GEN GROUP WELFARE BENEFITS PLAN

Plan Document

and

Summary Plan Description

Amended and Restated Effective

January 1, 2024

This document, together with the attached documents, constitutes the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102.

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1. INTRODUCTION

Symantec Corporation previously established and maintained the Symantec Corporation Group Welfare Benefits Plan. In 2019, Symantec Corporation sold a portion of its assets and changed its corporate name to NortonLifeLock Inc. ("NortonLifeLock"). Effective November 4, 2019, all references to Symantec Corporation were changed to NortonLifeLock and the name of the Symantec Corporation Group Welfare Benefits Plan changed to the NortonLifeLock Group Welfare Benefits Plan. In 2022, NortonLifeLock changed its corporate name to Gen Digital Inc. ("Gen"). Effective November 7, 2022, all references to NortonLifeLock were changed to Gen and the name of the NortonLifeLock Group Welfare Benefits Plan changed to the Gen Group Welfare Benefits Plan (the "Plan").

The Plan is hereby amended and restated effective January 1, 2024. The Plan is maintained exclusively to provide certain specified health and welfare benefits, as described in this instrument and the documents incorporated herein, to eligible Employees of Gen, and to their eligible spouses, domestic partners, and Qualifying Dependents.

The Plan and the Benefit Programs are a single plan for purposes of ERISA. This Plan is sometimes referred to as a "wrap plan", because it takes all of the different health and welfare benefit programs offered by Gen and wraps them up into one unified and bundled plan—the Gen Group Welfare Benefits Plan. In order to understand the idea and structure of the Plan, it may be helpful to visualize the wrap plan as an umbrella, with each specific health and welfare benefit program that is offered by Gen being viewed as a spoke in the umbrella that represents the overall Plan.

Each of the specific health or welfare benefit programs that is a part of this Plan is listed in Appendix A (attached to this Plan). They are called "Benefit Programs" throughout this Plan document, and they are specifically incorporated into this Plan by reference. Appendix A, and each of the Benefit Programs, may be changed or replaced from time to time without formal amendment to this Plan document.

This Plan document, together with Appendix A and each of the Benefit Programs, constitute the entire plan document required by Section 402 of ERISA and the summary plan description for each of the Benefit Programs as required by ERISA Section 102. Any benefits that are subject to ERISA but which are not "qualified benefits" under Code Section 125 are incorporated herein for purposes of satisfying Section 402 of ERISA but shall not be construed as being part of the Benefit Program that is a Code Section 125 cafeteria plan. Nothing herein shall be deemed to create, convey or impose any rights or obligations under ERISA with respect to any benefit offered under the Benefit Program that is a Code Section 125 cafeteria plan, to the Benefit Program that is a dependent care flexible spending account, or to the extent that ERISA does not otherwise apply to such benefit.

This Plan document supersedes any other summary plan descriptions for the Plan. This Plan document shall generally control and prevail in the event of any discrepancies or differences in interpretation between the terms, conditions or language in this Plan document, and in the terms, conditions or language contained in any other documents that comprise part of a Benefit Program

or in any information provided by the personnel of Gen or any of its agents in connection with the administration of the Plan or any of the Benefit Programs.

Gen reserves the right to unilaterally, at any time and at its sole and absolute discretion, amend, supplement, modify or eliminate the Plan in its entirety, any Benefit Program, or any Benefit described in this document.

2. GENERAL INFORMATION ABOUT THE PLAN

Plan Name: Gen Group Welfare Benefits Plan

Plan Sponsor: Gen Digital Inc.
ATTN: Benefits Department
60 East Rio Salado Parkway
Suite 1000
Tempe, AZ 85281

Employer Identification Number: 77-0181864

Plan Number: 501

Type of Plan: Employee welfare benefit plan, providing various health and other welfare benefits. The Plan also includes a health flexible spending account, a dependent care flexible spending account, and a cafeteria plan under Code Section 125.

Type of Administration: The Plan is administered by Gen, but Gen has delegated day-to-day responsibility for administration of each of the Benefit Programs, including claims administration responsibilities, to insurance companies and/or third-party administrators, as indicated on Appendix A.

Plan Administrator: Gen Digital Inc.
60 East Rio Salado Parkway
Suite 1000
Tempe, AZ 85281

Agent for Service of Legal Process: Service for legal process may be made upon the Plan Administrator.

Source of Contributions: The costs for any fully-insured Benefits are paid by insurance premiums, which are paid by Gen's contributions from its general assets, by Employees' contributions (generally through pre-tax payroll deductions under the Benefit Program that is a cafeteria plan under Code Section 125), or by a combination of these. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the Benefit Programs, as applicable.

The costs for any self-insured Benefit Programs are paid by Gen's contributions from its general assets, by Employees' contributions (generally through pre-tax payroll deductions under the Benefit Program

that is a cafeteria plan under Code Section 125), or by a combination of these.

Funding Medium: Some Benefits under the Plan are fully-insured and some are self-insured. This information is contained in the summary of each Benefit Program and is also reflected in the description of each Benefit Program that appears on Appendix A.

To the extent that any Benefit Program provides benefits that are fully-insured, the insurance companies and the health maintenance organizations providing the benefits (and not Gen) are responsible for paying claims with respect to benefits under that Benefit Program.

To the extent that any Benefit Program provides benefits that are self-insured, Gen is responsible for paying claims out of the general assets of Gen.

Participant benefit accounts under the Plan, if any, are merely bookkeeping entries. No assets or funds are ever paid to, held in or invested in any separate trust or account, and no interest is paid on or credited to any benefit account. No assets shall be segregated for the purpose of providing benefits under the Plan.

Plan Year: The Plan Year is January 1 to December 31, so that December 31 is the end of the year for purposes of maintaining the Plan's fiscal records.

3. DEFINITIONS

The following terms, when capitalized, shall have the following meanings, unless a different meaning is clearly required by the context. Words and phrases not defined in this Section shall have the meaning set forth in an applicable Benefit Program, and if not defined in an applicable Benefit Program, then such words and phrases shall have the meaning customarily given them by the applicable insurance company or other service provider, as the case may be. Masculine pronouns include the feminine, plural nouns include the singular, and vice versa, except where the context indicates otherwise.

ACA means the Patient Protection and Affordable Care Act of 2010 (as amended by the Health Care and Education Reconciliation Act of 2010).

Adverse Benefit Determination means the denial of a claim, in whole or in part. With respect to a Medical Plan, **Adverse Benefit Determination** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including (a) any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Covered Person's eligibility to participate, (b) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, (c) a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate, and (d) any Rescission of coverage (whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at the time). With respect to a claim for disability benefits filed on or after April 2, 2018, Adverse Benefit Determination includes a Rescission of coverage.

Benefit means a health and welfare option available to eligible Employees and to their eligible spouses, domestic partners and Qualifying Dependents, on an elective or non-elective basis, as further described herein and in the Benefit Programs.

Benefit Program means a plan or arrangement underlying the Plan that describes a benefit made available to Covered Persons. Such Benefit Programs are specifically incorporated into this Plan by reference and may include, without limitation: (i) any self-insured coverage or administrative services only, claims services only, third party administration, preferred provider or health maintenance organization contracts; (ii) any group insurance program or programs, insurance policies, documents, or arrangements; (iii) any level of life, disability, or accidental death or dismemberment insurance; (iv) any Code Section 125 cafeteria plan; or (v) any other insurance or coverage selected by or provided by Gen for inclusion in this Plan.

Claims Administrator means, with respect to each Benefit Program, the entity appointed by Gen to receive and review claims for benefits under the Plan, to determine what amount, if any, is due and payable, to make appropriate disbursements to persons entitled to benefits thereunder, and to review and determine denied claims. The Claims Administrator may be Gen, an insurance company, a health maintenance organization, a third-party administrator, or another similar entity.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and any regulations or interpretations issued thereunder.

Code means the Internal Revenue Code of 1986, as amended, and any regulations or interpretations issued thereunder.

Covered Person(s) means an individual who participates in, and is entitled to receive Benefits from, a Benefit Program. Covered Persons include any eligible Employees, and their eligible spouses, domestic partners and Qualifying Dependents. For purposes of Appendix B and Appendix C, where applicable, an authorized representative may act on behalf of a Covered Person.

Employee means a person who is a full-time or part-time regular employee of the Employer (as determined by the Employer). Notwithstanding the foregoing, Employee shall not include: (i) any Employee of the Employer who is a member of a collective bargaining unit covered under a collective bargaining agreement unless the collective bargaining agreement provides for the Employee's participation in the Plan; (ii) any leased employee as defined under Code Section 414(n); (iii) any person who is not classified by the Employer as a common law employee, notwithstanding the later reclassification by a court or any administrative agency of the person as a common law employee of the Employer; (iv) any person classified by the Employer as a temporary employee, seasonal employee, casual employee, fixed term employee, or intern; (v) any nonresident aliens with no U.S. source income; or (vi) any U.S. expatriate who is working for an overseas affiliate of an Employer but who is treated as a "localized worker" on the books and records of such Employer.

Employer means Gen or any affiliated or subsidiary corporation or business organization of Gen that, with the consent of Gen, shall agree to become a party to this Plan.

ERISA means the Employee Retirement Income Security Act of 1974, as amended, and the regulations and interpretations issued thereunder.

Final Internal Adverse Benefit Determination means: (i) with respect to a claims procedure under a Benefit Program, an Adverse Benefit Determination at the Benefit Program's last available level of mandatory review; (ii) an Adverse Benefit Determination under Section 5 of Appendix B or C, if applicable; or (iii) a claim for which the applicable internal claims and appeals process is deemed exhausted pursuant to 29 CFR § 2560.503-1.

FMLA means the Family and Medical Leave Act of 1993, as amended, and the regulations and interpretations thereunder.

Gen means Gen Digital Inc. and any successor entity. Gen shall be responsible for any federally mandated reporting and disclosure requirements.

Group Health Plan means any Benefit Program that provides medical care (as defined in Code Section 213(d)) to participants or beneficiaries directly or through insurance, reimbursement, or

otherwise. **Group Health Plan** does not include any Benefit Program where substantially all of the coverage is for qualified long-term care services (as defined in Code Section 7702B(c)).

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations and interpretations issued thereunder.

Medical Plan means a Group Health Plan that is subject to the group market reforms of the ACA. (For example, **Medical Plan** does not include the Cigna Global Plan, the Employee Assistance Program, the Dental Benefit Programs, the Vision Benefit Programs, or the Best Doctors program.)

Gen means Gen Digital, Inc. and any successor entity.

Plan means the Gen Group Welfare Benefits Plan as set forth herein, together with the Benefit Programs, as such Plan and the Benefit Programs may be amended from time to time.

Plan Administrator means Gen or any entity, person, or committee appointed by Gen to perform Plan Administrator duties. In the event that a Plan Administrator has not been appointed, or resigns from a prior appointment, Gen shall be deemed to be the Plan Administrator.

Plan Sponsor means Gen Digital Inc.

Plan Year means the twelve (12)-month period beginning each January 1 and ending December 31.

Qualified Medical Child Support Order or QMCSO means a medical child support order, judgment or decree (including a settlement agreement), issued by a court or through an administrative process established under state law which has the force and effect of law in that state, that (i) creates or recognizes the existence of a child's right to, or assigns to a child the right to, receive benefits for which an Employee is eligible under a Group Health Plan, and (ii) that the Plan Administrator determines to be qualified under the terms of ERISA and applicable state law. If not otherwise provided for herein, the Plan shall provide coverage to a child solely to the extent required by a QMCSO under Section 609(a) of ERISA or to an adopted child solely to the extent required by Section 609(c) of ERISA. Further, the Plan shall be interpreted and administered as necessary to comply with Section 609 of ERISA and the rulings and regulations issued thereunder. Any coverage provided as a result of a QMCSO shall be conditioned upon payment of any required contributions, if any, by the Employee.

Qualifying Dependent means an Employee's spouse (unless legally separated or divorced), domestic partner (who meets the Employer's policies and standards for status as such), or any child of the Employee or of the Employee's spouse or domestic partner, provided that the child is under the age of 27 (for Benefit Programs that are health or accident plans) or under the age of 19 (for other Benefit Programs) at the end of the taxable year. For these purposes, a "child" means a biological child, adopted child, a child placed for adoption, or a foster child. Any child whose parents are divorced shall be treated as a Qualifying Dependent of both parents for accident and health coverage. **Qualifying Dependent** includes any other individual who is the Employee's "dependent," as defined in Code Section 152. Notwithstanding the foregoing, a Benefit Program

may provide for additional Qualifying Dependents or may limit the Qualifying Dependents with respect to that Benefit Program. Gen reserves the right (i) to establish such verification procedures as it determines, in its sole discretion, are appropriate in order for Employees to provide documentation supporting the dependent status of individuals whom they claim as Qualifying Dependents under this Plan or any Benefit Program, and (ii) to appoint or contract with an independent service provider to administer such verification procedures and documentation requirements on behalf of Gen.

Rescission means a cancellation or discontinuance of coverage under a Medical Plan and that has a retroactive effect; provided, however that a cancellation or discontinuance is not a Rescission if (a) the cancellation or discontinuance of coverage has only a prospective effect; or (b) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to failure to timely pay required premiums or contributions towards the cost of coverage.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and the regulations and interpretations issues thereunder.

4. ELIGIBILITY AND PARTICIPATION REQUIREMENTS

4.1. Eligibility.

A. An individual is eligible to participate in this Plan if he is an Employee and regularly scheduled to work at least twenty (20) hours per week, or if he is otherwise a Covered Person.

B. In order to participate in any particular Benefit Program under this Plan, an individual must (i) have been designated by Gen as being eligible to participate in that particular Benefit Program; (ii) satisfy the eligibility requirements for that particular Benefit Program, including, by way of example and not limitation, any requirement for working a minimum number of hours per week; (iii) have met any applicable waiting periods set forth in that particular Benefit Program; and (iv) have satisfied the applicable enrollment requirements for that particular Benefit Program within the required time period.

C. Each Benefit Program sets forth the applicable terms and conditions for eligibility to participate, enrollment procedures, period during which participation continues, and any restrictions, limitations and additional requirements relating to a Covered Person's entitlement to benefits.

D. If an Employee's Qualifying Dependent is also an eligible Employee, both may elect coverage as an Employee or one may elect to cover the other as a Qualifying Dependent (but neither can be treated as both an Employee and a Qualifying Dependent or spouse or domestic partner at the same time). If a child is a Qualifying Dependent of two eligible Employees, only one Employee may elect coverage for that child.

E. When an Employee enrolls a Qualifying Dependent in a Benefit Program, the enrollment constitutes a representation by the Employee that: (i) the individual meets the definition of a Qualifying Dependent; (ii) the individual is eligible under the terms of the Benefit Program, and (iii) the Employee will provide evidence of eligibility on request. The enrollment also constitutes an acknowledgement by the Employee that: (i) the Benefit Program is relying on the Employee's representation of eligibility in accepting the enrollment of the Qualifying Dependent; (ii) if the Employee fails to provide evidence of eligibility when requested, that failure is evidence of fraud and material misrepresentation; and (iii) if the Employee fails to provide evidence of eligibility when requested, the Benefit Program may cancel coverage for the individual, which cancellation may be retroactive to the date as of which the individual first become ineligible, as determined by the plan administrator. Any retroactive cancellation will be subject to the Benefit Program's provisions on rescission of coverage.

F. If a Qualifying Dependent is enrolled in or covered by a Benefit Program, and if the Qualifying Dependent is not a "dependent" of the Employee as defined by Code Section 152, then to the extent required by the Code, any premiums paid by the Employer for such Qualifying Dependent shall result in imputed income to the Employee. Notwithstanding the foregoing, if the Benefit Program is an accident or health program, no income shall be imputed for a Qualifying Dependent who is the Employee's child, or who is the Employee's dependent as defined by Code Section 152 (but without regard to Code Sections 152(b)(1), 152(b)(2), or 152(d)(1)(B)).

4.2. <u>Enrollment and Election Procedures</u>.

A. <u>Enrollment of Newly-Eligible Employees (Including New Employees)</u>.

(1) Except as provided differently in a Benefit Program, a newly-eligible Employee shall be automatically enrolled in any non-elective Benefits made available under the Plan that apply to such Employee, such as short-term disability.

(2) Except as otherwise limited by subparagraph (4), below, with respect to any elective Benefits made available under the Plan, an Employee who is eligible for such Benefits must elect such Benefits within 31 days after his date of eligibility. Any such election and related salary reduction agreements shall take effect no later than the beginning of the first pay period to which the salary reduction agreement applies, and prior to the time the compensation is deemed to be received by the Employee. In no event shall an Employee's election form or salary reduction agreement apply retroactively, except to the extent permitted under the Code.

(3) An Employee who fails to enroll (or waive coverage) within 31 days of his eligibility date will be automatically enrolled in, and will pay for, the following Benefit Programs at the "employee only" coverage level:

(i) medical coverage under the Cigna HSA Plan;
(ii) dental coverage under the Delta Dental 1.0 Plan;
(iii) vision coverage under VSP 1.0 Plan;
(iv) short-term disability coverage;
(v) long-term disability coverage at 60% pretax;
(vi) basic life insurance coverage equal to two times salary; and
(vii) accidental death & dismemberment coverage equal to two times salary.

(4) Notwithstanding the foregoing, a newly-eligible Employee cannot enroll in any flexible spending account after December 1st of a given Plan Year for that Plan Year; any election by a newly-eligible Employee to enroll in a flexible spending account after December 1st of a given Plan Year will only be effective for the immediately following Plan Year.

B. Annual Open Enrollment.

(1) Prior to the beginning of each Plan Year, the Plan Administrator shall conduct an enrollment during which Employees who are otherwise eligible to receive Benefits under a Benefit Program may enroll, make new elections, or change existing elections for the next Plan Year. The deadline for enrolling and making annual elections shall be the date the Plan Administrator specifies, but in no event later than the day preceding the first day of the Plan Year to which the enrollment elections and salary reduction agreements apply.

(2) If, during the annual Open Enrollment process, an Employee fails to elect any of the elective Benefits or to complete a new salary reduction agreement relating to coverage under the Plan's elective Benefits, on or before the due date specified by the Plan Administrator, then the Employee shall be deemed to have made the same election for elective Benefits, and to have authorized salary reduction in his compensation for the appropriate costs of such elective Benefits, as was in effect just prior to the end of the preceding Plan Year. Such deemed election shall apply to all elective Benefits made available to such Employee under the Plan, except for any health flexible spending account or dependent care flexible spending account that may apply to such individual. Notwithstanding the foregoing, the Plan Administrator may require the Employee to make an affirmative election provided such requirement is communicated in advance.

C. Election Changes. An election of Benefits under the Plan, and any salary reduction agreements to pay the Employee's share of required contributions for such Benefits, are irrevocable during the entire Plan Year to which they apply, unless changed or revoked as provided below:

(1) If the Employee separates from the service of Gen during a Plan Year, the Employee may revoke his Benefit elections for the remainder of the Plan Year.

(2) The Employee may change his elections during the Plan Year, subject to the change-of-election requirements set forth in the Gen Premium-Only Plan or the Gen Flexible Benefits Plan, as

applicable. In addition, the Plan Administrator shall not be required to implement any change in Benefit elections during December.

(3) For any Medical Plan, each Employee (and his eligible spouse, domestic partner, and Qualifying Dependents) will be entitled to certain special enrollment rights, to the extent required under HIPAA. These special enrollment rights, which are explained in more detail in the documents for the Medical Plan, generally require that changes in Benefit elections be made within 31 days after the applicable event. Notwithstanding the foregoing, in the case of a newly born or newly adopted dependent or in the case of divorce, changes in Benefit elections may be made for up to 60 days after the birth, adoption, or divorce.

> ***Example:*** If an Employee gets married on August 1st, he can enroll his new spouse through midnight on August 31st. If the Employee misses that deadline, he must wait until the annual open enrollment for benefits to start January 1st of the following year.
>
> ***Example:*** If an Employee's child is born on September 1st, he can enroll his new child (and any other individuals who are entitled to a special enrollment right due to the birth of the child) through midnight on October 30th. If the Employee misses that deadline, he must wait until the annual open enrollment for benefits to start January 1st of the following year.

(4) If an Employee declines enrollment in a Medical Plan for himself or his Qualifying Dependents because of coverage under a Medicaid plan under Title XIX of the Social Security Act (a "Medicaid Plan") or under a State child health plan under Title XXI of the Social Security Act (a "State Child Health Plan"), and if eligibility for such coverage is subsequently lost, he may be able to elect coverage under a Medical Plan, provided that such Employee requests enrollment within 60 days after the termination of coverage under such Medicaid Plan or State Child Health Plan. Furthermore, if an Employee or his Qualifying Dependent becomes eligible for premium assistance under either a Medicaid Plan or a State Child Health Plan, the Employee may be able to elect coverage under a Medical Plan, provided that the premium assistance relates to the Medical plan and the Employee requests enrollment within 60 days of the date he or his Qualifying Dependent is determined to be eligible for such premium assistance.

4.3. **Coverage**. The types of coverage, the conditions to and limitations on coverage, the minimum and maximum amounts of coverage that may be elected for any Benefit for any Plan Year, and the circumstances under which coverage terminates shall be as set forth from time to time in the applicable Benefit Programs.

4.4. **Termination of Participation**.

A. The participation of an Employee in medical, dental, or vision coverage, and the participation of his eligible spouse, domestic partner or Qualifying Dependents, will terminate on the last day of the month in which he terminates employment with Gen. Except as otherwise specifically provided by any Benefit Program, the participation of an Employee in the Plan other than for medical, dental, or vision coverage, and the participation of his eligible spouse, domestic partner or Qualifying Dependents, will terminate on the last day for which he performs services for Gen. Coverage may also terminate (1) if the Employee or other Covered Person fails to pay his share of any applicable premium; (2) if the Employee's hours drop below any required hourly threshold; (3) if any Covered Person submits false claims (to the extent provided in any Benefit Program); (4) if the Plan terminates; or (5) if a Benefit Program in which a Covered Person is enrolled terminates. The participation of a Covered Person in the Plan or in any Benefit Program may also be terminated for any other reason as set forth in any Benefit Program. The applicable Benefit Program should be consulted for further details regarding specific termination events and information. In no event, however, will a Covered Person's coverage under a Medical Plan be Rescinded unless (a) the Covered Person (or a person seeking coverage on behalf of the Covered Person) performs an act, practice or omission that constitutes fraud; or (b) the Covered Person (or a person seeking coverage on behalf of the Covered Person) makes an intentional misrepresentation of material fact. In no case will coverage be Rescinded without providing at least thirty (30) days prior written notice.

B. An Employee on an approved disability leave may no longer be considered to satisfy any minimum hours or active employment requirements under the Benefit Programs in which he or she is enrolled, and coverage under each such Benefit Program may be terminated, subject to the terms and conditions of such Benefit Programs if the Employee is terminated from employment with Gen. As noted above, Gen's COBRA administrator will provide the Employee with COBRA information. The Plan Administrator intends to retain the sole discretion as to when an Employee on an approved disability leave is no longer eligible for Benefit Programs and is terminated from employment.

C. Termination of participation with respect to a specific Benefit automatically cancels the Employee's required contributions, whether through a salary reduction agreement or otherwise, effective as of the date his participation terminates.

4.5. <u>Reinstatement of Participation</u>.

A. If a former Employee returns to service with Gen within 30 days of his termination date and during the same Plan Year, his Benefit elections will be automatically reinstated for the remainder of the Plan Year, provided that he is still eligible to receive Benefits under the terms of each Benefit Program in which he is enrolled, unless the Employee (or his eligible spouse, domestic partner or Qualifying Dependents) has experienced a qualifying change in status or a HIPAA special enrollment right (as described in Paragraph C of Section 4.2 of this Plan), in which case applicable changes in Benefit elections may be made within 31 days of the Employee's rehire date.

B. If a former Employee returns to service with Gen more than 30 days after his termination date and during the same Plan Year, such individual may make a new Benefit election for the remainder of such Plan Year within 31 days of his rehire date.

C. Except to the extent otherwise specifically provided under any Benefit Program, an Employee who returns from an approved leave of absence during the same Plan Year is automatically reinstated in all Benefit elections in effect when Plan coverage was suspended (except for any election to participate in a dependent care flexible spending account), provided that the Employee is still eligible to receive Benefits under the terms of each applicable Benefit Program.

D If an Employee returns to service with Gen following termination or returns from an approved leave of absence during a different Plan Year, the Employee's Benefit Elections from the prior Plan Year will not be automatically reinstated, but the Employee shall be eligible to make a new Benefit election for the remainder of such different Plan Year for all applicable Benefit Programs, to the extent that the Employee is eligible to receive Benefits under the terms of such Benefit Programs.

E The Plan Administrator shall have the authority to seek repayment of any required contributions that an Employee failed to pay during a leave of absence, to the extent permitted under applicable law.

5. SUMMARY OF PLAN BENEFITS

5.1. **Description of Plan Benefits**. The Plan provides eligible Employees, and their eligible spouses, domestic partners and Qualifying Dependents, with certain non-elective Benefits, and with the opportunity to choose certain elective Benefits provided under each of the Benefit Programs. Benefits provided under the Plan are set forth in the Benefit Programs, and are subject to such terms, conditions, and limitations of such Benefit Programs, as the same may be modified from time to time. Each eligible Employee may elect to receive coverage under one or more of the Benefit options for himself, and his eligible spouse, domestic partner and/or Qualifying Dependents, to the extent provided in the Benefit Programs.

5.2. **Contributions**.

A. The cost of the Benefits provided through the Benefit Programs will be funded in part by Gen contributions and in part by Employee contributions (generally through pre-tax payroll deductions under the Benefit Program that is a Code Section 125 cafeteria plan) or as Gen shall determine from time to time. Gen will determine and periodically communicate the Employee's share of the cost of the Benefits provided through each Benefit Program, and it may change that determination at any time.

B. The amount of Gen contributions and Employee contributions shall be determined by Gen, after taking into account (i) the actuarially determined liability required to provide various Benefits under the Plan; (ii) the fees and expenses of any insurance companies or administrative services organizations for the provision of Benefits and performance of duties under the Plan; (iii) administrative and other expenses of the Plan; (iv) the Benefits due and owing under the Plan in accordance with the Benefit Programs; and (v) such other expenses as may be considered from time to time by Gen.

C. With respect to any Benefits under a Benefit Program that is fully-insured, Gen will pay its contributions and the aggregate contributions of all Employees to the appropriate insurance company or health maintenance organization.

D. With respect to any Benefits under a Benefit Program that is self-insured, Gen will use its contributions and the aggregate contributions of all Employees to pay benefits directly to those persons or entities entitled to such payments under the terms of such Benefit Program.

E. Notwithstanding any provision of the Plan or of any Benefit Program to the contrary, no assets shall be segregated for the purpose of providing Benefits under the Plan. Gen shall pay any insurance premiums necessary for the purchase of Benefits provided under a fully-insured Benefit Program, and

all Benefits provided under a self-insured Benefit Program, out of the general assets of Gen.

5.3. Sources of Benefits.

A. Fully-Insured Benefits. With respect to Benefits provided under a Benefit Program that is fully-insured under an insurance policy or contract, an individual or entity who claims the right to any payment with respect to such Benefits shall be entitled to receive only the insured Benefit for which provision is actually made under such insurance policy or contract. Each individual or entity shall be entitled to look only to the insurance policies or contracts for payment of any such Benefit and shall not have any rights, claim or demand therefor against Gen, the Plan Administrator, or any Employee, officer or director of Gen. Gen does not assume any liability or responsibility whatsoever for any insured Benefit that is provided under the Plan or under any Benefit Program. In the event of a conflict between the terms of an insurance contract and any other terms of the Plan, the terms of any insurance policy or contract shall govern.

B. Self-Insured Benefits. With respect to Benefits provided under a Benefit Program that is self-insured, Gen's general assets shall be the sole source of payment for such Benefits. Gen assumes no liability or responsibility for payment of such Benefits beyond that which is provided in this Plan or under the terms of any such Benefit Program. Each individual or entity shall be entitled to look only to the terms of this Plan and the Benefit Program for payment of any such Benefit and shall not have any rights, claims or demand therefor against Gen or any Employee, officer or director of Gen.

5.4. Special Provisions and Disclosures for Group Health Plans.

A. General Statement of Compliance**.** With respect to each Benefit Program that is a group health plan, the Plan will provide Benefits in accordance with, and subject to, the applicable requirements of all applicable laws, including, but not limited to, COBRA, HIPAA, USERRA, FMLA, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, the Newborns' and Mothers' Health Protection Act of 1996, the Women's Health and Cancer Rights Act of 1998, and the Genetic Information Nondiscrimination Act of 2008, and ACA, all of which requirements are incorporated herein by reference.

B. COBRA Continuation Rights. If coverage under a Group Health Plan ceases because of certain "qualifying events" specified in COBRA, then the individuals who have ceased to have such coverage may have the right to purchase continuation coverage for a temporary period of time, provided that they timely pay the applicable premium for such continuation coverage.

The Plan Administrator may elect to treat all Benefit Programs that provide medical coverage, dental coverage, and prescription drug coverage as a single "plan" for purposes of COBRA, and any Benefit Program that provides a health flexible spending account as a separate "plan" for purposes of COBRA.

(1) Qualifying Events. A Covered Person may elect continuation coverage only if he is covered under a Group Health Plan immediately prior to a "qualifying event" and loses that coverage because of that "qualifying event." The definition of a qualifying event differs for Employees, their spouses and domestic partners, and their Qualifying Dependent children.

(a) Qualifying Events for Employees. An Employee covered by a Group Health Plan may be entitled to elect continuation coverage if he loses that coverage (or, in some cases, if his required premium payments or contributions for coverage increase) for either of the following reasons:

- A termination of employment (for reasons other than gross misconduct); or
- A reduction in hours of employment.

(b) Qualifying Events for Spouses and Domestic Partners. If an Employee's spouse or domestic partner is covered under a Group Health Plan , he may be entitled to elect continuation coverage if he loses that coverage (or, in some cases, if required premium payments or contributions for coverage increase) for any of the following reasons:

- The Employee's termination of employment (for reasons other than gross misconduct);
- The Employee's reduction in hours of employment;
- The Employee's death;
- Divorce or legal separation from the Employee, or the domestic partner's loss of status as the Employee's domestic partner; or
- The Employee becomes entitled to Medicare (Part A or B).

(c) Qualifying Events for Qualifying Dependent Children. If an Employee's Qualifying Dependent child is covered under a Group Health Plan, the child may be entitled to elect continuation coverage if the child loses that coverage (or, in some cases, if required premium payments or contributions for coverage increase) for any of the following reasons:

- The Employee's termination of employment (for reasons other than gross misconduct);
- The Employee's reduction in hours of employment;
- The Employee's death;
- The Employee's divorce from their spouse or the domestic partner's loss of status as the Employee's domestic partner;
- The Employee becomes entitled to Medicare (Part A or B); or
- The child ceasing to be an eligible "dependent" under the Group Health Plan.

A child born to or placed for adoption with an Employee during the continuation coverage period may also elect continuation coverage.

(2) Notification Requirements for Covered Employees, Persons, and Dependents. Under the law, an Employee, his spouse, domestic partner, or another family member has the responsibility to inform Gen of a divorce, legal separation, a domestic partner losing "domestic partner" status, or a Qualifying Dependent losing "dependent status" under a Group Health Plan. This notification must be made in writing within 60 days from the later of: (i) the date of the qualifying event (*i.e.*, the divorce or child losing dependent status), or (ii) the date that coverage would otherwise cease because of the qualifying event. It must be sent to:

Gen (c/o Businessolver, Inc.)
ATTN: COBRA Administration
PO Box 850512
Minneapolis, MN 55485-0512

If this written notification is not made in a timely manner, then the right to continuation coverage will be forfeited.

Gen will notify Covered Persons of their right to elect continuation coverage as the result of a termination, reduction in hours of employment, death or Medicare entitlement.

(3) Election Period. A covered Employee, spouse, domestic partner, or child who experiences a qualifying event is known as a "qualified beneficiary." Each qualified beneficiary has a separate and independent election right and may elect continuation coverage within 60 days from the later of: (i) the date of the COBRA election letter, or (ii) the date coverage would otherwise cease because of the

qualifying event. This is the maximum election period. If a qualified beneficiary does not elect continuation coverage within this period, all rights to elect continuation coverage will end.

Special Second Election Period for TAA-Eligible Employees Who Did Not Elect COBRA. Certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period of 60 days or less. This special second election must be made within six months after plan coverage is lost. If you are an employee or former employee and you qualify for TAA or ATAA, CONTACT THE GEN BENEFITS DEPARTMENT PROMPTLY AFTER QUALIFYING FOR TAA OR ATAA OR YOU WILL LOSE ANY RIGHT THAT YOU MAY HAVE TO A SPECIAL SECOND ELECTION PERIOD.

If a qualified beneficiary elects to continue coverage and pays the applicable premium, then Gen is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the Group Health Plan to similarly situated active employees, including the opportunity to choose among options during an open enrollment period. If coverage is changed or modified for similarly situated active employees, then continuation coverage may be similarly changed and/or modified.

(4) Duration of Continuation of Coverage. The maximum duration of continuation coverage will depend on the qualifying event.

(a) 18-month period. If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in employment hours, then each qualified beneficiary will have the opportunity to continue coverage for up to 18 months.

(i) Disability extension. The 18-month period may be extended to 29 months if the Social Security Administration determines that, according to Title II or XVI of the Social Security Act, a qualified beneficiary was disabled during the first 60 days of continuation coverage, or in the case of a child born to or placed for adoption with a covered employee during a COBRA coverage period, during the first 60 days after a child's birth or placement for adoption.

All qualified beneficiaries with respect to the same qualifying event as the disabled qualified beneficiary are entitled to the extension. It is the disabled qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration, and the responsibility of any of the related qualified beneficiaries to provide a copy of the determination letter to Gen within 60 days of the date of determination and before the original 18 months of continuation coverage ceases. It must be sent to:

Gen (c/o Businessolver, Inc.)
ATTN: COBRA Administration
PO Box 850512
Minneapolis, MN 55485-0512

If there is a final determination that the qualified beneficiary is no longer disabled, Gen must be notified in writing by the qualified beneficiary or a related qualified beneficiary within 30 days of the determination. It must be sent to:

Gen (c/o Businessolver, Inc.)
ATTN: COBRA Administration
PO Box 850512
Minneapolis, MN 55485-0512

Any coverage extended beyond the maximum that would otherwise apply will be terminated for all qualified beneficiaries.

(ii) Secondary events. An extension may also occur if during the initial 18 months of continuation coverage, a second qualifying event occurs (*e.g.*, divorce, legal separation, death, entitlement to Medicare, or loss of status as a dependent child, and the event would have caused a loss of coverage had the first qualifying event not occurred). If these two requirements are met, then the 18 months of continuation coverage may be extended to 36 months. If a second event occurs, it is the qualified beneficiary's obligation to notify Gen in writing of the event within 60 days of the event and within the original 18-month period. It must be sent to:

Gen (c/o Businessolver, Inc.)
ATTN: COBRA Administration
PO Box 850512
Minneapolis, MN 55485-0512

In no event, however, will continuation coverage last beyond three years.

(b) 36-month period. If the original qualifying event causing the loss of coverage was the death of the Employee, divorce, legal separation, Medicare entitlement, or loss of status as a dependent child, then each qualified beneficiary will have the opportunity to elect up to 36 months of continuation coverage.

(5) Eligibility. A qualified beneficiary does not have to show that he is insurable to elect continuation coverage. Gen reserves the right to verify eligibility and terminate continuation coverage retroactively if the Covered Person is determined to be ineligible or if there has been a material misrepresentation of the facts.

(6) Premiums. A qualified beneficiary will be required to pay up to 102% of the applicable premium for active employees. The premium may be adjusted in the future if the applicable premium amount changes. In addition, if the continuation period is extended beyond 18 months due to a disability determination by the Social Security Administration, Gen may charge up to 150% of the applicable premium during the extended period for the disabled qualified beneficiary and any nondisabled qualified beneficiaries in the disabled beneficiary's coverage group.

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance. Under the tax provisions, eligible individuals can either take credit when they file their federal income taxes or get advance payment of 72.5% of premiums paid for qualified health insurance, including COBRA continuation coverage. More information about the tax credits and premiums payments is available at https://www.irs.gov/credits-deductions/individuals/hctc

Initial premium payments must be made within 45 days of the date continuation coverage is elected. Subsequent premium payments must be made monthly and are due on the first of each month. There is a grace period of 30 days for the regularly scheduled monthly premiums. This is the maximum grace period under the plan.

Failure to submit all premium payments by the end of the grace period will result in loss of the right to further continuation coverage.

(7) Conversion. At the end of the continuation coverage period, a qualified beneficiary will be given the option to enroll in an individual conversion health plan within 180 days, if such conversion plan is available.

(8) Termination of Continuation Coverage. The law allows continuation coverage to be terminated prior to the maximum continuation period for any of the following reasons:

- Gen ceases to provide group health coverage to any of its employees;
- Any required premium is not paid in a timely fashion;
- A qualified beneficiary becomes covered, after the date on which COBRA was elected, under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary (other than an exclusion or limitation that may be disregarded under law);
- A qualified beneficiary becomes entitled to Medicare after the date of the COBRA election;
- A qualified beneficiary who has extended coverage due to a disability is determined by the Social Security Administration to be no longer disabled;
- A qualified beneficiary notifies Gen that he wishes to cancel continuation coverage; or
- For cause, such as fraudulent claim submission, on the same basis that coverage could terminate for similarly situated active employees.

(9) Health Flexible Spending Account. If an Employee wishes to elect COBRA continuation coverage for his health flexible spending account, he must indicate this on the COBRA election form that he receives after the qualifying event. **Please note that the premiums for this coverage must be paid on an after-tax basis.**

The COBRA General Notice for the Health Flexible Spending Account can be found in an appendix to the Gen Flexible Benefits Plan.

C. USERRA Continuation Rights. Continuation and reinstatement rights may also be available if an Employee is absent from employment due to

uniformed services pursuant to USERRA. More information about coverage under USERRA is available from the Plan Administrator.

D. Qualified Medical Child Support Orders. A Medical Plan will provide benefits as required by any Qualified Medical Child Support Order in accordance with the requirements of Sections 609(a) and 609(c) of ERISA. Each Benefit Program that is a group health plan has detailed procedures for determining whether an order qualifies as a QMCSO, which can be obtained, without charge, from the Plan Administrator.

E. Newborns' and Mothers' Health Protection Act of 1996. Under federal law, a Medical Plan must not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, a Medical Plan may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods. The physician or provider may need to obtain advance approval from the specific Medical Plan for any stay beyond 48 or 96 hours in order to avoid any reduction in benefits.

F. Women's Health and Cancer Rights Act of 1998. If a Medical Plan covers mastectomies, and a Covered Person is eligible for mastectomy-related benefits, then the Medical Plan must also provide coverage for:

(1) Reconstruction of the breast on which mastectomy has been performed;

(2) Surgery and reconstruction on the other breast to produce a symmetrical appearance;

(3) Prostheses;

(4) Treatment of physical complications of all states of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under the applicable Medical Plan. Coverage is subject to applicable deductibles, copayments and coinsurance payments as provided under the applicable Medical Plan.

G. HIPAA Privacy and Security Rules. For purposes of this Paragraph G, a "HIPAA Group Health Plan" means a Group Health Plan that is subject to HIPAA's medical privacy and security rules, which are codified at 45 Code of Federal Regulations Parts 160 and 164, Subparts A and E (the "Privacy and Security Rules"). The Privacy and Security Rules require each HIPAA Group Health Plan to preserve the confidentiality of protected health information, or "PHI." PHI is health information that can be linked to a specific individual. It includes, for example, information about the health care received by an individual and the amount paid for such care. All capitalized terms that are used in this Paragraph H that are not otherwise defined by the provisions of the Plan or this Paragraph shall have the same meaning as given under HIPAA and the Privacy and Security Rules.

As described in the Notice of Privacy Practices, a HIPAA Group Health Plan will not use or disclose PHI, except as necessary to administer such plan (including performing treatment, payment and health care operations) or any organized health care arrangement in which the plan participates, or as otherwise permitted or required by law.

With regard to each HIPAA Group Health Plan, Gen will:

(1) Not use or further disclose PHI other than as permitted or required by the Privacy and Security Rules.

(2) Ensure that any agent, subcontractor, or other party with whom it shares PHI will agree to the same, or substantially similar, restrictions and conditions that apply to Gen with respect to PHI. To be considered substantially similar, those restrictions and conditions must meet the requirements of the Privacy and Security Rules.

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or benefit plan of Gen.

(4) Report to the HIPAA Group Health Plan any use or disclosure of PHI that it becomes aware of that is inconsistent with the Privacy and Security Rules or the plan's Notice of Privacy Practices.

(5) Make available to each individual covered under the HIPAA Group Health Plan his PHI so that he may exercise his rights under HIPAA, including seeing and copying his PHI, receiving an accounting of certain of its disclosures and, under certain circumstances, amending the information. These rights are more fully explained in the Notice of Privacy Practices for the HIPAA Group Health Plan.

(6) Make Gen's internal practices, books, and records relating to the use and disclosure of PHI received from such Benefit Program available to the Secretary of the U.S. Department of Health and Human Services, charged with the enforcement of the Privacy and Security Rules, for purposes of determining compliance with the Privacy and Security Rules. Providing this information to the Secretary will not waive any attorney-client, accountant-client, or other legal privilege or the work product rule.

(7) If feasible, return or destroy all PHI received from the HIPAA Group Health Plan when it is no longer needed. If this is not possible, Gen will limit further uses and disclosures of it to those purposes that meet the requirements of the Privacy and Security Rules and that make the return or destruction of the information infeasible.

(8) Ensure that there is adequate separation between functions that Gen performs in its capacity as employer or plan sponsor, and plan administration functions that Gen performs for the HIPAA Group Health Plan.

Employees are only given access to, and may only use and disclose PHI for, plan administration purposes. Any Employee who uses or discloses PHI for a purpose other than plan administration or as permitted or required by law will be subject to disciplinary action and sanctions, up to and including termination, in accordance with Gen's policies.

The following provisions apply to uses and disclosures of Electronic Protected Health Information ("Electronic PHI"):

(1) As a condition for obtaining Electronic PHI from each HIPAA Group Health Plan and its Business Associates, Gen agrees that it will:

(a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of each HIPAA Group Health Plan.

(b) Ensure the adequate separation between the HIPAA Group Health Plan and Gen, as required by 45 CFR Section 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.

(c) Ensure that any agent, subcontractor and other party to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information.

(d) Report to the HIPAA Group Health Plan any Security Incident of which it becomes aware.

(2) Notwithstanding anything to the contrary in this Paragraph G, this Paragraph H and the Privacy and Security Rules do not apply to the following:

(a) Information about whether an individual is participating in the Plan or any HIPAA Group Health Plan; and

(b) Summary Health Information, provided that Gen requests Summary Health Information for the purpose of obtaining premium bids providing insurance coverage under this Plan or any HIPAA Group Health Plan Program; or modifying, amending or terminating this Plan or any HIPAA Group Health Plan, all as permitted by the Privacy and Security Rules.

Questions about the Privacy and Security Rules or about the Notice of Privacy Practices issued by each Benefit Program that is a group health plan subject to HIPAA can be directed to the Plan Administrator.

5.5. <u>FMLA and Non-FMLA Leaves of Absence</u>.

A. <u>FMLA Leaves of Absence</u>.

(1) If an Employee goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, Gen will continue to maintain the Employee's coverage under a Group Health Plan, on the same terms and conditions as if the Employee were still active (that is, Gen will continue to pay its share of the premium to the extent that the Employee opts to continue coverage and continues to provide his or her share of any applicable premium payments). Gen may elect to continue all Group Health Plan coverage for Employees while they are on paid leave (so long as Employees on non-FMLA paid leave are required to continue coverage). If so, the Employee who is on FMLA leave will pay his share of the premiums by the method normally used during any paid leave (for example, on a pre-tax salary reduction basis if that is what was used before the FMLA leave began). Group Health Plan coverage will end when the

Employee ceases to pay his or her share of any applicable premiums for such coverage.

(2) If an Employee is going on unpaid FMLA leave and the Employee opts to continue his Group Health Plan coverage, then the Employee may pay his share of the premium in one of three ways: (a) with after-tax dollars while on leave; (b) by pre-paying all or a portion of the Employee's share of the premium for the expected duration of the leave, either with after-tax dollars or on a pre-tax salary reduction basis out of his pre-leave compensation, including unused sick days and vacation days (to pre-pay in advance, the Employee must make a special election before such compensation would normally be available to him)(note that pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon between the Employee and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from the Employee's compensation upon his return from leave).

(3) If the Employee's Group Health Plan coverage ceases while on FMLA leave (*e.g.*, for non-payment of required contributions), the Employee will be entitled to reinstatement of his Group Health Plan coverage upon return from such leave, on the same basis as before the leave, or as otherwise required by the FMLA. The Employee is entitled to have coverage for such Group Health Plans automatically reinstated so long as coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave. But despite the preceding sentence, with regard to Benefit Program that provides a health flexible spending account, if coverage ceased during FMLA leave, the Employee will be entitled to elect whether to be reinstated in the health flexible spending account at the same coverage level as in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which the Employee did not pay premiums. If the Employee elects the pro-rata coverage, the amount withheld from the Employee's compensation on payroll-by-payroll basis for the purpose of paying for reinstated health flexible spending account benefits will equal the amount withheld before FMLA leave.

(4) While on FMLA leave, the Employee cannot continue to participate in any Benefit Program that is a dependent care flexible spending account. With respect to any Benefit program that is not a dependent care flexible spending account or a Group Health Plan: coverage for an Employee who is commencing or returning from FMLA leave

will be treated in the same way as coverage for an Employee who is commencing or returning from non-FMLA leave. If an Employee is permitted to keep coverage but discontinue contributions while on leave, then upon returning from leave, the Employee will be required to repay any contributions not paid by the Employee during leave. Payment will be withheld from the Employee's compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Employee, or as the Plan Administrator otherwise deems appropriate.

B. Non-FMLA Leaves of Absence.

(1) If an Employee goes on an unpaid non-FMLA leave of absence, then with respect to any Benefit Program in which the Employee is participating prior to the leave and in which the Employee's eligibility is not affected by the leave, the Employee will continue to participate in the Benefit Programs. In such cases, the Employee's contributions for the leave period will be paid by pre-payment before going on leave, after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. Further details describing the Benefits provided to an Employee who goes on an unpaid leave are set forth in applicable Benefit Programs.

(2) If an Employee goes on a paid non-FMLA leave of absence, then with respect to any Benefit Program in which the Employee is participating prior to the leave and in which the Employee's eligibility is not affected by the leave, the Employee will continue to participate in the Benefit Programs. In such cases, the Employee's contributions for the leave period will be paid by pre-tax contributions while on leave. Further details describing the Benefits provided to an Employee who goes on a paid leave are set forth in applicable Benefit Programs.

6. CIRCUMSTANCES WHICH MAY AFFECT BENEFITS

6.1. **Denial or Loss of Benefits**. Benefits under the Plan or any of its Benefit Programs will cease when an individual's participation in the Plan or any of such Benefit Programs terminates. Benefits will also cease on termination of the Plan. Other circumstances can result in the termination, reduction or denial of benefits—for example, failure to obtain precertification for certain procedures covered under a Benefit Program. The particular Benefit Program should be consulted for additional information on other specific events that could cause the reduction or termination of Benefits.

6.2. **Amendment or Termination of Plan**.

A. The Plan has been established with the intention of it being maintained for an indefinite period of time; however, Gen, in its sole and absolute discretion, may amend or terminate this Plan or any provision of the Plan, including any Benefit Program, at any time, or any policies, contracts or arrangements with any insurance carriers, administrative service organizations, or other persons or entities. The Plan may be amended or terminated by a written instrument duly adopted by Gen or any of its duly-authorized delegates, and such amendment shall be binding on all affiliates.

B. No termination or amendment shall operate to reduce the amount of any benefit payment under the Plan or any Benefit Program for charges incurred prior to the effective date of such termination or amendment; however, nothing in this Plan shall be construed to require the continuation of the Plan or any Benefit Program with respect to existing or future participants or their beneficiaries.

C. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. To the extent that any Plan assets remain, they will be used for the benefit of Employees and Covered Persons in accordance with ERISA.

6.3. **Subrogation and Reimbursement**. This Section 6.3 applies to any Benefit Program which is self-insured (see Appendix A). In the event of a conflict between the provisions of this Section and the provisions of a Benefit Program, whichever provisions provide the greatest rights to the Benefit Program shall govern.

A. Definitions.

(1) "Covered Expenses" means expenses that would be covered by a Benefit Program and are on account of an injury, illness, or condition caused by the actions or omissions of a Third Party.

(1) "Recover," "Recovered," "Recovery" or "Recoveries" means all moneys paid to the Covered Person to compensate for all losses due to injury or illness resulting from the actions or omissions of a Third Party, whether or not those losses reflect expenses covered by the Benefit Program. These terms include all moneys paid by way of judgment, settlement, or otherwise. These terms include but are not limited to, moneys for medical, dental, or vision expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other form of damages or compensation whatsoever.

(2) "Reimbursement" means repayment to a Benefit Program for Benefits that the Benefit Program has paid toward care and treatment of the Covered Person's illness or injury.

(3) "Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical, dental, or vision expenses against a Third Party.

(4) "Third Party" means a person or business entity other than a Covered Person or the Plan, and includes the insurer of such person or business entity.

B. No Prejudicial Acts. The Covered Person must do nothing to prejudice the Benefit Program's right to Subrogation or Reimbursement.

C. Notice of Potential Recovery. If a Covered Person incurs expenses that would be covered under this Plan on account of an injury, illness or condition caused by the actions or omissions of a third party (hereinafter referred to as "Covered Expenses"), a Covered Person must notify the Plan Administrator immediately of any potential causes of action or claims for a Recovery that the Covered Person may have against a Third Party. A Covered Person must provide the Plan Administrator with a copy of any summons, complaint, or other process serviced in any lawsuit in which the Covered Person seeks a Recovery. Notice must be provided within a reasonable time, but no more than 30 calendar days after the Covered Person knows or should have known of the actions, omissions, or events that form the basis for any Recovery. Notice must be provided in writing:

Gen Digital Inc.
ATTN: Benefits Department
60 East Rio Salado Parkway
Suite 1000
Tempe, AZ 85281

D. Subrogation and Reimbursement Agreement. As a precondition to payment of Covered Expenses by a Benefit Program, the Benefit Program may, but need not, in its sole and absolute discretion, require a Covered Person to sign a subrogation and reimbursement agreement and to agree, in writing, to assist in securing the Benefit Program's right to Subrogation and Reimbursement.

E. Right to Subrogation. The Benefit Program may take action against any party (including, but not limited to, an attorney or trust) in possession of property or funds awarded or paid as a result of the Covered Person's illness or injury, if such property or funds should be or should have been paid to the Benefit Program pursuant to this Section. The Benefit Program has the right to seek a temporary restraining order against such party to prevent disbursement of such property or funds. In addition, the Benefit Program may seek restitution in equity (through the imposition of a constructive trust for the Plan's benefit) from such party for the full amount of benefits paid by the Benefit Program or for which it may have future responsibility. Should it be necessary for a Benefit Program to institute a legal action in order to enforce its right to Subrogation, the Benefit Program shall be entitled to all costs of collection, including reasonable attorney's fees.

F. Right to Reimbursement.

(1) Plan's Right to Notice of a Recovery. If any Recovery is received by or on behalf of a Covered Person from a Third Party, the Covered Person has an obligation to notify the Plan Administrator immediately in writing of receipt of and the amount of the Recovery. Such written notice must be sent to:

Gen Digital Inc.
60 East Rio Salado Parkway
Suite 1000
Tempe, AZ 85281

This notice requirement applies no matter the form of the Recovery (for example, the Recovery may be a judgment, a settlement, or a payment), no matter the identity of the Third Party (for example, the Third Party may be a wrongdoer, a wrongdoer's insurance carrier,

or a settlement fund), and regardless of fault, negligence or wrongdoing.

(2) Covered Persons' Duty to Hold Recovery For Plan. Covered Persons have a duty to hold the Recovery in trust, separately and not commingled with any other assets, until the Benefit Program has been repaid in full.

(3) Covered Persons' Duty to Repay the Plan. The Covered Person must repay the Benefit Program in full out of the Recovery for all Covered Expenses which have been paid by the Benefit Program or which will in the future have to be paid by the Benefit Program under this and which are reasonably foreseeable at the time of the Recovery. Reimbursement to the Benefit Program will be without reduction, set-off or abatement for attorneys' fees or costs incurred by the Covered Person in collecting the Recovery, unless the Benefit Program agrees otherwise in writing.

(4) Creation of Constructive Trust and Equitable Lien by Agreement. Covered Employee agrees that the Benefit Program has an equitable lien by agreement on the portion of the Recovery paid by the Benefit Program for Covered Expenses and a constructive trust on the entire Recovery.

(5) Benefit Program's Right of Reimbursement. The Benefit Program shall legally succeed the Covered Person's right of Recovery against a Third Party, up to the amount of benefits it has paid (or for which the Benefit Program may have future responsibility) with respect to that illness or injury. The Benefit Program contractual right to Reimbursement is in addition to and separate from its right to Subrogation.

(6) Covered Persons' Failure to Reimburse. Covered Persons have an obligation and duty to pay the Plan for Covered Expenses that should have been paid to the Plan from the Recovery. If full payment of Covered Expenses paid by the Plan is not made from any Recovery, Plan may, in its sole and absolute discretion, bring a legal action against the Covered Person or any related Covered Person or reduce the amount of, or set off the amount against, any future claim payment to the Covered Person or any related Covered Person. Should it be necessary for Plan to institute a legal action against the Covered Person for failure to reimburse Plan in full for Covered Expenses paid by the Plan, or for failure to honor the Plan's equitable interests in the amount recovered from a third party, the Covered Person shall be liable for all costs of collection, including reasonable attorney's fees.

G. Settlement Agreements/Judgment Awards. The Covered Person must obtain written consent from the Plan Administrator before entering into any settlement agreement with a Third Party that relates to Covered Expenses. If a settlement agreement or a judgment award includes payment for future medical expenses, a trust account may be established by the Plan Administrator or the Benefit Program. In the absence of such a trust, the Benefit Program has the right to exclude coverage for the Covered Person's future medical expenses, related to the illness or injury, up to the full amount of the settlement or award.

H. Priority; Other Legal Doctrines. If the Third Party makes any payment to the Covered Person, his or her attorney, or a trust for his or her benefit, such payment must first be used to provide equitable restitution to the Benefit Program, to the full extent of Benefits paid by or payable under the Benefit Program. This priority of the Benefit Program applies despite other legal doctrines or theories. The Benefit Program's rights of Subrogation and Reimbursement under this Section shall not be affected, reduced, or eliminated by the make-whole doctrine, the common fund doctrine, the doctrine of comparative fault theory, or any other legal doctrine or theory. Each Benefit Program expressly rejects the common fund doctrine with regard to attorneys' fees. The rights of the Benefit Program shall not be affected, reduced, or eliminated by any allocation which purports to allocation Recovery amounts in whole or in part to nonmedical damages.

I. Conditions Precedent.

(1) Cooperation. If a Covered Person refuses to comply with its obligations under this Section, fails to cooperate with the Benefit Program in regard to Subrogation and Reimbursement rights, or refuses to execute and deliver such papers as the Plan Administrator or Benefit Program may require in furtherance of its Subrogation and Reimbursement rights, then the Benefit Program shall have no obligation to pay benefits to the Covered Person.

(2) Minors. If the Covered Person is a minor, the Benefit Program shall have no obligation to pay benefits related to the illness or injury caused by a Third Party until after the Covered Person's legal representative obtains valid court recognition and approval of the Benefit Program's 100%, first-dollar Subrogation and Reimbursement rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement of such rights.

J. Limitation on Covered Person Assignment. Covered Person may not assign any Third Party Claims without the express written consent of the Plan.

K. Overpayment. In the event the Plan has made an erroneous or excess payment to or on behalf of a Covered Person, the Claims Administrator shall be entitled to take such action as the Claims Administrator shall deem necessary and equitable to correct such error, including requiring that the Covered Person, or the person or organization who received the overpayment, return the overpayment, or reducing any future benefit payments made to, or on behalf of, a Covered Person by the amount of the overpayment, to the extent permitted by applicable law. This right does not affect any other right of recovery with respect to such overpayment.

6.4. Coordination of Benefits. This Section 6.4 applies to any Benefit Program which is self-insured (see Appendix A). In the event of a conflict between the provisions of this Section and the provisions of a Benefit Program, whichever provisions provide the greatest rights to the Benefit Program shall govern.

Whenever a payment that should have been made under the Plan in accordance with this Section 6.4 has been made by an Other Group Health Program, including Medicare, the Claims Administrator shall have the right, exercisable alone in its sole and absolute discretion, to pay to the Other Group Health Program the amount that the Claims Administrator determines is warranted in order to satisfy the intent of this Section. The amount so paid shall be deemed to be a benefit provided under the Plan, and the Plan shall be fully discharged from liability for its payment. For purposes of this Section, an "Other Group Health Program" means any health care coverage on an insured or self-insured basis, including (but not limited to) group, blanket, or franchise insurance, group practice or prepaid coverage plans, labor-management trusted plans, union welfare plans, employer organization plans, coverage under a governmental program other than Medicare or Medicaid, and coverage required by applicable law.

A. Order of Benefits Determination. The Plan determines its order of benefits using the first of the following rules which applies:

(1) The Other Group Health Program is primary if it does not have a COB provision.

(2) If a child is covered under both parents' plans, and the parents are not divorced or separated, the primary plan is the plan that covers the parent whose birthday falls earlier in the calendar year (the "birthday rule"). If both parents have the same birthday, the plan that covered the person longer is primary.

(3) If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the plan of the parent with custody of the child;

(b) Next, the plan of the spouse of the parent with custody of the child; and

(c) Finally, the plan of the parent not having custody of the child.

Notwithstanding the above, if the parents have joint custody, the ordering rule described in subsection (2), above, shall apply. However, if there is a court decree which would otherwise establish financial responsibility for the medical or other health-care expenses with respect to the child, the benefits of a plan that covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child.

(4) The benefits of a plan that covers a person as an active Employee (or as that Employee's dependent) are determined before those of a plan that covers that person as laid off, terminated or as a retired Employee (or as his or her dependent). If the Other Group Health Program does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(5) If a person whose coverage is provided under a right of continuation pursuant to federal (COBRA) or state law is also covered under another plan, the benefits of the plan which covers the person as an Employee, participant or subscriber (or as that person's dependent) are determined before the benefits under continuation coverage. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(6) If none of the above rules determines the order of benefits, the benefits of the plan that has covered an individual longer are determined before those of the plan that has covered that individual for the shorter time.

B. Effect on Benefits Using COB. Benefits shall be payable under the Plan in accordance with the following:

(1) If the Plan is the primary plan, it will pay the same benefits for covered expenses that it would pay in the absence of this Section.

(2) If the Plan is the secondary plan, the combined benefits from the Plan and all Other Group Health Programs shall not exceed 100% of the total amount payable under either the Plan or the Other Group Health Program, whichever is greater. Notwithstanding the foregoing, the maximum benefit payable under the Plan shall not exceed 100% of the amount otherwise payable under the Plan in the absence of the Other Group Health Program.

C. Coordination of Plan Benefits with Medicare Benefits. The Plan shall be the primary payer and Medicare the secondary payer for any services, treatments, or supplies that are covered by the Plan for the following individuals:

(1) Employees and/or Eligible Spouses/Eligible Domestic Partners Age 65 or Older. The Plan shall be primary for any Employee or dependent of an Employee who is covered under this Plan by reason of current employment status with the Employer and who is entitled to Medicare on the basis of age, unless the Employee gives the Plan written notice waiving such Plan benefits and chooses to have Medicare be primary, in which event COBRA continuation coverage under the Plan is available.

(2) Medicare Disabled Covered Persons. The Plan shall be primary for any Covered Person who is entitled to Medicare on the basis of disability and who participates in this Plan on the basis of the current employment status of the Employee Participant.

(3) Covered Persons with End-Stage Renal Disease. The Plan shall be primary for any Covered Person who is entitled to Medicare benefits on the basis of end-stage renal disease (ESRD), for the period required by applicable law. Otherwise, the Plan is secondary.

Please contact the Plan Administrator for information regarding the Medicare coordination of benefits rules with respect to COBRA continuation coverage.

D. Coordination with Medicaid Benefits. The Plan shall not reduce or deny benefits for any Participant to reflect that such individual is eligible to receive medical assistance under a state Medicaid program. The Plan shall reimburse any state Medicaid program for the cost of any items and services provided under the state program that should have been paid for by the Plan, and the Plan will honor any subrogation rights that a state has to recoup such mistaken payments.

E. Right to Information. For purposes of determining the applicability and implementation of this Section 6.4 or a provision of similar purpose of an Other Group Health Program, the Claims Administrator, without consent of or notice to any person, may release or obtain information that the Claims Administrator reasonably deems necessary. An individual claiming benefits under the Plan shall furnish, upon request by the Claims Administrator, any written information requested to implement this provision.

7. HOW THE PLAN IS ADMINISTERED

7.1. **Plan Administration**. The Plan is administered by Gen, acting as the Plan Administrator. The Plan Administrator may delegate any of its duties or powers at any time, including, but not limited to, a delegation of its discretionary authority as described below, to a person or persons who are Employees of the Plan Administrator, or to a third party administrator selected by the Plan Administrator. The Plan Administrator shall have the right to change its delegates from time to time, or to take over functions previously delegated, all without cause. The Plan Administrator may allow the entities to which it delegates its duties or powers to further delegate such duties or powers.

7.2. **Named Fiduciary**. The Plan Administrator is the Plan's named fiduciary under ERISA and shall at all times discharge its duties with respect to the Plan in accordance with the standards set forth in Section 404(a)(1) of ERISA. The named fiduciary may delegate its fiduciary duties to the extent permitted by ERISA.

7.3. **Allocation of Fiduciary Duties**. In exercising its fiduciary duties, the named fiduciary shall have the discretionary authority described below. Each named fiduciary shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily or capriciously.

A. With respect to each Benefit Program that is fully-insured, the named fiduciary hereby delegates to each insurance company or health maintenance organization issuing the insurance policy or contract that provides such Benefits, the fiduciary duty and the sole and absolute discretion to determine eligibility for participation, coverage, payment of benefits, and all such other determinations set forth in the governing insurance policy or contract. In exercising these fiduciary duties, the applicable insurance company shall have the discretion to construe and interpret the provisions of the Plan. The Plan Administrator shall have no discretionary authority, except to the extent granted by the insurance company to perform certain administrative functions, such as determining eligibility for participation and enrolling eligible individuals in accordance with the terms and conditions of the insurance policy or contract issued in connection with such benefits. The Plan Administrator shall not have any liability or financial responsibility for any insured Benefits beyond the payment of premiums due with respect to such insurance policy or contract.

B. With respect to each Benefit Program that is self-insured, the Plan Administrator shall have sole and absolute discretionary authority with respect to determining an individual's claim for benefits, including, but not limited to, determining eligibility to participate, rendering final determinations regarding medical necessity, and determining and authorizing payment of benefits, except to the extent that such duties have been delegated under an administrative services contract. The Plan

Administrator shall have final authority to resolve disputes regarding the Plan's self-insured Benefits, except to the extent that such duties have been delegated under an administrative services contract. In exercising its fiduciary duties under this paragraph, the Plan Administrator shall have the discretion to construe and interpret the provisions of the Plan.

7.4. <u>Duties of the Plan Administrator</u>.

A. The Plan Administrator will operate and administer the Plan, will determine all questions arising under or in connection therewith (other than those delegated), and may from time to time prescribe and amend procedures for such administration, except to the extent that such responsibility has been delegated to an insurance company or to an administrative services organization, as described above. The Plan Administrator from time to time shall, in a uniform and nondiscriminatory manner, establish rules for the transaction of its business and shall have sole and absolute discretion to carry out its responsibilities to construe and interpret the provisions of the Plan. The Plan Administrator or its delegate shall have such duties and powers as may be necessary to discharge its responsibilities hereunder, including but not limited to the following:

(1) To construe the Plan, correct defects, supply omissions and reconcile inconsistencies to the extent necessary to effectuate the Plan, and such action shall be conclusive;

(2) To adopt such rules for the administration of the Plan as it considers desirable;

(3) To decide all questions of eligibility and participation;

(4) To prescribe enrollment procedures and forms;

(5) To prepare and distribute to Participants information explaining the Plan and the Benefits available hereunder in such a manner as the Plan Administrator deems appropriate;

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

(7) To appoint committees and to delegate thereto such of its powers as it shall determine; and

(8) To employ such agents and assistants, such counsel and such clerical and other services as the Plan Administrator may require in carrying

out the provisions of the Plan (the fees for which shall be paid by Gen).

B. In carrying out its responsibilities, the Plan Administrator shall have the sole and absolute discretion and authority to construe and interpret the provisions of the Plan, to make factual determinations, and to determine all questions concerning benefit entitlements, including the power to construe and determine disputed or doubtful terms. To the maximum extent permissible under law, the Plan Administrator's determinations on all such matters shall be final and binding upon all persons involved. Any interpretation or determination made pursuant to such discretionary authority shall be upheld on review unless it is shown that the interpretation or determination was an abuse of discretion (*i.e.*, arbitrary and capricious).

7.5. <u>Claims Administrator</u>.

A. The Plan Administrator and/or Gen shall have the authority to appoint, remove, and replace one or more Claims Administrators for each Benefit Program. In the absence of a Claims Administrator with respect to a Benefit Program, the Plan Administrator shall be the Claims Administrator. In exercising its fiduciary responsibility, each Claims Administrator has discretionary authority to construe and interpret the terms of the Benefit Program and the Plan, and to make factual determination regarding whether, and to what extent, individuals are entitled to Benefits. Each Claims Administrator shall have the duty to receive and review claims for benefits under the Plan, to review and determine denied claims, to determine what amount, if any, is due and payable under the terms and conditions of the Plan, and to make appropriate disbursements of benefits payments to persons entitled thereto. Each Claims Administrator shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily or capriciously.

B. With respect to a Benefit provided under a Benefit Program that is fully-insured with an insurance company or a health maintenance organization ("HMO"), the Claims Administrator shall be the insurance company or the HMO, as the case may be. The Plan Administrator shall have no discretionary authority except to the extent described in Section 7.3.

C. With respect to a Benefit provided under a Benefit Program that is self-insured, the Plan Administrator shall be the Claims Administrator and shall have all discretionary authority to the extent described in Section 7.3, except to the extent that such duties have been delegated to a third party or administrative services organization under an agreement between such organization and the Plan Administrator.

8. CLAIMS

8.1 Legal Action. Except as otherwise specifically stated in a Benefit Program, no legal action may be commenced or maintained to recover benefits under this Plan more than 2 years after the Final Internal Adverse Benefit Determination. A claimant must exhaust his or her administrative remedies under the Plan's claims procedures prior to bringing any legal action with respect to a claim for benefits.

8.2 Which Claims Procedure Applies. The claims procedures set forth in a specific Benefit Program shall govern claims and appeals under that Benefit Program. *However, in the event that the claim procedure language in an applicable Benefit Program fails to comply with the requirements of applicable law, the claims procedures in this document shall govern.* In the event that the claims procedures in this document govern: disability claims shall be governed by the claims procedures in Appendix C; all other claims shall be governed by the claims procedures in Appendix B. For these purposes only, a "disability claim" is a claim for disability benefits or a claim for other benefits that is contingent upon a finding of disability.

8.3 Forfeitures. Any benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the applicable expense was incurred shall be forfeited. Forfeitures may be used: to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements under the Plan; to defray administrative expenses for the Plan; to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Administrator deems appropriate, consistent with applicable regulations. In addition, to the extent permitted by applicable law, forfeitures may be retained by the Employer.

9. STATEMENT OF ERISA RIGHTS AND PROTECTIONS

All participants in the Plan are entitled to certain rights and protections under ERISA, which provides that all participants will be entitled to the following:

9.1. Receive Information About The Plan and Benefits.

A. Examine, without charge, at the Plan Administrator's office, all plan documents, including insurance contracts, 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 and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

B. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including any insurance contracts, 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.

C. 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.

9.2. Continue Group Health Plan Coverage. Continue health care coverage for any Covered Person, if there is a loss of coverage under the Plan as a result of a qualifying event. Each Covered Person will have to pay for such coverage. Further details about the rules governing COBRA continuation coverage rights can be found in the documents for each Benefit Program.

9.3. Prudent Actions by Plan Fiduciaries. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of this 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 and beneficiaries. No one, including Gen or any other person, may fire a Covered Person or otherwise discriminate against him in any way to prevent him from obtaining a welfare benefit or exercising his rights under ERISA.

9.4. Enforcement of Rights. If a Covered Person's claim for a welfare benefit is denied or ignored, in whole or in part, the Covered Person has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that can be taken to enforce the above rights. For instance, if the Covered Person requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110

a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the administrator. If the Covered Person has a claim for benefits which is denied or ignored, in whole or in part, he may file suit in a state or federal court after exhausting administrative remedies under the Plan's claims and appeals procedures. In addition, if the Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if a Covered Person is discriminated against for asserting his rights, the Covered Person may seek assistance from the U.S. Department of Labor, or he may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the persons sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees, for example, if it finds the claim is frivolous.

9.5. **Assistance With Questions**. If a Covered Person has questions about this Plan, he should contact the Plan Administrator. If a Covered Person has any questions about this statement or about his rights under ERISA, or if a Covered Person needs assistance in obtaining documents from the Plan Administrator, he should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in a 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. The Covered Person may also obtain certain publications about rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

10. GENERAL PLAN PROVISIONS

10.1. **No Guarantee of Employment**. No person shall have any rights under the Plan, except as, and only to the extent, expressly provided for in the Plan. Neither the establishment or amendment of the Plan, the payment of benefits, nor any action of Gen shall be held or construed to confer upon any person any right to be continued as an Employee of Gen, or upon dismissal, any right or interest in any Benefit other than as herein provided. Gen expressly reserves the right for Gen to discharge any Employee at any time and for any reason.

10.2. **Assignment of Benefits**. To the extent permitted by law, no benefits will be subject to assignment, alienation, sale, transfer, garnishment, execution or encumbrance of any kind, and any attempt to do so will be void. However, your benefits may be subject to a Qualified Medical Child Support Order. Under no circumstances will any provider rendering services be deemed a plan participant or beneficiary under the Plan and no payment to a provider will amount to an assignment of benefits hereunder.

10.3. **Medical Care Decisions and Treatment**. Certain of the Benefits under the Plan provide for the payment of specified health care expenses. All decisions regarding health care are solely the responsibility of each Covered Person in consultation with the health care providers selected. The Plan contains rules for determining the percentage of allowable health care expenses that will be reimbursed, and whether particular treatments or health care expenses are eligible for reimbursement. Any decision with respect to the level of health care reimbursements, or the coverage of a particular health care expense, may be disputed by the Covered Person in accordance with the Plan's claim procedures. Each Covered Person may use any source of care for health treatment and health coverage as selected, and neither the Plan nor the employer will have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a Covered Person not to seek or obtain such care, other than the liability of the Plan for the payments of benefits as outlined herein.

10.4. **No Waiver of Terms**. No term, condition or provision of the Plan shall be deemed waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written agreement of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

10.5. **Limitation of Rights**. Nothing appearing in or done pursuant to the Plan shall be held or construed to give any person any legal or equitable right against Gen or the Plan Administrator, or any person connected therewith, except as expressly

provided herein or as provided by applicable law, or to give any person any legal or equitable right to any assets of the Plan.

10.6. **Severability**. If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

10.7. **Use of Captions**. The section and subsection numbers and captions used throughout the Plan have been inserted solely as a matter of convenience and in no way define or limit the scope or intent of any provision of the Plan.

10.8. **No Oral Modifications**. The terms of the Plan cannot be modified except by means of a written amendment duly authorized and adopted by Gen. Any attempted oral modification is not binding on Gen.

10.9. **Tax Consequences**. Gen does not represent or guarantee that any particular federal or state income, payroll, personal property, Social Security or other tax consequences will result from participation in this Plan. A Covered Person should consult with professional tax advisors to determine the tax consequences of participation.

10.10. **Applicable Law**. This Plan shall be construed in accordance under the laws of the State of California except to the extent such laws are pre-empted by ERISA.

10.11 **Plurals and Gender**. Masculine pronouns include the feminine, plural nouns include the singular, and vice versa, except where the context indicates otherwise.

10.12 **Incapacity**. If a covered Employee or dependent is, in the judgment of Gen, legally, physically, or mentally incapable of personally receiving any payment due under the Plan, Gen, in its sole discretion, may direct payments due to such other person or institution who, in the opinion of Gen, are then maintaining or having custody of such covered Employee or dependent until claim is made by a duly appointed guardian or other legal representative of such covered Employee or dependent. Such payment will constitute a full discharge of liability of the Plan to the extent of such payment.

10.13 **Beneficiary Designations**. Unless the Benefit Program documentation referenced in Appendix A with respect to a given benefit expressly provides to the contrary, a covered Employee must designate a beneficiary in the form and manner specified by Gen. If there is no beneficiary designation form on file with Gen, benefits will be paid to the Employee's estate.

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DATED this 14th day of June, 2024.

GEN DIGITAL INC.

Kathy Marquez
Head Of Global Benefits

APPENDIX A
GEN GROUP WELFARE BENEFITS PLAN
PLAN 501

The Benefits provided under the Plan shall be those fully-insured and self-insured benefits as shall be made available to eligible Employees from time to time, as such benefits may be amended or terminated in the future. The terms, conditions and limitations of the Benefits are set forth in the Plan and the underlying Benefit Programs that are incorporated into the Plan. Certain documents are incorporated by reference to this Appendix A, including any written document pursuant to which the applicable Benefit is provided under the Plan (*e.g.*, written plans, vendor contracts, insurance policies, coverage certificates, summary plan descriptions, or other materials describing benefits provided under the Benefit Program). This Appendix is considered a part of the Plan and may be amended by Gen at any time for any reason without the consent of any person, except as otherwise provided by applicable law. Appendix A and the Benefit Programs may be changed or replaced from time to time without formal amendment to the Plan instrument.

BENEFIT PROGRAMS

Medical Benefit Programs

- Cigna Health Savings Account (HSA) Plan *(a self-insured program administered by Cigna)*
- Cigna HSA- UT Only *(a self-insured program administered by Cigna)*
- Cigna PPO- UT Only (*a self-insured program administered by Cigna)*
- Cigna Certificate Rider for Massachusetts Only (*a self-insured program administered by Cigna)*
- Cigna Open Access Plus (OAP) Plan *(a self-insured program administered by Cigna)*
- Cigna Open Access Plus (OAP) 500 Arizona Plan *(a self-insured program administered by Cigna)*
- Kaiser Northern California HMO Plan *(a fully-insured program with Kaiser)*
- Kaiser Chiropractic and Acupuncture Northern California HMO Plan *(a fully-insured program with Kaiser)*
- Kaiser Southern California HMO Plan *(a fully-insured program with Kaiser)*
- Kaiser Chiropractic and Acupuncture Southern California HMO Plan *(a fully-insured program with Kaiser)*

Dental Benefit Programs

- Delta Dental 1.0 Plan *(a self-insured program administered by Delta Dental)*
- Delta Dental 2.0 Plan *(a self-insured program administered by Delta Dental)*

Vision Benefit Programs

- VSP 1.0 & 2.0 Plan *(a self-insured program administered by Vision Service Plan)*

Flexible Benefit Programs

- Gen Flexible Benefit Plan *(a self-insured program administered by MyChoice Accounts and Gen)*, which includes:
    - Pre-tax payment of insurance premiums (non-ERISA)
    - Health Flexible Spending Account
    - Dependent Care Flexible Spending Account (non-ERISA)
    - Pre-tax contributions to Health Savings Account (non-ERISA)

Life and Disability Programs

- Group Short Term Disability Plan *(a self-insured program administered by Lincoln Financial Group, formerly Liberty Mutual)*, which includes:
    - California Voluntary Disability Insurance Plan (VDI) (non-ERISA)
    - Short Term Disability Plan
- Group Long Term Disability Plan *(a fully-insured program with Lincoln Financial Group, formerly Liberty Mutual)*
- Life, Accidental Death and Dismemberment, and Dependent Life Group Benefit Plan, including basic and supplemental coverage *(a fully-insured program with Lincoln Financial Group, formerly Liberty Mutual)*
- Business Travel Insurance *(a fully-insured program with Ace)*

Other Programs

- Employee Assistance Program *(for Nevada and California residents, a fully-insured program with Cigna) (for others, a self-insured program administered by Cigna)*
- Teledoc/Best Doctors (*a self-insured program administered by Teledoc/Best Doctors*)
- ARAG Ultimate Advisor Legal Services Plan (*a fully-insured program with ARAG*)
- ARAG Ultimate Advisor Plus Legal Services Plan (*a fully-insured program with ARAG*)

APPENDIX B
CLAIMS PROCEDURE
(for claims other than disability claims)

1. Submitting Claims for Benefits.

A. Generally a claim must be submitted in order to receive benefits from a Benefit Program. For some benefits, such as certain medical and prescription drug services, claims may be submitted by the provider. There are some time limits for submitting claims, and certain services must be pre-authorized as defined by the general plan specifications and outlined in the Benefit Programs. A delay in submitting a claim could result in the loss of benefits. Claim forms are available from the Benefits Department.

B. No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation for services or supplies received, is received by the Claims Administrator within the period prescribed in the applicable Benefit Program or as otherwise provided herein. As a condition of receiving a Plan benefit, a Covered Person must submit such evidence to the Claims Administrator as it may require in order to determine that a claim is reimbursable under the terms of the Plan. Unless otherwise stated in a Benefit Program, claims for medical and dental benefits must be received by the Claims Administrator within 12 months of the expenses being incurred.

C. If correct and complete claim forms are submitted, the claim will be processed within the time frames provided below. The time frames differ based on the category of benefits (and in the case of medical and dental claims, the type of claim). The determination of the type of claim is based on the nature of the specific claim or benefit, not the name of the component plan under which the claim is made or the benefit is offered.

D. Health Claims (Medical, Prescription Drug, Dental, and Vision).

(1) Urgent Care Claim. This type of claim includes those situations commonly treated as emergencies. If a treating physician believes that the Covered Person has an urgent care claim, the Covered Person or his representative must provide notice to the Plan. If the claim is an urgent care claim, the Covered Person or his authorized representative will be notified of the Plan's decision about the claim not more than 72 hours after receipt of a complete claim. If the claim does not include sufficient information for the Claims Administrator to make a decision, the Covered Person or his representative will be notified of the need to provide additional information within 24 hours after receipt of the incomplete claim. The Covered Person will have at least 48 hours to respond to this request. The Claims Administrator will inform the Covered Person of its decision within 48 hours of receipt of the additional information.

(2) Pre-Service Claim. A pre-service claim is a claim for which a Covered Person must get approval before obtaining medical care or treatment. This process is often referred to as pre-certification or pre-authorization. If the claim is a pre-service claim, the Claims Administrator will notify the Covered Person of its initial determination not more than 15 days from the date it receives a complete claim. If more time is needed, the Covered Person will be notified that an additional processing period is required. If an extension is due to a failure to submit all the necessary information to decide the claim, the Covered Person will have at least 45 days to provide the additional information requested.

(3) Post-Service Claim. A post-service claim is a claim for which payment is requested after medical care or treatment has already been provided. If the claim is a post-service claim, the Covered Person will be notified if the complete claim is denied in whole or in part within 30 days after it is received. If more time is needed for review, the Covered Person will be notified that an additional processing period is required. If an extension is due to a failure to submit all the necessary information to decide the claim, the Covered Person will have at least 45 days to provide the additional information requested.

(4) Concurrent Care Claim. A concurrent care decision occurs where the plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (a) where reconsideration of the approval results in a reduction or termination of the initially-approved period of time or number of treatments; and (b) where an extension is requested beyond the initially-approved period of time or number of treatments.

(a) Concurrent Care Early Termination. A decision by the plan to reduce or terminate an initially-approved course of treatment is an adverse benefit decision that may be appealed. Notification of a decision by the plan to reduce or terminate an initially-approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow an appeal of the adverse decision and receive a decision on review prior to the reduction or termination. All requests shall be decided in the otherwise applicable time frames for pre-service, post-service, or urgent care claims.

(b) Concurrent Care Extension Request. If the claim is a request to extend a concurrent care decision involving urgent care and if the claim is made at least 24 hours prior to the end of the initially-approved period of time or number of treatments, the claim shall be decided within no more than 24 hours after receipt of the claim. Any

other request to extend a concurrent care decision shall be decided in the otherwise applicable time frames for pre-service, post-service, or urgent care claims.

E. Health Flexible Spending Account Claims. Claims for reimbursement under a health flexible spending account are post-service claims and will be determined within the time frame described above for post-service medical and dental claims.

F. All Other Claims. The Claims Administrator will notify the Covered Person if his claim is denied in whole or in part, within 90 days after it is received. If more time is needed, the Covered Person will be notified that an additional processing period is required.

2. **Denial of Claims**. If all or part of a claim is denied, the Claims Administrator will notify the Covered Person of the denial. All denials will be in writing, unless the claim involves urgent care, in which case notice of the denial may initially be made orally. A denial notice will:

A. State specific reason(s) for the denial, with specific references to the Plan provision(s) on which the denial was based;

B. List any additional material or information that may be needed in order to perfect the claim and explain why such material or information is necessary;

C. Describe in detail how to have the decision reviewed, the review procedures, how to file an appeal, and the applicable time frame for requesting review (including, in the case of a health claim involving urgent care, a description of the expedited review process applicable to such claim);

D. State that the Covered Person has a right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review (if applicable);

E. For Health Claims, include:

(1) Information sufficient to identify the claim, including the date of service, the health care provider, the claim amount, and the denial code and its meaning, if applicable;

(2) A statement that diagnosis and treatment codes and their meanings, if applicable, will be provided upon request and free of charge;

(3) A description of the standard, if any, used in denying the benefit claim;

(4) A description of the process for having a decision reviewed, the review procedures and the applicable time frame for requesting review; and

(5) The contact information for a state office of health insurance consumer assistance or ombudsman, if applicable.

3. **Filing an Appeal**. If a claim has been denied, the denial can be appealed. The Covered Person must file the appeal, and the Claims Administrator must decide the appeal, within the time frames provided below. Someone other than an individual involved in the initial benefit determination or a subordinate of such individual will be appointed to decide the appeal. Please note that the time frames differ based on the category of benefit (and in the case of medical and dental claims, the type of claim).

A. Health Claims. A Covered Person has 180 days after the receipt of the denial notice to appeal the denial. The appeal must be in writing unless the claim involves urgent care, in which case the appeal may be made orally and documentation may be provided by facsimile or other expeditious method. The Claims Administrator must respond within the time frames provided below.

(1) Urgent Care Claims. Not later than 72 hours after receiving an appeal.

(2) Pre-Service Claims. Not later than 30 days after receiving an appeal.

(3) Post-Service Claims. Not later than 60 days after receiving an appeal.

(4) Concurrent Care Claims.

(a) Concurrent Care Early Termination Claims. Before the proposed reduction or termination takes place.

(b) Concurrent Care Extension Request Claims. The appeal time frame for urgent care, pre-service, or post-service claims (as described above), as appropriate.

B. Health Flexible Spending Account Claims. A Covered Person has 180 days after the receipt of a denial notice to appeal the denial. The appeal must be in writing. The Claims Administrator generally has 60 days to review a written appeal.

C. All Other Claims, Including Claims Under Life and Accidental Death and Dismemberment Programs (to the extent not based on disability). A Covered Person has 60 days after the receipt of a denial notice to appeal the denial. The appeal must be in writing. The Claims Administrator generally has 60 days to review the written appeal. In some cases, the Claims Administrator may be allowed an additional period to respond.

4. **Appeals Process**.

A. The Covered Person may request, free of charge, reasonable access to and copies of all relevant documents, records, and other information related to the claim, unless

such relevant documents, records or other information are privileged. The Covered Person can also submit comments, documents, records, and other relevant information regarding why the claim should not be denied. These submissions must be in writing.

B. If the applicable Benefit Program is a Group Health Plan and the claim was denied based on a medical judgment, the Claims Administrator will consult with a health care professional with appropriate training and experience. The health care professional consulted for the appeal will not be the professional (if any) consulted during the prior determination, nor a subordinate of such professional.

C. If the applicable Benefit Program is a Medical Plan, the Claims Administrator will provide the Covered Person with any new or additional evidence considered, relied upon, or generated by the Claims Administrator in connection with the claim; and any new or additional rationale relied upon in making a determination regarding an appeal. Such information will be provided to the Covered Person as soon as possible, and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is made to give the Covered Person a reasonable opportunity to respond prior to that date.

5. **Final Decision**. The final decision will be sent to the Covered Person in writing. If the final decision is a denial, it will:

A. State the specific reasons(s) for the denial, with specific references to the Plan provision(s) on which the denial was based;

B. State that the Covered Person 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 for benefits;

C. Describe any voluntary appeal procedures offered by the Benefit Program;

D. Inform the Covered Person of his right to bring a civil action under Section 502(a) of ERISA (if applicable);

E. If the applicable Benefit Program is a Group Health Plan, include:

(1) Any internal rule, guideline, protocol, or other similar criterion relied upon or a statement that a copy of such will be provided upon request and free of charge;

(2) An explanation of the scientific or clinical judgment for a determination based on a medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Benefit Program to the Covered Person's medical circumstances, or a statement that such explanation will be provided upon request and free of charge.

F. If the applicable Benefit Program is a Medical Plan, include:

(1) Information sufficient to identify the claim, including the date of service, the health care provider, the claim amount, and the denial code and its meaning, if applicable;

(2) A statement that diagnosis and treatment codes and their meanings, if applicable, will be provided upon request and free of charge;

(3) A description of the standard, if any, used in denying the benefit claim;

(4) A description of any external review procedures and how to request external review (including any expedited time frame that may apply to an urgent care claim); and

(5) The contact information for a state office of health insurance consumer assistance or ombudsman (if applicable).

6. <u>External Review</u>.

A. Any Adverse Benefit Determination (including a Final Internal Adverse Benefits Determination) that is made under a Medical Plan shall be eligible for external review under this Section 6 if such determination:

(1) Either: (a) involves medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational); or (b) relates to a Rescission; and

(2) Either: (a) the Claims Administrator does not adhere to all claim determination and appeal requirements under federal law; or (b) the standard levels of appeal have been exhausted.

An Adverse Benefit Determination based upon a determination as to eligibility is not eligible for external review.

B. The following rules shall apply with respect to an external review hereunder:

(1) <u>Request for External Review</u>. A claimant must formally request an external review in accordance with the procedures established by the Claims Administrator within four (4) months of the date the Covered Person received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If the last filing date would fall on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or federal holiday.

(2) Preliminary Review. Within five (5) business days of receipt of an external review request, the Claims Administrator shall complete a preliminary review request to determine whether:

(a) The claimant is or was covered by the Medical Plan at the time the health care item or service was requested or, in the case of retrospective review, was covered under such plan at the time the health care item or service was provided;

(b) The Adverse Benefit Determination or Final Internal Adverse Benefit Determination relates to the claimant's failure to meet the eligibility requirements under the Medical Plan;

(c) The claimant has exhausted or is deemed to have exhausted the Medical Plan's internal claims and appeals process; and

(d) The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Claims Administrator shall issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification must describe the information or materials needed to make the request complete, and allow the claimant to perfect the request for external review within the original four (4) month filing period or 48 hours of the receipt of the notification, whichever is later.

(3) Referral to Independent Review Organization. If a claim is eligible for external review, the Claims Administrator shall assign an accredited independent review organization (IRO) to conduct the external review.

(4) Notice of Receipt from IRO. The assigned IRO shall timely notify the claimant in writing that his request for external review has been accepted. This notice shall provide that the claimant may submit additional information regarding his claim in writing to the assigned IRO within ten (10) days following the date of receipt of the notice. Any information received by the IRO within this time frame shall be considered by the IRO as part of the external review.

(5) Delivery of Claims History to IRO. Within five (5) business days after the IRO is assigned, the Claims Administrator shall provide the IRO with the documents and information considered in making the Adverse Benefit

Determination or Final Internal Adverse Benefit Determination. If the Claims Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review by making a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. The IRO must notify the claimant and the Claims Administrator within one (1) business day of making such a decision.

(6) Claims Administrator's Right to Reconsideration. Upon receipt of any information submitted by the claimant, the assigned IRO must, within one (1) business day, forward that information to the Claims Administrator. Upon receipt of any such information, the Claims Administrator may reconsider the Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claims Administrator will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claims Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one (1) business day after making such a decision, the Claims Administrator will provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO will terminate the external review upon receipt of any such notice from the Claims Administrator.

(7) Review By the IRO. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* and not be bound by the decisions or conclusions of the Claims Administrator. In addition to the documents and information provided, the IRO may, to the extent it deems appropriate, consider the following in reaching a decision:

(a) The claimant's medical records;

(b) The attending health care professional's recommendation;

(c) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(d) The terms of the Plan to ensure that the IRO's decision is not contrary to its terms, unless the terms are inconsistent with applicable law;

(e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(f) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(g) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this Section 6.B.(7) to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(8) Notice of Final External Review Decision. The IRO will provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for external review. The IRO will deliver the final external review decision to the claimant and the Plan.

(9) Contents of Final External Review Decision. The final external review decision will contain:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the reason for the previous denial; and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

(b) The date the IRO received the request for external review and the date of the IRO's decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards considered in reaching the decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decisions and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the claimant;

(f) A statement that judicial review may be available to the claimant; and

(g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

(10) Maintenance of Records. After a final external review decision, the IRO will maintain all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claimant, the Plan, or a State or Federal oversight agency upon request, except where such disclosure would violate State or Federal law.

(11) Reversal of Claims Administrator's Decision. Upon receipt of an external review decision reversing an Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

C. The following rules shall apply with respect to an expedited external review hereunder:

(1) Request for Expedited External Review. A claimant may request an expedited external review at the time the claimant receives:

(a) An Adverse Benefit Determination, if that determination involves a medical condition of the claimant for which the time frame for the completion of an expedited internal appeal under Section 6.A.(1) would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

(b) A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

(2) Preliminary Review. Immediately upon receipt of a request for external review the Claims Administrator will determine whether the request meets the reviewability requirements set forth in Section 6.B.(2) and send a notice that meets the requirements set forth in said Section 6.B.(2).

(3) Referral to IRO. Upon a determination that a request is eligible for external review following the preliminary review, the Claims Administrator will

assign an IRO pursuant to the requirements set forth in Section 6.B.(3). The Claims Administrator will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the IRO electronically or by telephone or facsimile or any other available expeditious method.

The IRO shall review the claim in accordance with the standards set forth in Section 6.B.(7).

(4) Notice of Final External Review Decision. The IRO will provide notice of the final external review decision in accordance with Section 6.B.(8) as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to the claimant and the Plan.

D. Notwithstanding the provisions of this Section 6, if a Medical Plan complies with an external review process provided in DOL Technical Releases 2010-01 and 2011-02, as they may be amended by subsequent guidance under Section 2719 of the ACA, then such Medical Plan shall be deemed to have complied with this Section 6.

7. **Culturally and Linguistically Appropriate Notices**. With respect to any Benefit Program that is a Medical Plan, all notices described in this Appendix B shall be culturally and linguistically appropriate to the extent required by 45 CFR Section 147.136(e).

8. **Construction**. The provisions of this Appendix B are intended to comply with Section 2719 of the ACA and the guidance issued thereunder. If any provision of this Article 8 is subject to more than one interpretation or construction, such ambiguity shall be resolved in favor of the interpretation or construction that is consistent with the provision complying with Section 2719 of the ACA and the guidance issued thereunder.

APPENDIX C
DISABILITY CLAIMS PROCEDURE

1. **Submitting Claims for Benefit**.

A. Generally a claim must be submitted in order to receive benefits from a Benefit Program. A delay in submitting a claim could result in the loss of benefits. Claim forms are available from the Benefits Department.

B. No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation for services or supplies received, is received by the Claims Administrator within the period prescribed in the applicable Benefit Program or as otherwise provided herein. As a condition of receiving a Plan benefit, a Covered Person must submit such evidence to the Claims Administrator as it may require in order to determine that a claim is reimbursable under the terms of the Plan. Unless otherwise stated in a Benefit Program, claims for medical and dental benefits must be received by the Claims Administrator within 12 months of the expenses being incurred.

C. If correct and complete claim forms are submitted, the claim will be processed within the following time frames. A Covered Person will be notified if a complete Disability Claim is denied in whole or in part, within 45 days after the claim is received. If more time is needed, the Covered Person will be notified that an additional processing period is required. In certain circumstances, a second extension may be necessary. If an extension is due to a failure to submit all the necessary information to decide the claim, the Covered Person will have at least 45 days to provide the additional information requested by the Claims Administrator.

2. **Denial of Claims**. If a claim is denied, in whole or in part, the Claims Administrator will notify the Covered Person of the denial. All denials will be in writing. A denial notice will:

A. State specific reason(s) for the denial, with specific references to the Plan provision(s) on which the denial was based;

B. List any additional material or information that may be needed in order to perfect the claim and explain why such material or information is necessary;

C. Describe in detail how to file an appeal, the appeal procedures, and the applicable time frame for requesting an appeal;

D. State that the Covered Person has a right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review (if applicable);

E. If an internal rule, guideline, protocol, or other similar criterion was relied upon in the denial, provide a copy of the rule, guideline, protocol, or other similar criterion, or include a statement that such a copy will be provided upon request and free of charge;

F. If the denial was based on a medical necessity, experimental treatment or similar exclusion or limit, explain the scientific or clinical judgment for the denial, applying the terms of the Benefit Program to the Covered Person's medical circumstances, or include a statement that such explanation will be provided upon request and free of charge;

G. Explain the basis for disagreeing with or not following: (i) the views of health care professionals treating the Covered Person and vocational professionals who evaluated the claimant, if any such views were presented to the Plan by the Covered Person; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the Covered Person made by the Social Security Administration, if any such determination was present by the Covered Person to the Plan;

H. State that the Covered Person 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 for benefits; and

I. Be provided in a culturally and linguistically appropriate manner, as defined by 29 CFR §2560.503-1(o).

3. **Filing an Appeal**. If a claim has been denied, in whole or in part, the denial can be appealed. A Covered Person has 180 days from the time notice of a denial is received in order to file a written appeal. The Claims Administrator generally has 45 days to review a written appeal. In some cases, the Claims Administrator may be allowed an additional period to respond.

4. **Appeals Process**.

A. In connection with an appeal, the Covered Person may request, free of charge, reasonable access to and copies of all relevant documents, records, and other information related to the claim, unless such relevant documents, records or other information are privileged.

B. In connection with an appeal, the Covered Person may also submit comments, documents, records, and other relevant information regarding why the claim should not be denied. These submissions must be in writing.

C. Before the Claims Administrator can issue a final decision, the Claims Administrator will provide the Covered Person, free of charge, any additional evidence considered, relied upon, or generated by the person or entity making the final decision. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the Claims Administrator is required to provide a notice of the final decision to give the Covered Person a reasonable opportunity to respond prior to that date.

D. Before the Claims Administrator can issue a final decision based on a new or additional rationale, the Claims Administrator shall provide the Covered Person, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the Claims Administrator is required to provide a notice of the final decision to give the Covered Person a reasonable opportunity to respond prior to that date.

5. **Final Decision**. The final decision will be sent to the Covered Person in writing. If the final decision is a denial, it will:

A. State the specific reasons(s) for the denial, with specific references to the Plan provision(s) on which the denial was based;

B. State that the Covered Person 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 for benefits;

C. Describe any voluntary appeal procedures offered by the Benefit Program;

D. Inform the Covered Person of his right to bring a civil action under Section 502(a) of ERISA (if applicable), including the date on which any limitations period imposed by the applicable Benefit Program will expire;

E. If an internal rule, guideline, protocol, or other similar criterion was relied upon in the denial, provide a copy of the rule, guideline, protocol, or other similar criterion, or include a statement that such a copy will be provided upon request and free of charge;

F. If the denial was based on a medical necessity, experimental treatment or similar exclusion or limit, explain the scientific or clinical judgment for the denial, applying the terms of the Benefit Program to the Covered Person's medical circumstances, or include a statement that such explanation will be provided upon request and free of charge;

G. Explain the basis for disagreeing with or not following: (i) the views of health care professionals treating the Covered Person and vocational professionals who evaluated the claimant, if any such views were presented to the Plan by the Covered Person; (ii) the views of medical or vocational experts whose advice was obtained

on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the Covered Person made by the Social Security Administration, if any such determination was present by the Covered Person to the Plan; and

H. Be provided in a culturally and linguistically appropriate manner, as defined by 29 CFR §2560.503-1(o).