*** is ***incurred*** but prior to reimbursement under the ***Plan*** for such an expense, reimbursement, to the extent not paid directly to a third party on behalf of the ***participant***, shall be made available to the following persons based on the following priority:

1. Executor of the Estate of the deceased ***participant;***

2. ***Spouse*** or ***domestic partner;***

3. Family member held responsible for payment of deceased's medical bills;

4. ***Spouse, domestic partner*** or ***dependent*** with COBRA continuation rights.

APPEALING A DENIED HRA CLAIM

If a claim for benefits under this ***Plan*** is denied, the claimant (or authorized representative) may request a review of the denied claim by making a written request to the ***claims processor*** within one hundred eighty (180) days from receipt of the notification of the denial and stating the reasons the claimant feels the claim should not have been denied. The ***claims processor*** shall provide the claimant (or authorized representative) with a written notice of the appeal decision within sixty (60) days of receipt of a written request for the appeal.

The following describes the review process and rights of the claimant.

1. The claimant has a right to submit documents, information and comments and to present evidence and testimony;

2. The claimant has the right to receive and access, free of charge, information relevant to the claim for benefits;

3. Before a final determination on appeal is rendered, the claimant will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by this ***plan*** in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal adverse benefit determination to give the claimant a reasonable opportunity to respond prior to that date. If it is impossible to provide the

new or additional evidence or rationale in time for the claimant to have a reasonable opportunity to respond, the timing for appeal determinations as outlined above, will be tolled until the earliest of:

a. The date the claimant responds to the new or additional evidence or rationale; or
b. Three (3) weeks from the date the new or additional evidence or rationale was sent via U.S. mail; or
c. Ten (10) calendar days from the date the new or additional evidence or rationale was sent electronically.

4. The review must take into account all information submitted by the claimant, even if it was not considered in the initial benefit determination;

5. The review shall not afford deference to the original denial; and

6. The reviewer shall not be the individual who originally denied the claim, nor a subordinate to the individual who originally denied the claim.

7. If original denial was, in whole or in part, based on medical judgment:
   a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment; and
   b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:
      (i.) An individual who was consulted in connection with the original denial of the claim, nor
      (ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original denial.
8. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NAMED FIDUCIARY FOR HRA CLAIM APPEALS

The ***claims processor*** shall be the "named fiduciary" for purposes of reviewing an HRA claim for benefits upon appeal, as described in U.S. Department of Labor Regulation 2560.503-1 (issued November 21, 2000).

NOTICE OF BENEFIT DETERMINATION ON APPEAL

The ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.
2. Reference to specific ***Plan*** provisions on which the denial is based.
3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
4. A statement of the ***covered person's*** right to request an external review and a description of the process for requesting such a review.
5 A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
   a. A copy of that criterion, or

b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

7. If the denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***plan administrator*** (or its designee) will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

EXTERNAL APPEAL

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of a denied appeal if the claim determination involves medical judgment or a rescission by making written request to the ***named fiduciary*** within four (4) months of receipt of notification of the final internal denial of benefits. Medical judgment includes, but is not limited to:

1. ***Medical necessity***;
2. Appropriateness;
3. ***Experimental*** or ***investigational*** treatment;
4. Health care setting;
5. Level of care; and
6. Effectiveness of a ***covered expense***.

If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. {*Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or Federal holiday.*}

RIGHT TO EXTERNAL APPEAL

Within five (5) business days of receipt of the request, the ***claims processor*** will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that the final internal denial was the result of:

1. Medical judgment; or
2. Rescission of coverage under this ***Plan***.

NOTICE OF RIGHT TO EXTERNAL APPEAL

The ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 866-444-3272, if the request is complete but not eligible for external review.
2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the ***covered person*** to perfect the external review request by the later of the following:

   a. The four (4) month filing period; or
   b. Within the forty-eight (48) hour time period following the ***covered person's*** receipt of notification.

INDEPENDENT REVIEW ORGANIZATION

For external reviews by an Independent Review Organization (IRO), such IRO shall be accredited by URAC or a similar nationally recognized accrediting organization and shall be assigned to conduct the external review. The assigned IRO will timely notify the ***covered person*** in writing of the request's eligibility and acceptance for external review.

NOTICE OF EXTERNAL REVIEW DETERMINATION

The assigned IRO shall provide the ***plan administrator*** (or its designee) and the ***covered person*** (or authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the ***covered person***, the ***Plan*** and ***claims processor***, except to the extent that other remedies may be available under State or Federal law.

DISCRETIONARY AUTHORITY AND REQUIREMENT TO EXHAUST CLAIM AND APPEAL PROCESS

The ***plan administrator*** has discretionary authority to determine all claims and internal appeals and to interpret all documents governing the ***plan***. All determinations of the ***plan administrator*** will be binding on all parties. The ***plan administrator's*** decision on an appeal will be accorded judicial deference in any later court action or administrative proceeding to the extent that it does not constitute an abuse of discretion and is not arbitrary or capricious. A claimant must exhaust the ***Plan's*** appeal procedures before the claimant is permitted to bring any court action or administrative proceeding against the ***Plan***, the ***plan administrator***, the ***employer***, the ***plan sponsor***, the ***claims processor***, any other fiduciary, or their employees.

LIMITATIONS PERIOD AND VENUE FOR LEGAL ACTIONS

The decision by the ***claims processor***, the ***plan sponsor***, or the ***plan administrator*** on review will be final, binding, and conclusive, and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the ***Plan*** must be exhausted before any legal or equitable action is brought. Notwithstanding any other state or federal law, any and all legal actions to recover benefits, whether against the ***Plan***, the ***plan sponsor***, the ***plan administrator***, the ***claims processor***, any other fiduciary, or their employees, must be filed within two years from the date the expense was incurred or one year from the date the completed claim was filed, whichever occurred first.
The situs of the ***Plan*** is in California. Legal actions must be brought in the appropriate state or federal court located in California.

ASSIGNMENTS

A ***covered person's*** right to receive benefit payments, appeal a claim, or bring a cause of action against the ***Plan*** is personal to the ***covered person***. Any claim or rights under the ***Plan***, which includes but is not limited to any right to appeal a claim under the procedure set forth in the ***Plan***, any right to bring a cause of action against the ***Plan*** in any forum, or any right to receive benefits or benefit payments from the ***Plan***, is not assignable or transferrable in whole or in part to any other person, provider, or other entity at any time. Any assignment or transfer of a claim or other rights to receive benefit payments is void unless the ***covered person*** receives written consent from the ***plan sponsor***. Nothing in this clause will prevent the ***Plan*** from paying a provider or similar entity directly and any such payment shall not constitute a waiver of this anti-assignment clause. In addition, the ***plan sponsor's*** consent or lack thereof to the assignment or transfer of benefits does not affect a ***covered person's*** eligibility for benefits under the ***Plan***.

COORDINATION OF BENEFITS

The *Coordination of Benefits* provision is intended to prevent duplication of benefits. It applies when the ***covered person*** is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed one hundred percent (100%) of "allowable expenses."

The *Coordination of Benefits* provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses ***incurred*** while covered under this ***Plan***, part or all of which would be covered under this ***Plan***.

When this ***Plan*** is secondary, "Allowable Expense" will include any deductible or coinsurance amounts not paid by the Other Plan(s).

This ***Plan*** is not eligible to be elected as primary coverage in lieu of automobile benefits. Payments from automobile insurance will always be primary and this ***Plan*** shall be secondary only.

When this ***Plan*** is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the ***covered person*** for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any plan, policy or coverage other than the ***Medical Plan***, providing reimbursement, benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for ***covered persons*** in a group, whether on an insured or uninsured basis, including, but not limited to, hospital indemnity benefits and hospital reimbursement-type plans;

2. Hospital or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;

5. Any coverage under a government program and any coverage required or provided by any statute;

6. Individual medical, dental or vision insurance policies;

7. Group automobile insurance;

8. Individual automobile insurance coverage;

9. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;

10. Any plan or policies funded in whole or in part by an employer**,** or deductions made by an employer from a person's compensation or retirement benefits;

11. Labor/management trusteed, union welfare, employer organization, or employee benefit organization plans.

"This ***Plan***" shall mean that portion of the ***employer's Plan*** that provides benefits that are subject to this provision.

"Claim Determination Period" means a calendar year or that portion of a calendar year during which the ***covered person*** for whom a claim is made has been covered under this ***Plan***.

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a ***covered person*** for each claim determination period for the Allowable Expenses. If this ***Plan*** is secondary, the benefits paid under this ***Plan*** may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expense.

If the rules set forth below would require this ***Plan*** to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this ***Plan***.

ORDER OF BENEFIT DETERMINATION

The order of benefit determination applicable to this ***Plan*** in coordination with Other Plans and/or Medicare shall be identical to the order of benefit determination applicable to the ***Medical Plan*** in its coordination with such Other Plans and/or Medicare, Medicaid, Tricare or state child health insurance program (CHIP), so that the ***Plan*** and the ***Medical Plan*** together shall have the same order of benefit determination in coordination with Other Plans and/or Medicare, Medicaid, Tricare state child health insurance program (CHIP). In the event a ***qualified expense*** is covered by both this ***Plan*** and a "flexible spending account" (within the meaning of section 125 of the ***code*** and related regulations) sponsored by the ***employer***, the amount of benefits available under this ***Plan*** shall be paid prior to any payment by flexible spending account with respect to such ***qualified expense***.

LIMITATIONS ON PAYMENTS

In no event shall the ***covered person*** recover under this ***Plan*** and all Other Plan(s) combined more than the total Allowable Expenses offered by this ***Plan*** and the Other Plan(s).

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this *Coordination of Benefits* provision, the ***Plan*** may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information, regarding other insurance, with respect to any ***covered person***. Any person claiming benefits under this ***Plan*** shall furnish to the ***employer*** such information as may be necessary to implement the *Coordination of Benefits* provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this ***Plan*** in accordance with this provision have been made under any Other Plan, the ***employer*** shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this ***Plan*** and, to the extent of such payments, the ***employer*** shall be fully discharged from liability.

SUBROGATION/REIMBURSEMENT

The ***Plan*** is designed to only pay ***qualified expenses*** for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a ***covered person*** in a time of need, however, the ***Plan*** may pay ***qualified expenses*** that may be or become the responsibility of another person, provided that the ***Plan*** later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the ***Plan***, as well as by applying for payment of ***qualified expenses***, a ***covered person*** is subject to, and agrees to, the following terms and conditions with respect to the amount of ***qualified expenses*** paid by the ***Plan***:

1. Assignment of Rights (Subrogation). The ***covered person*** automatically assigns to the ***Plan*** any rights the ***covered person*** may have to recover all or part of the same ***qualified expenses*** from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the ***Plan***. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a ***covered person*** or paid to another for the benefit of the ***covered person***. This assignment applies on a first-dollar basis (*i.e.*, has priority over other rights), applies whether the funds paid to (or for the benefit of) the ***covered person*** constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the ***Plan*** to pursue any claim that the ***covered person*** may have, whether or not the ***covered person*** chooses to pursue that claim. By this assignment, the ***Plan's*** right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The ***Plan*** shall have an equitable lien against any rights the ***covered person*** may have to recover the same ***qualified expenses*** from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the ***Plan***. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the ***Plan*** has paid ***qualified expenses*** prior to a determination that the ***qualified expenses*** arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the ***covered person***, the ***covered person's*** attorney, and/or a trust) as a result of an exercise of the ***covered person's*** rights of recovery (sometimes referred to as "proceeds"). The ***Plan*** shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the ***plan administrator***, the ***Plan*** may reduce any future ***qualified expenses*** otherwise available to the ***covered person*** under the ***Plan*** by an amount up to the total amount of Reimbursable Payments made by the ***Plan*** that is subject to the equitable lien.

   This and any other provisions of the ***Plan*** concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002). The provisions of the ***Plan*** concerning subrogation, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

3. Assisting in ***Plan's*** Reimbursement Activities. The ***covered person*** has an obligation to assist the ***Plan*** to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the ***covered person***, and to provide the ***Plan*** with any information concerning the ***covered person's***

other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the ***covered person***. The ***covered person*** is required to (a) cooperate fully in the ***Plan's*** (or any ***Plan*** fiduciary's) enforcement of the terms of the ***Plan***, including the exercise of the ***Plan's*** right to subrogation and reimbursement, whether against the ***covered person*** or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the ***Plan*** as a co-payee for the amount of the Reimbursable Payments and notifying the ***Plan***), (c) sign any document deemed by the ***plan administrator*** to be relevant to protecting the ***Plan's*** subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the ***plan administrator*** or ***claims processor*** to enforce the ***Plan***'s rights.

The ***plan administrator*** has delegated to the ***claims processor*** the right to perform ministerial functions required to assert the ***Plan's*** rights; however, the ***plan administrator*** shall retain discretionary authority with regard to asserting the ***Plan's*** recovery rights.

CONTINUATION OF COVERAGE

In order to comply with federal regulations, this ***Plan*** includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. *Continuation coverage under this **Plan** is available only in conjunction with continued coverage under the **Medical Plan**.*

QUALIFYING EVENTS

Qualifying events under this ***Plan*** are any of the events that constitute a "qualifying event" under the ***Medical Plan***. For further information on the specific events that constitute qualifying events under both the ***Medical Plan*** and this ***Plan***, please consult the relevant Summary Plan Description of the ***Medical Plan***.

For purposes of this *Continuation of Coverage* section, the term "***dependent***" will be used to refer to the ***employee's spouse, domestic partner*** and/or ***dependents***.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse or ***domestic partner*** being divorced or legally separated from a covered ***employee***, or a child's loss of ***dependent*** status, the ***employee*** or ***dependent*** must submit a completed Qualifying Event Notification form to the ***plan administrator*** or its designee within sixty (60) days of the latest of:

    a. The date of the event;

    b. The date on which coverage under this ***Plan*** is or would be lost as a result of that event; or

    c. The date on which the ***employee*** or ***dependent*** is furnished with a copy of this Plan Document and Summary Plan Description.

    A copy of the Qualifying Event Notification form is available from the ***plan administrator*** (or its designee). In addition, the ***employee*** or ***dependent*** may be required to promptly provide any supporting documentation as may be reasonably requested for purposes of verification. Failure to provide such notice and any requested supporting documentation will result in the person forfeiting their rights to continuation of coverage under this provision.

    Within fourteen (14) days of the receipt of a properly completed Qualifying Event Notification, the ***plan administrator*** (or its designee) will notify the ***employee*** or ***dependent*** of his rights to continuation of coverage, and what process is required to elect continuation of coverage. This notice is referred to below as "Election Notice."

2. When eligibility for continuation coverage results from any qualifying event other than the ones described in Paragraph 1 above, the ***employer*** must notify the ***plan administrator*** (or its designee) not later than thirty (30) days after the date on which the ***employee*** or ***dependent*** loses coverage under the ***Plan*** due to the qualifying event. Within fourteen (14) days of the receipt of the notice of the qualifying event, the ***plan administrator*** (or its designee) will furnish the Election Notice to the ***employee*** or ***dependent.***

3. In the event it is determined that an individual seeking continuation coverage (or extension of continuation coverage) is not entitled to such coverage, the ***plan administrator*** (or its designee) will provide to such individual an explanation as to why the individual is not entitled to continuation coverage. This notice is referred to here as the "Non-Eligibility Notice." The Non-Eligibility Notice will be furnished in accordance with the same time frame as applicable to the furnishing of the

4. In the event an Election Notice is furnished, the eligible ***employee*** or ***dependent*** has sixty (60) days to decide whether to elect continued coverage. Each person who is described in the Election Notice and was covered under the ***Plan*** on the day before the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the ***employee*** or ***dependent*** chooses to have continuation coverage, he must advise the ***plan administrator*** (or its designee) of this choice by returning to the ***plan administrator*** (or its designee) a properly completed Election Notice not later than the last day of the sixty (60) day period. If the Election Notice is mailed to the ***plan administrator*** (or its designee), it must be postmarked on or before the last day of the sixty (60) day period. The Non-Eligibility Notice will be furnished within ten (10) days of receipt of the request:

   a. The date coverage under the ***Plan*** would otherwise end; or

   b. The date the person is sent the Election Notice from the ***plan administrator*** (or its designee).

5. Within forty-five (45) days after the date the person notifies the ***plan administrator*** (or its designee) that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide retroactively from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continuation coverage are to be made monthly, and are due in advance, on the first day each month.

COST OF COVERAGE

1. The ***Plan*** requires that ***covered persons*** pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. Except for the initial payment (see above), payments must be remitted to the ***plan administrator*** (or its designee) by or before the first day of each month during the continuation period. The payment must be remitted on a timely basis in order to maintain the coverage in force. A grace period of thirty (30) days is allowed by law.

2. For a person originally covered as an ***employee*** or as a spouse or ***domestic partner***, the cost of coverage is the amount applicable to an ***employee*** if coverage is continued for himself alone. For a person originally covered as a child and continuing coverage independent of the family unit, the cost of coverage is the amount applicable to an ***employee***.

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the initial payment is made within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for ***dependents*** acquired and properly enrolled in the ***Medical Plan*** during its continuation period will be treated as also covered under this ***Plan*** as of the same date. *Notwithstanding any other provision of this **Plan** to the contrary, continuation coverage for any individual shall not be in effect for any period during which that individual has no coverage under the **Medical Plan**.*

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

Qualified expenses incurred by a ***spouse, domestic partner*** or ***dependent*** child newly acquired during continuation coverage are reimbursable under this ***Plan*** in like manner as those incurred by similarly situated ***spouses, domestic partners*** or ***dependents***. In other words, the standard enrollment provision of the ***Plan*** applies to enrollees during continuation coverage. However, a ***dependent*** acquired and enrolled after the original qualifying event, other than a child born to or *placed for adoption* with a covered ***employee*** during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

The amount of ***employer contributions*** is subject, at the ***employer's*** discretion, to adjustment for any mid-plan year change in the ***participant's*** elected coverage under the ***Medical Plan*** (e.g., employee-only coverage, employee and spouse or ***domestic partner*** coverage, or family coverage).

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. The end of the period for which contributions are paid if the ***covered person*** fails to make a payment by the date specified by the ***plan administrator*** (or its designee). In the event continuation coverage is terminated for this reason, the individual will receive a notice describing the reason for the termination of coverage, the effective date of termination, and any rights the individual may have under this ***Plan*** or under applicable law to elect an alternative group or individual coverage, such as a conversion right. This notice is referred to below as an "Early Termination Notice."

2. The date coverage under this ***Plan*** ends and the ***employer*** offers no other group health benefit plan. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

3. The date continuation coverage under the ***Medical Plan*** ends for any reason. In the event continuation coverage is terminated for this reason prior to the end of the maximum continuation coverage period available under the ***Medical Plan***, the individual will receive an Early Termination Notice.

4. The date the ***covered person*** first becomes entitled, after the date of the ***covered person's*** original election of continuation coverage, to ***Medicare*** benefits under Title XVIII of the Social Security Act. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

5. The date the ***covered person*** first becomes covered under any other employer's group health plan after the original date of the ***covered person's*** election of continuation coverage, but only if such group health plan does not have any exclusion or limitation that affects coverage of the ***covered person's*** pre-existing condition. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

SPECIAL RULES REGARDING NOTICES

1. Any notice required in connection with continuation coverage under this ***Plan*** must, at minimum, contain sufficient information so that the ***plan administrator*** (or its designee) is able to determine from such notice the ***employee*** and ***dependent(s)*** (if any), the qualifying event, and the date on which the qualifying event occurred.

2. In connection with continuation coverage under this ***Plan,*** any notice required to be provided by any individual who is either the ***employee*** or a ***dependent*** with respect to the qualifying event may be provided by a representative acting on behalf of the ***employee*** or the ***dependent,*** and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.

3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:

    a. A single notice addressed to both the ***employee*** and the ***spouse*** or ***domestic partner*** will be sufficient as to both individuals if, on the basis of the most recent information available to the ***Plan,*** the ***spouse*** or ***domestic partner*** resides at the same location as the ***employee;*** and

b. A single notice to the ***employee*** or the ***spouse*** or ***domestic partner*** will be sufficient as to each ***dependent*** child of the ***employee*** if, on the basis of the most recent information available to the ***Plan,*** the ***dependent*** child resides at the same location as the individual to whom such notice is provided.

MILITARY MOBILIZATION

If an ***employee*** is called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), the ***employee*** and the ***employee's dependent*** may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the ***employee*** and ***employee's dependent*** may not be required to pay more than the ***employee's*** share, if any, applicable to that coverage. If the leave is thirty-one (31) days or longer, then the ***plan administrator*** (or its designee) may require the ***employee*** and ***employee's dependent*** to pay no more than one hundred and two percent (102%) of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or

2. A period beginning on the day that the leave began and ending on the day after the ***employee*** fails to return to employment within the time allowed.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA. Upon return from active duty and subject to premium contribution requirement and other applicable requirements as described in the *Participation* section, coverage for the ***employee*** and the ***employee's dependent*** will be reinstated without pre-existing conditions exclusions or a waiting period, regardless of their election of COBRA continuation coverage.

PLAN CONTACT INFORMATION

Questions concerning this ***Plan,*** including any available continuation coverage, may be directed to the ***plan administrator.***

ADDRESS CHANGES

In order to help ensure the appropriate protection of rights and benefits under this ***Plan, covered persons*** should keep the ***plan administrator*** informed of any changes to their current addresses.

HIPAA PRIVACY

The following provisions are intended to comply with applicable ***Plan*** amendment requirements under Federal regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (***HIPAA***).

DISCLOSURE BY PLAN TO PLAN SPONSOR

The ***Plan*** may take the following actions only upon receipt of a plan amendment certification:

1. Disclose protected health information to the ***plan sponsor***.

2. Provide for or permit the disclosure of protected health information to the ***plan sponsor*** by a health insurance issuer or HMO with respect to the ***Plan***.

USE AND DISCLOSURE BY PLAN SPONSOR

The ***plan sponsor*** may use or disclose protected health information received from the ***Plan*** to the extent not inconsistent with the provisions of this *HIPAA Privacy* section or the ***privacy rule***.

OBLIGATIONS OF PLAN SPONSOR

The ***plan sponsor*** shall have the following obligations:

1. Ensure that:

    a. Any agents (including a subcontractor) to whom it provides protected health information received from the ***Plan*** agree to the same restrictions and conditions that apply to the ***plan sponsor*** with respect to such information; and

    b. Adequate separation between the ***Plan*** and the ***plan sponsor*** is established in compliance with the requirement in 45 C.F.R. 164.504(f)(2)(III).

2. Not use or further disclose protected health information received from the ***Plan***, other than as permitted or required by the ***Plan*** documents or as ***required by law***.

3. Not use or disclose protected health information received from the ***Plan***:

    a. For employment-related actions and decisions; or

    b. In connection with any other benefit or employee benefit plan of the ***plan sponsor***.

4. Report to the ***Plan*** any use or disclosure of the protected health information received from the ***Plan*** that is inconsistent with the use or disclosure provided for of which it becomes aware.

5. Make available protected health information received from the ***Plan***, as and to the extent required by the ***privacy rule***:

    a. For access to the individual;

    b. For amendment and incorporate any amendments to protected health information received from the ***Plan***; and

    c. To provide an accounting of disclosures.

6. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the ***Plan*** available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the ***Plan*** with the ***privacy rule***.

7. Return or destroy all protected health information received from the ***Plan*** that the ***plan sponsor*** still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the ***Plan*** was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

8. Provide protected health information only to those individuals, under the control of the ***plan sponsor*** who perform administrative functions for the ***Plan***; (i.e. eligibility, enrollment, payroll deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information received from the ***Plan*** for any reason other than for ***Plan*** administrative functions nor to release **protected health information** received from the ***Plan*** to an unauthorized individual.

9. Provide protected health information received from the ***Plan*** only to those entities required to receive the information in order to maintain the ***Plan***.

10. Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.

11. Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the ***plan sponsor*** on behalf of the ***Plan***. Specifically, such safeguarding entails an obligation to:

    a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the ***plan sponsor*** creates, receives, maintains, or transmits on behalf of the ***Plan***;

    b. Ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) 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.

EXCEPTIONS

Notwithstanding any other provision of this *HIPAA PRIVACY* Section, the ***Plan*** may:

1. Disclose summary health information to the ***plan sponsor***:

    a. If the ***plan sponsor*** requests it for the purpose of:

        (i.) Obtaining premium bids from health plans for providing health insurance coverage under the ***Plan***; or

        (ii.) Modifying, amending, or terminating the ***Plan***;

2. Disclose to the ***plan sponsor*** information on whether the individual is participating in the ***Plan***;

3. Use or disclose protected health information:

a. With (and consistent with) a valid authorization obtained in accordance with the ***privacy rule***;

b. To carry out treatment, payment, or health care operations in accordance with the ***privacy rule***; or

c. As otherwise permitted or required by the ***privacy rule***.

PLAN ADMINISTRATION

PLAN ADMINISTRATOR

The ***plan administrator*** shall be responsible for the administration of the ***Plan.***

PLAN ADMINISTRATOR'S DUTIES

In addition to any rights, duties or powers specified throughout the ***Plan,*** the ***plan administrator*** shall have the following rights, duties and powers:

1. to interpret the ***Plan,*** to determine the amount, manner and time for payment of any benefits under the ***Plan,*** and to construe or remedy any ambiguities, inconsistencies or omissions under the ***Plan***;

2. to adopt and apply any rules or procedures to ensure the orderly and efficient administration of the ***Plan***;

3. to determine the rights of any ***participant, spouse, domestic partner*** or ***dependent*** or beneficiary to benefits under the ***Plan***;

4. to develop appellate and review procedures for any ***participant, spouse, domestic partner, dependent*** or designated beneficiary with regard to denied benefits under the ***Plan***;

5. to provide the ***employer*** with such tax or other information it may require in connection with the ***Plan***;

6. to employ any agents, attorneys, accountants or other parties (who may also be employed by the ***employer***) and to allocate or delegate to them such powers or duties as are necessary to assist in the proper and efficient administration of the ***Plan,*** provided that such allocation or delegation and the acceptance thereof are in writing;

7. to report to the ***employer,*** or any party designated by the ***employer,*** after the end of each ***plan year***, regarding the administration of the ***Plan;*** and to report any significant problems as to the administration of the ***Plan*** and to make recommendations for modifications as to procedures and benefits, or any other change which might ensure the efficient administration of the ***Plan***.

However, nothing in this section is meant to confer upon the ***plan administrator*** any powers to amend the ***Plan*** or change any material administrative procedure or adopt any other material procedure involving the ***Plan*** without the express written approval of the ***employer***. Notwithstanding the preceding sentence, the ***plan administrator*** is empowered to take any actions he sees fit to assure that the ***Plan*** complies with the nondiscrimination requirements of Sections 105 of the ***code***, and that the ***Plan*** is and remains as a "health reimbursement arrangement" as described in IRS Notice 2002-45.

INFORMATION TO BE PROVIDED TO PLAN ADMINISTRATOR

The ***employer,*** or any of its agents, shall provide to the ***plan administrator*** any employment records of any ***employee*** eligible to participate under the ***Plan***. Such records shall include, but will not be limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment, or any other information the ***plan administrator*** may need for the proper administration of the ***Plan***. Any ***participant***, ***spouse, domestic partner*** or ***dependent*** entitled to benefits under the ***Plan*** shall furnish to the ***plan administrator*** his or her correct post office address, his date of birth, the names, correct addresses and

dates of birth of any designated beneficiaries, with proper proof thereof, or any other data the ***plan administrator*** might reasonably request to ensure the proper and efficient administration of the ***Plan***.

DECISION OF PLAN ADMINISTRATOR FINAL

Subject to applicable State or Federal law and the provisions of this ***Plan,*** any interpretation of any provision of this ***Plan*** made in good faith by the ***plan administrator*** as to any rights or benefits of a ***participant***, ***spouse, domestic partner*** or ***dependent*** under this ***Plan*** is final and shall be binding upon the parties. Any misstatement or other mistake of fact shall be corrected as soon as reasonably possible upon notification to the ***plan administrator*** and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the ***plan administrator*** as he considers equitable and practicable.

RULES TO APPLY UNIFORMLY

The ***plan administrator*** shall perform his duties in a reasonable manner and on a nondiscriminatory basis and shall apply uniform rules to all ***participants*** similarly situated under the ***Plan***.

GENERAL PROVISIONS

EMPLOYER OBLIGATION

The ***employer***, upon adopting the ***Plan***, shall have the obligation to pay, or to have paid on its behalf, the contributions required for payment of benefits under the ***Plan*** in respect of its employees. Generally, ***employer contribution*** under the ***Plan*** for a ***plan year*** shall be fixed as of first day of that ***plan year***. The ***employer contribution*** amount for a ***participant*** shall bear no direct or indirect relationship to (i) the amount of any salary reduction election (if any) made by the ***participant*** for the ***Medical Plan*** or any other plan or arrangement, or (ii) the amount forfeited by that individual under a flexible spending account arrangement under section 125 of the ***code***. Further, no portion of any salary reduction elected under a cafeteria plan (within the meaning of section 125 of the ***code***) shall be used, directly or indirectly, to credit any ***benefit account*** under the ***Plan***.

AMENDMENT AND TERMINATION

Wente Family Estates may amend, modify, or terminate this ***Plan*** at any time, to any extent, and for any reason, all in its sole discretion. Any amendment may be made effective retroactively to the extent not prohibited by ERISA and the Internal Revenue Code. Coverage upon termination shall be governed by the terms of the ***Plan***.

NONASSIGNABILITY

Any benefits under this ***Plan*** shall be nonassignable and for the exclusive benefit of ***participants, spouses, domestic partners*** and ***dependents***. No benefit shall be voluntarily or involuntarily assigned, sold or transferred.

MEDICAL CHILD SUPPORT ORDERS

To the extent applicable, the ***plan administrator*** shall adhere to the terms of any judgment, decree or court order (including a court's approval of a domestic relations settlement agreement) which

1. relates to the provision of child support related to health benefits for a child of a ***participant*** of a group health plan
2. is made pursuant to a state domestic relations law and
3. which creates or recognizes the right of an alternate recipient to, or assigns to an alternate recipient the right to receive benefits under the group health plan under which a ***participant*** or other beneficiary is entitled to receive benefits.

The ***plan administrator*** shall promptly notify the ***participant*** and each alternate recipient named in the medical child support order of the ***Plan's*** procedures for determining the qualified status of the medical child support orders. Within a reasonable period after receipt of a medical child support order, the ***plan administrator*** shall determine whether such order is a Qualified Medical Child Support Order as defined in Section 609 of ERISA (QMCSO) or National Medical Support Notice as defined in Section 401 of the Child Support Performance and Incentive Act of 1998 and shall notify the ***participant*** and each alternate recipient of such determination. If the ***participant*** or any affected alternate payee objects to the determination of the ***plan administrator,*** the disagreeing party shall be treated as a claimant and the claims procedure of the ***Plan*** shall be followed. The ***plan administrator*** may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the ***Plan.***

Any such QMCSO or NMSN must clearly specify the name and last known mailing address of the ***participant,*** name and address of each alternate recipient covered by the order, a description of the coverage to be provided by the group health plan or the manner in which such coverage is to be determined, the period of coverage that must be provided, and each plan to which such order applies.

Any such QMCSO or NMSN shall not require the ***Plan*** to provide any type or form of benefits, or any option, that it is not already offering except as necessary to meet the requirements of a state medical child support law described in Section 1908 of the Social Security Act as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1983 (OBRA '93).

Upon determination that a medical child support order is a QMCSO or NMSN, the ***Plan*** must recognize the QMCSO or NMSN by providing benefits for the ***participant's*** child in accordance with such order.

NOT AN EMPLOYMENT CONTRACT

By creating this ***Plan*** and providing benefits under the ***Plan,*** the ***employer*** in no way guarantees employment for any ***employee***. Participation in this ***Plan*** shall in no way assure continued employment with the ***employer***.

TAX EFFECTS

Neither the ***employer*** nor the ***plan administrator*** makes any warranty or other representation as to whether any payments made hereunder will be treated as includable or excludible in gross income for federal or state income tax purposes.

ADDRESSES, NOTICE AND WAIVER OF NOTICE

Each ***participant*** shall furnish the ***employer*** with his correct post office address. Any communication, statement or notice addressed to a ***participant*** at his last post office address as filed with the ***employer*** will be binding on such person. The ***employer*** or ***plan administrator*** shall be under no legal obligation to search for or investigate the whereabouts of any person benefiting under this ***Plan.*** Any notice required under the ***Plan*** may be waived by such person entitled to such notice.

SEVERABILITY

In any case where any provision of the ***Plan*** is held to be illegal or invalid, such illegality or invalidity shall apply only to that part of the ***Plan*** and shall not apply to any remaining provisions of the ***Plan,*** and the ***Plan*** shall be construed as if such illegal or invalid provision had never existed under the ***Plan.***

ADOPTION

Wente Family Estates has caused this Wente Family Estates Health Reimbursement Arrangement (HRA) Plan (***Plan***) to take effect as of the first day of January 1, 2021, at Livermore, CA. I have read the document herein and certify the document reflects the terms and conditions of the employee welfare benefit plan as established by Wente Family Estates.

BY:_____ DATE: _____