



PayPal

SHORT TERM DISABILITY PLAN

**EFFECTIVE WITH RESPECT TO DISABILITIES COMMENCING
ON OR AFTER JANUARY 1, 2024**

PayPal

SHORT TERM DISABILITY PLAN

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PayPal, Inc.

SHORT TERM DISABILITY PLAN

INTRODUCTION

The purpose of this PayPal Short Term Disability Plan (the “Plan”) is to assist eligible employees in the establishment of financial security for themselves in the event of short term disability. This Plan does not replace other disability benefits sources which may be available to an employee, such as workers’ compensation, Social Security, or State mandated coverages. This Plan provides a benefit supplement, if necessary, to such other benefit sources, in order to assist an employee in meeting reasonable income needs while disabled.

PayPal, Inc.

SHORT TERM DISABILITY PLAN

Effective with respect to Disabilities commencing on or after January 1, 2024, PayPal Holdings, Inc. hereby amends and restates, in its entirety, the PayPal Short Term Disability Benefit Plan, as set forth below.

ARTICLE I

DEFINITIONS

GENERAL

The following are general provisions applicable to this Plan. As applicable, wherever the terms defined in this Section are used in this Plan, they will have the meaning specified below unless the context clearly indicates to the contrary.

ACTIVELY AT WORK

“Actively at Work” or “Active Work” means the Employee is working at least twenty (20) hours per week for the Company performing the material and substantial duties of the Employee’s regular occupation, during a regular workday, at the Employee’s Worksite, and receiving regular compensation for performing services for the Company.

CLAIMS ADMINISTRATOR

“Claims Administrator” means Sedgwick Claims Management Services, Inc., an independent party providing claims administration services to the Plan. Claims are sent to Sedgwick Claims Management Services, Inc., P.O. Box 14435, Lexington, KY 40512-4435 (Phone Number: 855-233-7599).

COMPANY

“Company” means PayPal, Inc. and its designated U.S. affiliates who are approved to participate in this Plan by the Company.

DISABILITY

“Disability” or “Disabled” means a Disability as defined in Section 3.02.

EFFECTIVE DATE

“Effective Date” means January 1, 2024.

EMPLOYEE

“Employee” means an individual who, on or after the Effective Date of the Plan, is an individual on the Company’s U.S. payroll system, who the Company classifies and treats as a common law employee for income and employment tax withholding purposes, in accordance with Section 2.01 of the Plan, , and is regularly scheduled to work for the Company twenty (20) hours per week or more. “Employee” does not include Interns, contract employees, independent contractors, leased workers, leased employees, seasonal workers, or casual or temporary workers (e.g., individuals paid by an employment agency). Whether an individual meets the definition of an Employee under this section will not be changed in the event an individual is later reclassified as an employee of the Company in a court order, settlement of an administrative or judicial proceeding, or in a determination by the Internal Revenue Service, the Department of the Treasury, or the Department of Labor.

ERISA

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended from time to time.

ESSENTIAL FUNCTIONS

“Essential Functions” means functions which are normally required for the performance of the Employee’s occupation and which cannot be reasonably omitted or modified.

HEALTH CARE PROVIDER

“Health Care Provider” means a doctor of medicine or osteopathy who is authorized and licensed to practice medicine or surgery (as appropriate) by the State in which the doctor practices and that the provider must be authorized and licensed to diagnose and treat physical or mental health conditions; or others capable of providing health care services such as:

- (1) Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice in the State and performing within the scope of their practice as defined under State law;
- (2) Nurse practitioners, nurse-midwives, clinical social workers and physician assistants who are authorized to practice under State law and who are performing within the scope of their practice as defined under State law;
- (3) Any health care provider from whom an employer or the employer's group health plan's benefits manager will accept certification of the existence of a serious health condition to substantiate a claim for benefits (e.g., Licensed Professional Counselor).

Notwithstanding the foregoing, for purposes of seeking benefits under the Plan, a Participant must obtain medical advice and treatment from a Health Care Provider that is appropriately licensed, educated, and trained to treat the Participant’s particular Sickness or Injury. A Health Care Provider cannot be a Company Employee; their spouse, daughter, son, mother, father, sister or brother by marriage, blood, or adoption, or domestic partner or civil union partner.

HOSPITAL/HOSPITAL CONFINEMENT

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

"Hospital Confinement" means any twenty-four (24) hour period of time, or part of any twenty-four (24) hour period of time, for which the employee is charged a full day's rate for room and board as a registered inpatient in hospital. Hospital Confinement does not include Emergency Room visits, outpatient surgery, or twenty-three (23) hour Hospital stay.

INJURY

"Injury" means bodily injury that is caused by and results directly from an accident, independently of all other causes. A Disability will be considered due to an Injury only if the Injury occurred while the Employee is a Participant.

INTERN

"Intern" means an individual who is a student at an educational institution who is gaining supervised, practical work and educational experience at the Company for a limited period of time.

OBJECTIVE MEDICAL EVIDENCE

"Objective Medical Evidence" means medical demonstration of anatomical, physiological, or psychological abnormalities manifested by signs/symptoms of said abnormalities or laboratory findings, apart from Participant's perception of mental or physical impairments. These signs are observed through generally accepted medical clinical techniques such as medical history, physical examination, and laboratory tests.

PAID MATERNITY BENEFIT

"Paid Maternity Benefit" means an additional benefit available to the eligible birth parent following delivery of a child.

PAID SICK LEAVE

"Paid Sick Leave" or "PSL" means accrued paid time off under the Company's paid sick leave policy for exempt and non-exempt employees and is considered active employment.

PAID TIME OFF

"Paid Time Off" or "PTO" means accrued paid time off under the Company's paid time off policy for non-exempt employees and is considered active employment.

PARTICIPANT

"Participant" means an Employee who satisfies the eligibility requirements of Section 2.01.

PLAN

"Plan" means this PayPal Short Term Disability Plan.

PLAN ADMINISTRATOR

The "Plan Administrator" is PayPal Holdings, Inc.

PLAN SPONSOR

"Plan Sponsor" means PayPal Holdings, Inc.

PLAN YEAR

"Plan Year" begins on January 1 and ends on the following December 31. The financial records of the Plan are kept on a Plan Year basis.

RECOVER...RECOVERY

"Recover," "Recovered," "Recovery" or "Recoveries" means all moneys paid to the Participant to compensate for all losses due to Sickness or Injury resulting from the actions or omissions of a third party, whether or not said losses reflect expenses covered by the Plan. 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.

REGULAR OCCUPATION

"Regular Occupation" means the work activity which, immediately prior to the Injury or start of the Sickness for which Employee is applying for benefits (1) the Employee was regularly performing for the Company, and (2) was the source of Employee's income from the Company.

REGULAR WAGES

"Regular Wages" means base salary for salaried Employees, or standard weekly earnings for hourly Employees based on the hourly rate of pay and scheduled hours, subject to applicable law. Regular Wages include any Employee pre-tax contributions to a Company employee benefit plan or state-mandated insurance program, including qualified deferred compensation plans, health and welfare plans, state disability insurance premiums, and voluntary disability insurance plan premiums, and flexible spending accounts. "Regular Wages" do not include the following: bonus, over-time, commissions, or the value of any stock awards or other employee benefit plans or fringe benefit.

REASONABLE EMPLOYMENT OPTION

“Reasonable Employment Option” means an employment position within the Company for which an Employee is able to perform the Essential Functions given the Employee’s education, training, and experience.

REIMBURSEMENT

“Reimbursement” means repayment to the Plan for benefits that the Plan has paid to a Participant as a result of the Participant’s Sickness or Injury.

SICKNESS

“Sickness” means an illness or disease; infection; or pregnancy.

SUBROGATION

“Subrogation” means the Plan’s right to pursue and place a lien upon the Participant’s claims benefits against a Third Party.

TRACKING FREE VACATION

“Tracking Free Vacation” or “TFV” under the Company’s Tracking Free Vacation policy is considered paid time off for exempt employees and is considered active employment.

WAITING PERIOD

“Waiting Period” has the meaning set forth in Section 3.01.

WORKSITE

“Worksite” means the Employee’s usual place of business for performing services for the Company; an alternative worksite, as directed by the Company; or a location to which the Employee’s job requires the Employee to travel.

ARTICLE II

ELIGIBILITY AND PARTICIPATION

2.01 ELIGIBILITY FOR PARTICIPATION; ENROLLMENT

A. An exempt Employee is eligible to participate in this Plan, and becomes a Participant, beginning on the first (1st) day an Employee is Actively at Work.

B. A non-exempt Employee is eligible to participate in this Plan, and becomes a Participant, beginning on the first (1st) day an Employee is Actively at Work. However, notwithstanding the foregoing, a non-exempt Employee is not eligible for Paid Maternity Benefit until after six (6) months of Actively at Work employment with the Company.

C. For exempt and non-exempt Employees, Plan coverage is provided automatically to Employees without the need to affirmatively enroll.

D. Coverage under the Plan continues while a Participant (i) is on a Company-approved leave granted pursuant to applicable state or federal law, (ii) is on a Sabbatical under the PayPal, Inc. Sabbatical Plan, (iii) is on a leave approved by the Company, or (iv) is on PTO, PSL, or TFV.

Interns, contract employees, independent contractors, leased workers, leased employees, seasonal workers, or casual or temporary workers (e.g., individuals paid by an employment agency), and those individuals otherwise not treated as a common law employee by the Company for payroll or tax purposes are excluded from eligibility.

Additionally, if during any period the Company has not treated an individual as an Employee and, for that reason, has not withheld employment taxes with respect to that individual, then that individual will not be eligible to participate in the Plan for that period, even in the event that the individual is determined, retroactively, to have been an Employee during all or any portion of that period. An individual's status as an eligible Employee will be determined by the Company and any such determination will be conclusive and binding on all persons and be afforded the maximum deference under applicable laws.

2.02 CESSATION OF PARTICIPATION

An Employee's participation in the Plan will end on the earliest of the following:

- A. on the date the Participant begins an unauthorized or unpaid leave of absence;
- B. at midnight on the date their employment with the Company terminates for any reason (including no reason);
- C. on the date the Participant is no longer eligible to participate in the Plan;
- D. on the date the Participant retires;
- E. on the date the Participant dies;

- F. on the date PayPal, Inc. discontinues the Plan; or
- H. on the date the Participant is no longer classified as an Employee in accordance with Section 1.06 of this Plan.

ARTICLE III

DISABILITY BENEFIT

3.01 ELIGIBILITY FOR BENEFIT

A Participant who the Claims Administrator determines is Disabled shall, subject to the provisions of the Plan, become eligible to receive the benefit described in Section 3.05 on the earlier of:

- A. the first (1st) day of Hospital Confinement, or
- B. the eighth (8th) consecutive day of Disability.

Participants will be subject to a seven (7) day waiting period, which begins on the first day of Sickness or Injury that constitutes a Disability (“Waiting Period”). During the Waiting Period, a Participant must use any available PSL, accrued PTO, or TFV. If the Participant does not have PSL or accrued PTO available, the Waiting Period will be unpaid. If the Participant exhausts PSL or accrued PTO during the Waiting Period, the remaining portion of the Waiting Period will be unpaid.

3.02 DISABILITY DEFINED

A Participant will be considered to have a “Disability” or be “Disabled” under the Plan if the Claims Administrator determines that as a result of Sickness or Injury, the Employee is unable to perform with reasonable continuity the Essential Functions of the Employee’s Regular Occupation or of a Reasonable Employment Option offered to the Employee by the Company and:

- the Employee is under the regular and continuous care and treatment by a Health Care Provider, unless such regular and continuous care and treatment are not medically necessary given the Sickness or Injury, as determined by the Claims Administrator;
- the Disability is supported (as determined by the Claims Administrator) by Objective Medical Evidence provided by a Health Care Provider; and
- as a result of the condition, the Employee is unable to earn more than eighty percent (80%) of their pre-Disability Regular Wages.

3.03 LIMITATIONS AND EXCLUSIONS

No Participant will be entitled to benefits with respect to a Disability which arises out of, relates to, is caused by, or results from:

- A. an intentionally self-inflicted injury or attempted suicide - while sane or insane;
- B. an Injury, Sickness, mental illness, substance abuse, or pregnancy not being treated by a Health Care Provider;
- C. a Sickness or Injury due to active participation in an unlawful act, including a riot or fight (unless the Participant was defending the Participant’s self against an unprovoked assault);

- D. a loss of professional license, occupational license, or certification;
- E. a Sickness or Injury to which a contributing cause was the Participant's commission or attempted commission of a crime;
- F. a Sickness or Injury due to the Participant's active participation in war or any act of war, declared or undeclared;
- G. a Sickness or Injury sustained while the Participant was not covered under the Plan;
- H. a vague or indefinable condition such as "tiredness" or "pain" for which their Health Care Provider cannot provide Objective Medical Evidence acceptable to the Claims Administrator in its sole discretion;
- I. Cosmetic Surgery, except for surgery made necessary by accidental injury or by a disabling condition which was incurred while the Participant was covered under the Plan or by surgery made necessary to accomplish gender reassignment;
- J. working for oneself (in an income-producing capacity) or for an employer other than the Company;

No Benefits Are Payable:

- A. to a Participant who is a) incarcerated, in any federal, state, city, county, or municipal penal institution, jail, medical facility, public or private hospital or in any other place because of a criminal conviction of a federal, state, city, county, or municipal law or ordinance, or b) who commits a crime and is Disabled due to a Sickness or Injury, caused by, or arising out of the commission of, arrest, investigation, prosecution of any crime that results in a felony conviction,
- B. to a Participant who willfully, for the purpose of obtaining benefits, either makes a false statement or representation or misrepresentation, with actual knowledge of the falsity thereof, or withholds a material fact in order to obtain benefits under this Plan,
- C. to a Participant who commits a fraudulent act or omission in order to obtain benefits under this Plan,
- D. during any period of Disability for which benefits are paid or payable to the Participant under any unemployment compensation act or similar law of the United States or of any state, or
- E. to a Participant who refuses to return to work at a Reasonable Employment Option offered by the Company.

3.04 RECURRENT AND SUCCESSIVE PERIODS OF DISABILITY

- A. If, after being determined Disabled, a Participant returns to Active Work and experiences another Sickness or Injury that constitutes a Disability, and such Sickness or Injury is (i)

due to the same cause or due to a related cause, and (ii) the Participant has been Actively at Work for 30 calendar days or less, the Sickness or Injury is considered to be recurrent. The period of Disability prior to the return to work and the recurrent Disability will be considered to be a continuous length of time during which the Participant is Disabled under the Plan, and no Waiting Period is required. However, the maximum amount of benefits for the recurrent Disability is 26 weeks.

- B. If a Participant experiences a Sickness or Injury that constitutes a Disability that is not due to the same or related cause and is not a recurrent Disability, the Sickness or Injury will be treated as a new separate Disability which must independently satisfy all the requirements of this Plan including, but not limited to, the Waiting Period. However, if a Participant is already receiving benefits under the Plan, the maximum amount of Benefits for the existing Disability and the separate Disability will not extend beyond 26 weeks total.
- C. For purposes of this Section 3.04, the 26-week benefit is determined on a rolling 12-month calendar year. As such, a Participant cannot receive 26 weeks of benefits within one rolling calendar year.

3.05 AMOUNT OF BENEFIT

Weeks 1 through 6 of Disability (benefit will not be paid during the Waiting Period):

Week 1 begins following the completion of the Waiting Period. The amount of weekly benefit for a Disabled Participant who is covered under the Plan will be one hundred percent (100%) of the Participant's Regular Wages, reduced by income from all other sources and applicable withholdings.

Weeks 7 through the maximum benefit period:

For weeks 7 through the maximum benefit period, the amount of weekly benefit for a Disabled Participant who is covered under the Plan will be eighty percent (80%) of the Participant's Regular Wages, reduced by income from other all sources and applicable withholdings.

Special Rule for Paid Maternity Benefit

For Participants who qualify for the Paid Maternity Benefit, Weeks 1 through 8 of Disability will be paid at one hundred percent (100%) of Regular, reduced by income from all other sources and applicable withholdings.

Weeks 9 through the maximum benefit period will be paid at eighty percent (80%) of Regular Wages, reduced by income from all other sources and applicable withholdings.

Benefits for Partial Weeks

Notwithstanding anything in this Plan to the contrary, if a Participant's Disability benefits are payable for less than one week, the Plan will pay one-seventh the amount of the weekly benefit for each day the Participant was eligible to receive Disability benefits for the week.

3.06 MAXIMUM BENEFIT

The Claims Administrator will determine the start of a certified period of Disability for which Plan benefits are payable. A certified period of Disability will end, and in no event will benefits continue beyond, the earliest occurrence of any of the following:

- A. Twenty-six (26) weeks of Disability. Active Work days do not count toward the maximum 26 week benefit period.
- B. The date of the Participant's death;
- C. The date the Participant is no longer under the care of a Health Care Provider;
- D. The date the Participant starts regular work on a full-time basis at a Reasonable Employment Option occupation;
- E. The date the Participant refuses to be examined by an independent physician at the Plan's or Claims Administrator's request;
- F. The date the Participant refuses recommended treatment that is generally acknowledged by Health Care Providers to cure, correct, or limit the disabling condition;
- G. The date an independent medical exam report fails to confirm the Participant's Disability;
- H. The date the Participant's Disability cannot be confirmed because the Claims Administrator has not received the appropriate medical evidence or other requested documents, records, or information;
- I. The date the Participant is not undergoing effective and appropriate treatment for alcoholism or drug abuse, if the Disability is due to any extent by alcoholism or drug abuse;
- J. The date the Participant fails to provide proof that the Participant is unable to perform the duties of any occupation for compensation or profit equal to more than eighty percent (80%) of their pre-disability Regular Wage;
- K. The date the Participant no longer has a Sickness or Injury that constitutes a Disability;
- L. The date the Participant's Health Care Provider releases the Participant to return to work;
- M. The date the Participant is no longer Disabled or the date the Disability ends; or
- N. The date the Participant performs services for another employer while the Participant is receiving benefits under this Plan.

3.07 REDUCTION OF BENEFITS

Plan benefits will be reduced by any other income the Participant receives or is eligible to receive as a result of the Disability (or the Sickness or Injury causing the Disability) for which the Participant is claiming benefits under this Plan, regardless of whether the Participant applies for such other benefits. Other sources of income include, but are not limited to:

- A. Federal, state, county, local, or municipal disability benefits, or any benefits under any other Company plan, program or arrangement established in lieu thereof;
- B. State disability benefits paid under a Voluntary Disability Insurance Plan for California employees (CA-VDI);
- C. Benefits paid pursuant to any state or federal workers' compensation or disability law or other law of similar purpose; such benefits will include, but will not be limited to, temporary disability and permanent disability payments (whether total or partial), vocational rehabilitation indemnity benefits, attorney's fees and any amounts awarded or allocated for future medical expenses. Any amount awarded or paid in a lump sum, in accordance with a workers' compensation plan, whether voluntarily or by operation of law, will be deducted from the Plan benefit payable commencing from the date of the award or settlement and continuing for as many future weeks as is necessary to equal the amount of such lump sum;
- D. Remuneration from the Company, including but not limited to, wages for part-time or light duty work and, PTO. However, for any day for which the Employee receives wages or regular wages from the Company, benefits will be paid for any (7) seven day week or partial week, in an amount not to exceed the maximum weekly amount provided by this Plan, which together with the wages or regular wages received, does not exceed the weekly wage, exclusive of wages paid for overtime, immediately prior to the commencement of the Employee's Disability.
- E. Any Federal Social Security or Supplemental Security Income for which the Participant and their dependents are eligible because of the Participant's Disability or retirement under Social Security (Old Age, Survivors, Disability and Health Insurance) [OASDHI] of the United States. Dependent benefits are not included if the Participant is divorced and benefits are being paid to the divorced spouse or child(ren) instead of to the Participant. For purposes of computing this offset, any statutory cost of living increases awarded after the initial Social Security Award date, will not be used. However, if the initial award is subsequently adjusted for any other reason, other than a statutory cost of living increase, the new award will be offset;
- F. Benefits for loss of income due to unemployment or disability under any law or compulsory government program;
- G. Compulsory "no-fault" automobile insurance;
- H. Any Company-sponsored or Company-funded pension plan or retirement plan;
- I. Any government pension or railroad (RRA) pension;
- J. Recoveries resulting from acts of a third party as outlined in Section 3.08;
- K. The portion of a settlement or judgment, without deduction for any associated costs, of a lawsuit that represents or compensates for their loss of earnings;
- L. Any amount provided under federal maritime law;
- M. Veteran's Administration benefits;

- N. Any compensation a Participant receives from the Company while the Participant is receiving benefits under this Plan; and
- O. Any compensation the Participant receives from any other employer while the Participant is receiving benefits under this Plan.

3.08 ACTS OF THIRD PARTIES; SUBROGATION AND REIMBURSEMENT

- A. Notice. A Participant must notify the Plan Administrator immediately of any potential causes of action or claims for a Recovery that the Participant may have against a third party. A Participant must provide the Plan Administrator with a copy of any summons, complaint, or other process served in any lawsuit in which the Participant seeks a Recovery. A Participant must notify the Plan Administrator immediately of any settlement offer regarding a potential Recovery.
- B. No Prejudicial Acts; Cooperation. A Participant shall take no action to prejudice the rights of the Plan. A Participant must cooperate and assist the Plan in enforcing its Subrogation and Reimbursement rights. Upon request, the Participant must: (i) provide details of the Sickness or Injury; (ii) authorize the release of information, including the names of all Health Care Providers from whom the Participant received service or treatment; (iii) provide information about other insurance coverage and benefits; (iv) provide such other information as may be requested by the Plan; (v) assist the Plan in any action against the third party; and (vi) execute a subrogation agreement, assignment of recoveries, and reimbursement agreement in favor of the Plan. The Participant must obtain written consent from the Plan Administrator before entering into any settlement agreement with a third party. If a Participant refuses to comply with its obligations under this Article, fails to cooperate with the Plan in regard to Subrogation and Reimbursement rights, or refuses to execute and deliver such papers as the Plan may require in furtherance of its Subrogation and Reimbursement rights, then the Plan shall have no obligation to pay benefits to the Participant.
- C. Reimbursement. In the event a Recovery is paid from a third party directly to the Participant, the Participant must reimburse the Plan the amount of any Disability payments previously made to the Participant by the Plan (or for which the Plan may have future responsibility) with respect to that Sickness, Injury, or Disability.
- D. Priority; Other Legal Doctrines. If the third party makes any payment to the Participant, or their attorney, or a trust for their benefit, such payment must first be used to provide equitable restitution to the Plan, to the full extent of benefits paid by or payable under the Plan. This priority of the Plan applies despite other legal doctrines or theories. The Plan's rights of Subrogation and Reimbursement under this Article 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 or equitable doctrine or theory. The Plan expressly rejects the common fund doctrine with regard to attorneys' fees. The rights of the Plan shall not be affected, reduced, or eliminated by any allocation which purports to allocate Recovery amounts in whole or in part to nonmedical damages.
- E. Rights of the Plan.

1. Subrogation. The Plan 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 Participant's Sickness, Injury, or Disability if such property or funds should be or should have been paid to the Plan under this Article. The Plan has the right to seek a temporary restraining order against such party to prevent disbursement of such property or funds. In addition, the Plan 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 Plan or for which it may have future responsibility.
2. Reimbursement. The Plan shall legally succeed the Participant's right of Recovery against a third party, up to the amount of benefits it has paid (or for which the Plan may have future responsibility) with respect to that Sickness, Injury, or Disability. The Plan shall have first priority on any money Recovered from the third party, including any amounts paid for medical costs over the uninsured or underinsured motorist's coverage, homeowner's or renter's coverage, medical malpractice, or any liability plan. The Plan's contractual right to Reimbursement is in addition to and separate from equitable Subrogation, and may be enforced under the same terms as discussed in this Section 3.08.
3. Fees and Costs. If the Plan files suit in order to enforce its right to Recover from the Participant, the Plan reserves the right to be reimbursed for its court costs and attorneys' fees in relation to such suit. This Plan will not be responsible for expenses or attorney's fees incurred by a Participant in connection with any Recovery unless the Plan expressly agreed in writing to pay those expenses or fees.
4. This Plan reserves the right to reduce the amount of its recoverable Subrogation interest where in the discretion of the Plan a reduction is in the best interests of this Plan and its Participants and warranted by the circumstances. This Plan also reserves the right to initiate an action in the name of the Plan or in the name of the Participant to recover its Subrogation or Recovery interests. In no instance will the recoverable Subrogation interest exceed total Plan benefits paid with respect to the Disability.

F. Specific Participant Requirements.

If a Participant is Injured through the acts or omissions of a third party, the Participant shall be eligible for benefits under the Plan only if the Participant agrees in writing:

1. That this Plan will be subrogated to all rights of recovery that the Participant, their heirs, guardians, executors, agents, estate, or other representatives (hereafter individually and collectively "Participant") may have as a result of the Injury, regardless of whether the Participant pursues any legal or equitable actions against the person or organization causing the Injury, including, without limitation, rights to recovery pursuant to:
 - a. any legal action initiated by this Plan;
 - b. any action in intervention;
 - c. any action, at law or in equity, legally permissible to enforce this Plan's rights of subrogation and recovery against any person or entity that caused, contributed to, or is in any way responsible for the Injury.

- d. any action, at law or in equity, legally permissible to enforce this Plan's rights of subrogation and recovery against any person, insurance company, health care provider, or other entity that is in any way responsible for providing indemnification, coverage, compensation, or other payment for or as a result of the Injury;
 - e. any action, at law or in equity, legally permissible to enforce this Plan's rights of subrogation and recovery against any person who received payment of funds from either (a) a person or entity that caused, contributed to, or is in any way responsible for the Injury; or (b) any insurance company, health care provider, or other entity that is in any way responsible for providing indemnification, coverage, compensation, or other payment as a result of the Injury;
 - f. any suit to impose a constructive trust on funds paid by any source as a result of the Injury;
 - g. any suit to enforce an equitable lien on funds paid by any source as a result of the Injury;
 - h. under no fault, personal injury protection, financial responsibility, uninsured motorist, and underinsured motorist insurance;
 - i. under motor vehicle medical and wage loss reimbursement insurance;
 - j. under homeowners, renters, premises and owners, and landlords and tenants insurance, including medical reimbursement coverages; and
 - k. under group accident and health insurance, and athletic team, sporting event, school, club and other specific risk insurance coverages or accident benefit plans.
2. To reimburse the Plan for the full amount of payments made under the terms of this Plan, immediately upon receipt of the proceeds of any settlement of, or judgment in, an action at law or in equity, arbitration, claim, or other proceeding to determine said Participant's rights of recovery arising out of said Injury, without reduction for the Participant's reasonable expenses in collecting such amount, including reasonable attorney's fees, and without reduction for any amounts which are allocated by terms of any judgment for the payment of unreimbursed medical expenses of the Participant; said Participant will execute and deliver instruments and papers and do whatever else is necessary to secure the rights of the Plan to subrogation and reimbursement out of such proceeds; said Participant will do nothing to prejudice such rights;
3. To provide the Plan and Plan Administrator with a lien on the proceeds described above, to the extent of the full amount of payments made under the terms of this Plan; said lien may be filed with the person or organization whose act or omission injured the Participant, with them or its agents, or may be filed with a court; when this Plan provides a notice of lien regarding a subrogation claim to any person, insurer, attorney, or other responsible party, the notice is sufficient to protect the Plan's subrogation rights though the Plan may not be compelled to initiate or to intervene in any legal action in order to establish or maintain its right of subrogation;

4. To provide the Plan Administrator with a credit against payments to be made in the future under this Plan; said credit to be equal to the proceeds above described; and
5. That the Plan will be entitled to first dollar recovery from any amounts paid as a result of the Participant being injured by a third party and this first dollar recovery right will be superior to any other lien's held by other insurers, persons, attorneys' fees, or other entity. The amount of this Plan's subrogation interest will be deducted first from any recovery by or on behalf of the Participant, no matter how such recovery is characterized.

3.09 FACILITY OF PAYMENT

- A. Benefits under this Plan are paid through the Company's normal payroll processes.
- B. Withholding and related tax reporting may be applied to amounts paid or payable pursuant to this Plan for all federal, state, local, or other taxes with respect to any amounts paid or payable under this Plan.

3.10 OTHER EMPLOYEE BENEFITS

- A. Disabled Participants may continue their coverage under the employee benefit plans in which they were enrolled immediately prior to such Disabilities at the then current contribution rates, subject to the terms and conditions of each employee benefit plan in which the Participant is enrolled.
- B. Disabled Participants receiving benefits under this Plan are required to pay for the cost of coverage (e.g., premiums) for the employee benefit plans in which they were enrolled immediately prior to their Disabilities at the then-current contribution rates that apply to active Employees who are not receiving Disability benefits. If the amount of PSL or PTO (if any) is insufficient to cover the cost of coverage, the Participant is required to pay the remaining amounts.

ARTICLE IV

CLAIMS AND APPEALS PROCEDURES

4.01 APPLICATION FOR BENEFITS

To be entitled to any Plan benefits for which a Participant is otherwise eligible under the Plan, a Participant must be in compliance with such procedures and requirements as the Plan Administrator and Claims Administrator have prescribed, with respect to the completion and filing of an application for such benefits, and submission of evidence that such Participant is entitled to such benefits.

The Plan Administrator or its designee will have the right to:

- A. Require proof of Disability, at the Participant's expense during the pendency of a claim, except as provided in Section 4.03;
- B. Require information with respect to the Participant's age, address, marital status, dependents, employment record, and medical history;
- C. Require evidence that such Participant has applied for Social Security benefits or other benefits as outlined in Section 3.07;
- D. Personally contact and interview the Participant, the Participant's Physician, employer or any other persons, including an independent Physician engaged by the Plan or Claims Administrator, who can provide relevant information regarding the Participant's Disability. Failure to cooperate with the Plan Administrator or Claims Administrator in a reasonable investigation or processing of a claim may result in benefits being denied or terminated; and
- E. Require any other information reasonably relevant to a determination of whether such Participant is eligible to receive Plan benefits.

The Plan Administrator or its designee also has the authority to require that the Participant provide, and to make Plan benefits conditioned upon the Participant providing, timely written authorization permitting the Plan Administrator to:

- 1. Obtain information from all Health Care Providers of the Participant applying for Plan benefits, with respect to such Participant's physical and mental condition, diagnosis, prognosis, date of expected return to work, and related matters;
- 2. Request and receive relevant medical records on file in any hospital, Health Care Provider, health care facility, or government office; and
- 3. Obtain such other records from any person or entity having information reasonably relevant to a determination.

4.02 TIME LIMIT FOR APPLICATION FOR BENEFITS

Application for benefits, in accordance with the procedures and requirements prescribed by the Plan Administrator and Claims Administrator, must be made within -forty- nine days following the date of a Sickness or Injury that is or may be a Disability. Failure to make application within this time limit without just cause (as determined by the Claims Administrator in its sole discretion), may result in denial of benefits, in whole or in part, if it was not reasonably possible to do so, provided such application was made as soon as was reasonably possible.

Absent extraordinary circumstances, no claim shall be accepted more than 6 months following the date upon which benefits under the Plan may become payable.

Claims must be submitted to:

Sedgwick Claims Management Services, Inc.
P.O. Box 14435
Lexington, KY 40512-4435
855-233-7599
<https://login.mysedgwick.com/paypal>

4.03 MEDICAL EXAMINATIONS

The Plan Administrator or its designee may require that a Participant applying for Disability benefits, or appealing an adverse benefit determination, submit to an examination by one or more Health Care Providers or vocational experts designated by the Plan Administrator (or its designee), for a medical or vocational opinion, as to whether such Participant is Disabled so as to meet the eligibility requirements under the Plan for Plan benefits, and whether the Disability has existed for the prerequisite Waiting Period. Reexaminations of a Participant receiving Plan benefits may be required by the Plan Administrator or its designee from time to time for the purpose of assisting the Plan Administrator in determining whether continued eligibility for such benefits exists. The fees of such Health Care Providers or vocational experts and the expenses of such examinations will be paid by the Company.

4.04 CLAIM DETERMINATION

An application for benefits must be submitted to the Claims Administrator. The Participant or the Participant's authorized representative must provide an Employee/Claimant's Statement, an authorization for release of medical information, a statement from a Health Care Provider demonstrating the Sickness or Injury causing a Disability ("Physician's Statement"), and any other documents or information the Plan Administrator requests or requires. The Physician's Statement will be from a Health Care Provider attending the Participant for the Sickness or Injury, which is the basis of the Disability claim.

Following receipt of a claim by the Claims Administrator, the Plan will provide the Participant, within a reasonable period of time, but no more than forty-nine days (49) days, with a written determination of whether the claim qualifies for benefits under the Plan. However, this period of time may be extended as follows:

- i. If there are unresolved issues that prevent a decision on the claim, and additional information is needed with respect to the claim, the time period is tolled from the date on which the notice of additional information required is sent until the date the Participant

responds to the notice. In each instance, the notice to the Participant will specify the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. The Participant will be given at least forty-nine (49) days from receipt of the notice to provide such information.

- ii. If matters beyond the control of the Plan require an extension of the time for determination more than forty-nine (49) days after receipt by the Claims Administrator of the claim, written notice indicating the reasons for an extension of up to two (2) thirty (30) day extensions will be given to the Participant within the initial forty-nine (49) day period. The notice will specify the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.
- iii. The Participant will be notified in writing within the first (1st) thirty (30) day extension period.

If it is determined that the Participant is entitled to benefits, the written notice will specify the amount of the benefit payment to be provided under this Plan. The notice will include the method by which the amount of the benefit payment was computed.

If it is determined that a Participant is not entitled to benefits, the written notice will set forth the specific reasons for the determination, specify the Plan provisions upon which the denial was based, describe any additional material or information deemed necessary in order to perfect the claim, along with an explanation why this additional material or information is necessary, provide an explanation of the basis for disagreeing with any views of treating medical physicians or vocational specialists, provide an explanation of the basis for not following a Social Security disability determination, disclose any new or additional evidence considered, relied upon, or generated by the Plan, and describe any contractual limitations period that applies to the Participant's right to bring an appeal of an adverse determination (including the actual calendar date upon which said contractual limitations period ends),. If the Claims Administrator or any representative thereof relied on an internal rule, guideline, protocol or other similar criterion in making the determination, the Claims Administrator or representative will inform the Participant and will offer, at the Participant's request and at no cost, a copy of the rule, guideline, protocol or other similar criterion. This notice also will set forth the Claim Review Procedure described in Section 4.05 of the Plan and include a notice of the Participant's ability to bring a civil action against the Plan following review by the Plan Administrator of an appealed adverse benefit determination and the Participant's exhaustion of the Plan's claims and appeals procedures.

All decisions by the Plan Administrator and Claims Administrator will be afforded the maximum deference permitted by law.

4.05 APPEALS PROCEDURE

A Participant whose claim has been denied, in whole or in part, may, within one hundred and eighty (180) days after receipt of notice of such denial, make written request for review of the claim to the Claims Administrator. The Participant will have the right to review, on written request, and free of charge, all documents pertinent to their claim. The Participant will have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. The review will take into account all comments, documents, records, and other information the Participant submits, without regard to whether such information was submitted or considered in the initial benefit determination. In connection with

the review procedure, the Claims Administrator or its representative will have discretionary authority to interpret the Plan, including any ambiguous provisions, and to determine eligibility for benefits.

The appeal will not defer to the initial adverse determination, and it will be conducted by an individual who is neither the individual who made such initial determination, nor the subordinate of such individual. The appeal of a claim that was denied based on a medical judgment will be reviewed by the Claims Administrator or its representative in consultation with a qualified health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional cannot be an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor the subordinate of such individual. The Claims Administrator or its representative must identify for the Participant medical or vocational experts whose advice was obtained by it in connection with an adverse determination, without regard to whether the advice was relied upon in making the benefit determination.

The Claims Administrator or its representative will provide the Participant with a written decision. In the case of an adverse benefit determination, the notice will include the specific reasons for the adverse determination, reference to the specific plan provisions on which the determination is based, describe any additional material or information deemed necessary in order to perfect the appeal along with an explanation why this additional material or information is necessary, provide an explanation of the basis for disagreeing with any views of treating medical physicians or vocational specialists, provide an explanation of the basis for not following a Social Security disability determination, disclose any new or additional evidence considered, relied upon, or generated by the Plan, and describe any contractual limitations period that applies to the Participant's right to bring an action against the plan for the denied appeal (including the actual calendar date upon which said contractual limitations period ends), and a statement that the Participant is entitled to receive, upon request and free of charge, documents, records, and other information relevant to the claim for benefits. If the Claims Administrator or the representative relied on an internal rule, guideline, protocol, or other similar criterion in making the determination, the Claims Administrator or representative will inform the Participant and will offer, at the Participant's request and free of charge, a copy of the rule, guideline, protocol or similar criterion.

This decision will be provided within a reasonable period of time, but no more than forty-nine (49) days after receipt of the request for review. If special circumstances require an extension of the time for review, written notice indicating the reason for such extension will be given to the Participant within such forty-nine (49) day period. In case of an extension, the decision will be provided within a reasonable period of time but no more than ninety (90) days after receipt of the request for review.

No action for benefits may be commenced against the Plan, Plan Sponsor, Plan Administrator, Company, Claims Administrator, or designated representative of the Plan prior to the completion and exhaustion of the Plan's claims and appeals procedures.

All decisions by the Plan Administrator and Claims Administrator will be afforded the maximum deference permitted by law.

4.06 NON-ALIENATION OF BENEFITS

To the extent permitted by law, no benefit payable at any time under the Plan will be assignable or transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise, including, but not by way of limitation, execution, levy, garnishment, attachment, pledge, bankruptcy, or in any other manner, and no benefit payable under the Plan will be liable for, or be subject to, any obligation or liability of any Participant. If any Participant entitled to a benefit under the Plan will attempt to, or will alienate, sell, transfer, assign, pledge or otherwise encumber such benefit, or any part thereof, or if by reason of bankruptcy, or other event happening at any time, such benefit would devolve upon anyone else or would not be enjoyed by them then the Plan Administrator, in its discretion, which will be exercised uniformly by treating individuals in similar circumstances alike, may terminate the Participant's interest in any such benefit, and hold or apply it to or for their benefit, or the benefit of their spouse, children or other dependents, or any of them, in such manner as the Plan Administrator may deem proper and in accordance with law.

4.07 PAYMENT TO REPRESENTATIVE

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

4.08 PAYMENT IN THE EVENT OF DEATH

If the final payment of Disability income is payable as the result of the death of a Participant, such payment will be paid to the Participant's estate. Any such payment will fulfill and discharge the Plan's and Company's responsibility for the amount paid.

4.09 OVERPAYMENT

If a Participant receives an overpayment from the Plan (including any overpayment caused by their receipt of income from other sources that should have reduced Plan benefits that were paid to them, the Participant must immediately reimburse the Plan for the overpayment. The Plan will have an equitable lien on any overpayment that the Participant receives from the Plan and any payment the Participant receives (or is entitled to receive) from a third party that is owed to the Plan because it should have reduced Plan benefits that have already been paid. If a Participant receives money from a third party for which the Plan is entitled to reimbursement, the Participant or their attorney (if the attorney is holding the money), will hold the money in constructive trust for repayment to the Plan, and will promptly repay the Plan for the amount of the overpayment. The Participant or their attorney (if the attorney is holding the money), will be considered a fiduciary with respect to the monies held in constructive trust. The Plan will have first priority in any amounts received from a third party that are owed to the Plan, regardless of the manner in which the terms of the payment are structured or worded. The Plan's reimbursement will not be reduced by attorney's fees or any other costs or expenses.

Participants are legally obligated to avoid doing anything that would prejudice the Plan's rights of reimbursement. However, the Plan will be entitled to recover in accordance with these rules, even if Participant does not sign or return any forms required by the Plan. Failure to cooperate may result in Participants disqualification from receipt of further benefits from the Plan.

Until arrangements which are satisfactory to the Plan Administrator are made to repay an overpayment, any Plan benefits that become payable may be reduced to offset the overpayment.

ARTICLE V

FUNDING

5.01 CONTRIBUTIONS

A. The Plan is self-funded by the Company. The Company pays the entire cost of the Plan, including benefits, solely out of the Company's general assets.

B. There are no Participant or Employee contributions to the Plan.

5.02 THE COMPANY'S LIABILITY IN THE EVENT OF AMENDMENT, SUSPENSION OR TERMINATION OF THE PLAN

No amendment, suspension, or termination will occur that would except as may otherwise be required by law, impair the right of a Participant upon the adoption of such amendment to receive benefits provided for herein to which they already became entitled prior to such amendment. Upon termination of the Plan, the Company will make provision for the payment of benefits hereunder to each Participant to whom benefits are payable on the date of termination. Notwithstanding the foregoing, Employees and Participants do not have any vested interests or benefits under this Plan and do not obtain or attain any vesting in this Plan at any time, including upon termination or amendment of the Plan.

ARTICLE VI

ADMINISTRATION OF THE PLAN

6.01 APPOINTMENT OF PLAN ADMINISTRATOR

The Company is the Plan Administrator; however, the Company retains the right to appoint another Plan Administrator which Plan Administrator may be any Employee of the Company, or such other person or entity as the Company may select.

6.02 DUTIES OF PLAN ADMINISTRATOR

A. The Plan Administrator is responsible for the administration of this Plan in accordance with the provisions of the Plan. The Plan Administrator will have such powers and perform such duties as are necessary for the proper operation of the Plan. For this purpose, the Plan Administrator's full and discretionary powers include, but are not limited to, the following:

1. The discretionary power and authority to interpret and construe the terms of the Plan, including any ambiguous terms;
2. Determining eligibility for benefits;
3. To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable law;
4. To consider and decide claims and appeals filed under the Plan;
5. To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan; and
6. To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan. Any such allocation, delegation or designation shall be in writing.

B. The Plan Administrator may, from time to time, designate representatives who will carry out the delegated responsibilities on behalf of the Plan Administrator. Contemplated designees include, but are not limited to, a Claims Administrator. All such designees will serve at the pleasure of the Plan Administrator and, if employees, will serve without compensation.

C. All decisions by the Plan Administrator will be afforded the maximum deference permitted by law.

6.03 LIMITATION OF LIABILITY

The Plan Administrator and any representative thereof will be entitled to rely upon any information from any source assumed in good faith to be correct. Neither the Plan Administrator nor any of its representatives, nor the Company, nor any officer or other representative of the Company will be liable because of any act or failure to act on the part

of the Plan Administrator or any of its employees, to any person whomsoever except that nothing herein will be deemed to relieve any individual from liability for their own fraud, bad faith, or gross negligence.

ARTICLE VII

DURATION AND AMENDMENT OF THE PLAN

7.01 PERMANENCE OF THE PLAN

Although the Plan Sponsor has established the Plan with the bona fide intention and expectation that it will be able to continue the Plan indefinitely, nevertheless, the Plan Sponsor is not, and will not be under any obligation or liability whatsoever to continue or to maintain the Plan for any given length of time. The Plan Sponsor or its authorized representative may, in its sole and absolute discretion, terminate the Plan in accordance with its provisions at any time without any liability whatsoever for such discontinuance or termination. If the Plan is terminated, the Plan will continue to pay all benefits then due and payable to Participants, subject to Section 5.02. The right of the Plan Sponsor or its authorized representative to terminate the Plan shall not require the consent, concurrence, or any other action by the Company.

7.02 RIGHT TO AMEND

The Plan Sponsor or its authorized representative reserves the right, any time and from time to time, to modify, alter, or amend, in whole or in part, any or all of the provisions of the Plan. The right of the Plan Sponsor or its authorized representative to modify, alter, or amend the Plan shall not require the consent, concurrence, or any other action by the Company.

No modification, alteration or amendment will have any retroactive effect so as to deprive any Participant of any benefit then payable. Notwithstanding the foregoing, any modification, alteration, or amendment of the Plan may be made retroactive to the extent necessary for the Plan to comply with applicable law.

ARTICLE VIII

GENERAL PROVISIONS

8.01 NO LIMITATION OF MANAGEMENT RIGHTS

Participation in the Plan will not lessen or otherwise affect the responsibility of an Employee to perform fully their duties in a satisfactory and worker like manner, nor will it affect the Company's right to discipline, discharge, or take any other action with respect to an Employee. Nothing in the Plan stipulates or implies participation in the Plan guarantees continued employment with the Company.

8.02 PARTICIPANT'S RESPONSIBILITIES

Each Participant will be responsible for providing the Plan Administrator with their current address. Any notices required or permitted to be given hereunder will be deemed given if directed to such address and mailed by regular United States mail. The Plan Administrator, Claims Administrator, and the Company do not have any obligation or duty to locate a Participant. If a Participant becomes entitled to a payment under the Plan and such payment cannot then be made because any of the following: (i) the current address referred to above is incorrect, (ii) such Participant fails to respond to the notice sent to the current address referred to above, (iii) of conflicting claims to such payment, or (iv) of any other reason, the amount of such payment, if and when made, will be that determined under the provisions of Article III hereof, without interest thereon.

8.03 GOVERNING LAW; STATUTE OF LIMITATIONS

A. The Plan is intended to be a "payroll practice" under 29 C.F.R. § 2510.3-1(b) that is not subject to ERISA. This Plan is governed by the laws of the State of California. Any action relating to, arising out of, or involving the Plan that must be litigated in a state or federal court located in Santa Clara County, California, and no other federal or state court. In consideration of participating in and receiving benefits under the Plan, Employees, dependents, Participants, beneficiaries, and other persons receiving benefits under the Plan agree to the provisions of this section.

B. No legal or equitable action relating to a claim or any other action involving the Plan may be commenced later than two (2) years after the date the person bringing the action knew, or had reason to know, of the circumstances giving rise to the action. This provision shall not bar the Plan, the Plan Administrator, its delegates, or its representatives from recovering overpayments of benefits, initiating Subrogation actions, initiating actions for Reimbursements, or taking actions to recover, under any legal or equitable theory, other amounts incorrectly paid to any person at any time or from bringing any legal or equitable action against any party.

8.04 MISSING PERSONS

If, within one (1) year after any amount becomes payable hereunder to a Participant, said amount will not have been claimed by the Participant, provided due and proper care will have been exercised by the Plan Administrator or Claims Administrator in attempting to make such

payment, the amount thereof will be forfeited to and become the property of the Company and will cease to be a liability of the Plan.

8.05 ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator or Claims Administrator.

8.06 NO GUARANTEE OF TAX CONSEQUENCES

The Company and Plan Administrator do not make any commitment, guarantee, or representation regarding any tax treatment of benefits under this Plan.

8.07 SEVERABILITY

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

8.08 WORKERS' COMPENSATION

The Plan is not in lieu of, and does not affect any requirement for coverage by, workers' compensation insurance.