Nutanix, Inc.
Employee Welfare Benefit Plan

January 1, 2023

TABLE OF CONTENTS

ARTICLE I

PLAN ESTABLISHMENT

1.1 Effective Date

The Nutanix, Inc. Employee Welfare Benefit Plan ("the Plan") is amended and restated effective upon execution as indicated on page 66.

1.2 Purpose

The Plan has been created to provide specified health and welfare benefits for the exclusive benefit of Covered Persons, as defined in Article II.

1.3 Qualification

To the extent this Plan provides specified health and welfare benefits, it is intended to satisfy the written plan document requirements of Section 402 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The portion of the Plan that constitute the health and welfare plan under ERISA are: the Medical Premium Payment Benefits, Dental Premium Payment Benefits, Vision Premium Payment Benefits, Employee Assistance Plan Benefits, Basic Life Benefits, Supplemental Life Benefits, Dependent Life Benefits, Basic AD&D Benefits, Supplemental AD&D Benefits, Short-Term Disability Benefits, Long-Term Disability Benefits, Business Travel Accident Benefits, Health Reimbursement Account (HRA), Health Care Spending Account and the Limited Purpose Health Care Spending Account, along with those other provisions of this document that are necessary or appropriate to the implementation and administration of listed benefits.

1.4 Duration

The Plan is established with the intention of being maintained for an indefinite period of time; however, the Company, as defined in Article II, in its sole discretion and in accordance with the provisions of Article XI may amend or terminate the Plan or any provision of the Plan at any time.

ARTICLE II

DEFINITIONS

The following words and phrases, when capitalized, shall have the following meanings. Words and phrases not defined in this Article shall have the meaning set forth in an applicable Incorporated Document, and if not defined in an applicable Incorporated Document, then such words and phrases shall have the meaning customarily given them by the applicable insurance company, third party administrator, or other service provider, as the case may be.

2.1 Benefits

Benefits mean the health and welfare coverages provided under the Plan and as described in the Incorporated Documents. Certain benefits are provided to any Employee who meets the eligibility requirements of Section 3.1, while certain other benefits are provided only upon selection by an Employee who meets the eligibility requirements of Section 3.1.

2.2 Change in Status

Change in Status means:

A. A “special enrollment” event under HIPAA,

B. The Employee's marriage, divorce, legal separation, or annulment,

C. Commencement and dissolution of domestic partnership,

D. The birth, adoption, placement for adoption, or change in dependency or custody of an Employee's child,

E. The death of the Employee's Spouse or Dependent child,

F. A change in employment status by the Employee, Spouse or Dependent, including commencement or termination of employment, a change in work shift, a change in worksite, a reduction or increase in hours of employment including changing from part-time to full-time employment status, a strike or lockout,

G. Commencement or return from an unpaid leave of absence by the Employee, Spouse or Dependent,

H. A change in worksite or personal residence resulting in eligibility or loss of eligibility of coverage for the Employee, Spouse or Dependent under any health maintenance organization offered through the Plan,

I. A change in legal custody (including the issuance of a Qualified Medical Child Support Order) that affects the child’s eligibility for coverage under this Plan or the plan of the child's other parent,

J. Entitlement or loss of entitlement to Medicare or Medicaid by the Employee, Spouse or Dependent,

K. Attainment by Dependent child of limiting age for a benefit provided under this Plan,

L. Any other event the Plan Administrator determines permits the revocation of an election without violating the Code.

2.3 Claim Administrator

Claim Administrator means the person(s) or entity (or entities) authorized and responsible for receiving and reviewing claims for benefits under the Plan; determining what amount, if any, is due and payable; making appropriate disbursements to persons entitled to benefits under the Plan; and reviewing and determining denied claims and appeals.

2.4 COBRA

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X), as amended, and the regulations issued thereunder or pursuant thereto.

2.5 Code

Code means Internal Revenue Code of 1986, as amended, and regulations issued thereunder or pursuant thereto.

2.6 Company

Company means Nutanix, Inc. a corporation, and any successor, by merger or otherwise.

2.7 Covered Employee

Covered Employee means an Employee who satisfies the eligibility, participation, and coverage requirements of Article III.

2.8 Covered Person

Covered Person means a Covered Employee, or Dependent who has satisfied the eligibility and enrollment provisions of Article III or, if applicable, the provisions of Article VII.

A Covered Person may have Plan coverage with respect to certain benefits, but not all benefits, as hereinafter described in the Plan.

2.9 Dependent

Dependent means a Spouse, Domestic Partner, or dependent child of an Employee who is a Covered Person as determined under the applicable Incorporated Document.

Regardless of whether a Dependent is eligible for a Benefit under this Plan, a Covered Employee may only make Salary Reduction Contributions for Benefits for an Employee's dependent who is a Covered Person as follows:

A. Spouse,

B. dependent as defined in Code Section 152 (without regard to (b)(1), (b)(2), and (d)(1)(B)) or,

C. for health Benefits for the Covered Employee's child as defined in Code Section 152(f)(1) who has not attained age 27 as of the end of the taxable year.

A Dependent may be eligible for coverage with respect to certain benefits, but not all benefits, as hereinafter described in the Plan.

2.10 Domestic Partner

Domestic Partner means an individual, who is not a Spouse, with whom the Covered Employee has entered into a domestic partnership meeting the requirements set forth in the Nutanix, Inc. Employee Welfare Plan Summary Plan Description.

Domestic Partners of Covered Employees and children of Domestic Partners are eligible for medical, dental, vision, dependent life and accidental death and dismemberment benefits under Sections 4.4(A), (B), (C), (G), and (H).

2.11 Effective Date

Effective Date means the date the Plan becomes operative, as set forth in Article I.

2.12 Employee

For purposes of this Plan only, the term Employee means a common law employee of the Employer.

The term *Employee* includes, but is not limited to, a person who is:

A. a leased employee, as defined in Code Section 414(n),

B. a nonresident alien who receives earned income (within the meaning of Code Section 911(d)(2)) from an Employer that constitutes income from sources within the United States, as defined in Code Section 861(a)(3),

C. a collective bargained employee.

The term *Employee* does not mean:

D. a self-employed individual, as defined in Code Section 401(c)(1)(A),

E. a member of the board of directors who is not otherwise an employee,

F. a person whom the Plan Administrator determines has been engaged by the Employer as an independent contractor, and

G. a person whom the Plan Administrator determines has been engaged by the Employer as a consultant or advisor on a retainer or fee basis.

A person the Plan Administrator determines is not an "Employee" as defined above shall not be eligible to participate in the Plan regardless of whether such determination is

upheld by a court or tax or regulatory authority having jurisdiction over such matters. However, a person the Company determines is not an "Employee" as defined above and who later is required to be reclassified as an Employee shall be eligible to participate in the Plan benefits under the Plan prospectively only, provided that the Employee is otherwise eligible pursuant to Section 3.1.

2.13 Employer

Employer means the Company and any subsidiary or affiliated organization and any successor(s) of any of them which, with the approval of the Company, and subject to such conditions as the Company may impose, adopts the Plan.

For purposes of satisfying the nondiscrimination requirements of Sections 105(h), the term "Employer" shall include any other corporation or other business entity which must be aggregated with the Employer under Sections 414(b), (c), (m) or (o) of the Code, but only for such period of time when the Employer or such other corporation or other business entity must be aggregated as aforesaid.

2.14 ERISA

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

2.15 FMLA

FMLA means the Family and Medical Leave Act of 1993, as amended, and the regulations issued thereunder or pursuant thereto.

2.16 HIPAA

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

2.17 Incorporated Document

Incorporated Document means a certificate of coverage, evidence of coverage, summary plan description or other document incorporated by reference, together with any exhibits, supplements, addendums, or amendments thereto. The Incorporated Documents are listed in Appendix A.

2.18 Plan

Plan means the Nutanix, Inc. Employee Welfare Plan as herein set forth and as amended from time to time.

2.19 Plan Administrator

Plan Administrator means the person(s) authorized and responsible for managing and directing the operation and administration of the Plan.

2.20 Plan Sponsor

Plan Sponsor means the Company.

2.21 Plan Year

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

2.22 Salary Deduction Agreement

Salary Deduction Agreement means the authorization to the Employer by the Covered Employee to reduce such Employee's pay by an amount on an after-tax basis for selected Plan benefits.

2.23 Salary Deduction Contributions

Salary Deduction Contributions means the contributions taken from the Covered Employee's salary on an after-tax basis, pursuant to a Salary Deduction Agreement.

2.24 Salary Reduction Agreement

Salary Reduction Agreement means the authorization to the Employer by the Covered Employee to reduce such Employee's pay by an amount on a before-tax basis for selected Plan benefits.

2.25 Salary Reduction Contributions

Salary Reduction Contributions means the contributions taken from the Covered Employee's salary on a before-tax basis, pursuant to a Salary Reduction Agreement.

2.26 Spouse

Spouse means, for purposes of this Plan only, a person recognized as married to the Covered Employee by a state, possession, or territory of the United States in which the marriage is entered into, regardless of domicile. Where the marriage was entered into in a foreign jurisdiction, a person is recognized as married to the Covered Employee or Retiree if the relationship is recognized as marriage under the laws of at least one state, possession, or territory of the United States, regardless of domicile.

ARTICLE III

ELIGIBILITY, PARTICIPATION AND COVERAGE

3.1 Eligibility

An Employee who is classified by the Employer as regularly scheduled to work at least 20 hours per week or who is otherwise eligible to participate for applicable benefits under the Nutanix, Inc. Employee Welfare Benefit Plan Summary Plan Description shall become eligible for Plan participation in the benefits identified in Article IV on the Employee's date of hire.

The following Employees are not eligible to participate in the Plan:

A. Employees regularly scheduled to work fewer than 20 hours per week;

B. Employees who are hired on a *temporary* basis, with the classification *temporary* meaning any Employee hired to fill a job vacancy for a limited time, as designated by the Plan Administrator;

C. Employees who are hired on a *seasonal* basis, with the classification seasonal meaning hired to fill a job vacancy relating to or occurring during a particular season, as designated by the Plan Administrator;

D. Leased employees, as defined in Code Section 414(n); and

E. Nonresident aliens who receive no earned income (within the meaning of the Code Section 911(d)(2)) from an Employer that constitutes income from sources within the United States, as defined in Code Section 861(a)(3).

Specific eligibility for certain benefits shall be set forth in Article IV, the Nutanix, Inc. Employee Welfare Benefit Plan Summary Plan Description, or in the applicable Incorporated Documents.

3.2 Participation

Employees become Plan participants with respect to non-elective Benefits on the date they satisfy the eligibility requirements of Section 3.1. Employees become Plan participants with respect to elective Benefits on the date they also satisfy the enrollment and election requirements of Section 5.4.

3.3 Coverage

A. Date Coverage Begins

The provisions and requirements describing when and how Employees and Dependents become Covered Persons, the conditions and limitations to coverage, and the circumstances wherein coverage terminates shall be set forth as applicable in the Incorporated Documents by reference under Section 4.1. In addition, coverage is governed by the rules stated below and in Section 5.8.

B. Coverage During Leave of Absence

1. Paid Leave

During a paid leave of absence, a Covered Employee continues to participate in the premium payment benefits they elected.

2. Unpaid Leave

Except as otherwise provided below, for Plan benefits requiring an Employee contribution, coverage for a Covered Employee on an approved unpaid leave of absence is suspended on the last date of coverage for which a premium payment benefit has been paid. The terms of the plan to which the participant's selected premium payment benefits were paid control whether and to what extent coverage and benefits under that plan continue.

To the extent the Covered Employee may continue coverage during an unpaid leave, and except as required below, the Covered Employee is required to pay for coverage on an after-tax basis.

If the unpaid leave of absence is taken pursuant to FMLA, Covered Employees may elect to continue participation in premium payment benefits described in Sections 4.4(A), (B), (C), (D), and (E) by (i) pre-paying on a before-tax basis the premiums for coverage during the leave, (ii) paying premium payment benefits during the FMLA leave on an after-tax basis, or to the extent possible on a before-tax basis, or (iii) paying on a before-tax basis upon return from the leave the premium payment benefits for coverage during the leave, and adjusting the Salary Reduction Contribution accordingly for the balance of the Plan Year. Benefits described in Section 4.4(F) are suspended.

With respect to premium payment benefits described in Section 4.4(E), if the Covered Employee elects to revoke such coverage during the unpaid leave, no expenses incurred during the leave shall be reimbursed. Upon return from leave, the Employee can either: i) elect to be reinstated in the prior election amount, reduced by the dollar amount of the annual election not contributed during the unpaid leave, or ii) elect to be reinstated to the full annual election amount, with the Salary Reduction Contribution adjusted accordingly for the balance of the Plan Year.

With respect to premium payments benefits described in Section 4.4(G), (H), and (I), Employee may elect to continue participation by paying premium payment benefits during the FMLA leave on an after-tax basis.

C. Date Coverage Ceases

Coverage for a specific benefit offered under the Plan ceases at the earliest of:

1. For the benefits described in Section 4.4(A), (B), and (C), the end of the month in which the Covered Employee last satisfies the eligibility and participation requirements of Sections 3.1 and 3.2, respectively,

2. For all other benefits described in Article IV, the date in which the Covered Employee last satisfies the eligibility and participation requirements of Sections 3.1 and 3.2, respectively,

3. except where participation continues during an unpaid leave of absence, the last day of the last pay period for which a Covered Employee makes a Salary Reduction Contribution or Salary Deduction Contribution with respect to an elective Benefit,

4. the effective date of a Plan amendment that terminates coverage for the Covered Employee's job category,

5. the date the Plan terminates.

A Covered Employee's Dependent shall cease to be a Covered Person if the Employee ceases to be a Covered Person or as provided for in an applicable Incorporated Document, except as otherwise provided in Article VII.

D. Effect of Terminated Coverage

Termination of coverage automatically cancels a Covered Employee's Salary Reduction Agreement and Salary Deduction Agreement on the date coverage terminates. Coverage and benefits may continue in effect to the extent provided in an applicable Incorporated Document.

E. Reinstatement of Coverage

1. If Previously Suspended

A Covered Employee who returns to an Employer's service during the same Plan Year in which they took an unpaid leave of absence will have reinstated automatically the Benefits in effect when Plan coverage was suspended provided such benefits continue to be provided by the Company. If an unpaid leave of absence was taken in accordance with FMLA, such Covered Employee may reinstate his or her election and Salary Reduction Agreement for the remainder of the Plan Year if participation has not continued pursuant to Section 3.3(B). In all other cases, the Covered Employee may only make any new benefit elections for the remainder of the Plan Year, as described in Section 5.8.

2. If Previously Terminated

A Covered Employee who returns to an Employer's service shall be eligible to participate in the Plan and make new benefit elections, provided such Employee satisfies the eligibility requirements of Section 3.1. Notwithstanding the foregoing, if a former Covered Employee returns to service during the same Plan Year and within 30 days of the date prior

participation ended, his or her elections for Benefits described in Section 4.4 (A), (B), (C), (D), (E), and (F) shall be reinstated for the remainder of the Plan Year, except as described in Section 5.8. The above rule shall not apply and the rehired Employee shall be eligible to make new elections for Benefits described in Section 4.4(A), (B), (C), (D), (E), and (F) for the balance of the Plan Year, if it is determined to the satisfaction of the Plan Administrator that the prior termination of employment and reinstatement was bona fide and not an attempt to avoid the irrevocable rule described in Section 5.8(A).

3.4 Coverage under the Family and Medical Leave Act and Section 609 of ERISA

A. Family and Medical Leave Act of 1993

If not otherwise provided for herein, the Plan shall provide coverage for a Covered Employee solely to the extent necessary to comply with FMLA, and the Plan shall be interpreted and administered as necessary to comply with FMLA and the rulings and regulations issued thereunder.

B. Section 609 of ERISA

If not otherwise provided herein, the Plan shall provide coverage to a child solely to the extent required by a qualified medical child support order defined under Section 609(a) of ERISA or to an adoptive child or child placed for adoption 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.

C. Coverage Contingent Upon Contribution

Any coverage provided as a result of this Section 3.4 shall be conditioned upon payment of applicable contributions by the Employee.

3.5 Uniformed Services Employment and Reemployment Rights Act

Solely to the extent required by the Uniformed Services Employment and Reemployment Rights Act (hereafter the “Uniformed Services Act”), a Covered Person who is an Employee who enters military service shall have the right to continue coverage under the Plan for the period prescribed under the Uniformed Services Act. Continuation of coverage shall be conditioned upon payment of the required premiums, if any.

This Section 3.5 shall be interpreted and applied to give an Employee only those rights as are prescribed under the Uniformed Services Act and rulings and regulations issued thereunder.

3.6 Health Insurance Portability and Accountability Act of 1996

A. HIPAA Title I

Solely to the extent required by the Health Insurance Portability and Accountability Act of 1996 (hereinafter “HIPAA”), an Employee shall be a Covered Person under

the Plan no later than such time as required under HIPAA, and the Plan shall be subject to the special enrollment and nondiscrimination in health status provisions of HIPAA. This Section 3.6 shall be interpreted and applied to give a Covered Person only those rights as prescribed under HIPAA and the rulings and regulations issued thereunder, except that an Employer may extend certain HIPAA special enrollment rights to Domestic Partners if designated in the Nutanix, Inc. Employee Welfare Benefit Plan Summary Plan Description.

B. HIPAA Title II

The Plan shall comply with the privacy and security regulations of HIPAA, in accordance with the provisions set forth in Article XIII.

3.7 Coordination with State Medicaid Program

The fact that a Covered Person is eligible for coverage by, or is covered by, a State Medicaid program shall not affect the Covered Person's eligibility to participate in the Plan or to receive benefits. While a Covered Person's purported assignments are void under Section 12.4 in all other cases, the payment of benefits under the Plan with respect to any Covered Person shall be made in accordance with any assignment of rights made by or on behalf of the Covered Person or a beneficiary of the Covered Person as and to the extent required by any State Medicaid program, as provided in Section 609(b) of ERISA. To the extent a payment has been made to or with respect to a Covered Person pursuant to a State Medicaid program and the amount so paid is for a medical expense that the Plan has a legal liability to pay, the Plan will pay such expense in accordance with any State law that provides that the State has acquired the right with respect to the Covered Person to receive payment for such expense.

3.8 Mental Health Parity and Addiction Equity Act

Solely to the extent required by the Mental Health Parity and Addiction Equity Act of 2008, as amended, the Plan shall provide mental health benefits to the same extent as other medical benefits.

This Section 3.8 shall be interpreted and applied to give Covered Persons only those rights as prescribed under the Mental Health Parity and Addiction Equity Act, and the rulings and regulations issued thereunder.

3.9 Women's Health and Cancer Rights Act

Solely to the extent required under the law of the Women's Health and Cancer Rights Act (hereinafter "WHCRA"), the Plan shall provide certain benefits related to benefits received in connection with a mastectomy.

In the case of a Covered Person who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the coverage shall be provided in a manner determined in consultation with the attending physician and the patient for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Such reconstructive benefits are subject to annual plan deductibles and coinsurance provisions such as other medical and surgical benefits covered under the Plan.

This Section 3.9 shall be interpreted and applied to give Covered Persons only those rights as prescribed under WHCRA, and the rulings and regulations issued thereunder.

3.10 Newborns and Mothers' Health Protection Act

Solely to the extent required by the Newborns' and Mothers' Health Protection Act (hereinafter "NMHPA"), the Plan shall provide that coverage for childbirth may not be limited to a hospital stay of less than 48 hours for normal delivery, or less than 96 hours for cesarean section, or require the provider to obtain approval for shorter hospital stays. The requirement shall not apply if the attending provider, in consultation with the mother, decides to discharge the mother or newborn earlier than the time prescribed by the NMHPA.

This Section 3.10 shall be interpreted and applied to give Covered Persons only those rights as prescribed under the NMHPA, and the rulings and regulations issued thereunder.

3.11 Genetic Information Nondiscrimination Act of 2008

The Plan shall also comply with the Genetic Information Nondiscrimination Act of 2008 (hereinafter "GINA").

This Section 3.11 shall be interpreted and applied to give Covered Persons only those rights as prescribed under GINA, and the rulings and regulations issued thereunder.

3.12 Children's Health Insurance Program Reauthorization Act of 2009

The Plan shall also comply with the Children's Health Insurance Program Reauthorization Act of 2009 (hereinafter "CHIP").

This Section 3.12 shall be interpreted and applied to give Covered Persons only those rights as prescribed under CHIP, and the rulings and regulations issued thereunder.

3.13 Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act

The Plan shall also comply with the applicable provisions of the Patient Protection and Affordable Care Act (hereinafter "PPACA") as amended by the Health Care and Education Reconciliation Act (hereinafter "HCERA").

This Section 3.13 shall be interpreted and applied to give Covered Persons only those rights as prescribed under PPACA as amended by HCERA, and the rulings and regulations issued thereunder.

3.14 Transparency in Coverage Regulations and Consolidated Appropriations Act, 2021

The Plan shall also comply with the applicable provisions of the Transparency-In-Coverage Regulations and the Consolidated Appropriations Act, 2021 ("CAA") as they

become effective, based on a good faith, reasonable interpretation of the statute, existing regulations, and other official guidance.

This Section 3.14 shall be interpreted and applied to give Covered Persons only those rights as prescribed under the Transparency-in-Coverage Regulations and the CAA, and the rulings and regulations issued thereunder.

3.15 Hawaii Prepaid Health Care Act

The Plan shall also comply with the applicable provisions of the Hawaii Prepaid Health Care Act. This Section 3.14 shall be interpreted and applied to give Covered Persons only those rights as prescribed under the Hawaii Prepaid Health Care Act.

ARTICLE IV

BENEFITS

4.1 Benefits

The benefits provided under the Plan are described as set forth below and as further described in any applicable Incorporated Document. Any such applicable Incorporated Document is hereby incorporated by reference as if set forth in full herein. Pursuant to Section 8.1(B) any Salary Reduction Agreements and/or Salary Deduction Agreements issued in conjunction with the Plan are incorporated by reference.

4.2 Options

Covered Employees must elect one of the following:

A. to receive the full unreduced compensation benefit described in Section 4.3, and receive automatic coverage under Benefits described in Section 4.5;

B. to forgo all or part of the unreduced compensation benefit described in Section 4.3 and make before- or after-tax contributions in exchange for one or a combination of Benefits described in Section 4.4 and receive automatic coverage under Benefits described in Section 4.5.

Employee contributions for Benefits described in Sections 4.4 (A), (B), (C), (D), (E), and (F) must be made on an entirely before-tax basis through a Salary Reduction Agreement. Employee contributions for Benefits described in Section 4.4 (G), (H), and (I) may be made only on an after-tax basis through a Salary Deduction Agreement. There are no Employee Contributions for Benefits described in Section 4.5. Notwithstanding the foregoing, Employee contributions for coverage for Domestic Partners and their children who are not the Employee’s tax dependent will be made on an after-tax basis through a Salary Deduction Agreement.

4.3 Unreduced Compensation Benefit

In lieu of all or some of the Benefits described in Section 4.4 that a Covered Employee otherwise could elect, they may elect to receive unreduced compensation in an amount equal to the value of the Benefits available for election that are not elected. The unreduced compensation benefit is subject to the Employer's regular payroll practices; applicable local, state, and federal income tax withholding; and other applicable deductions. The unreduced compensation benefit is not additional compensation; it is the amount by which a Covered Employee's compensation is not reduced each pay period by not electing a premium payment benefit. The unreduced compensation benefit shall cease whenever the Covered Employee commences an unpaid leave of absence, terminates employment, or the Covered Employee's Employer determines, in its sole discretion, that compensation is not payable to such Employee.

4.4 Elective Benefits

By electing one or more premium payment benefits, an Employee converts a portion of his or her compensation for the Plan Year into contributions for the Benefits selected. Covered Employees may elect one or more of these premium payment benefits:

A. Medical Premium Payment Benefit

Covered Persons shall have the right to the medical benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Incorporated Document. A description of such benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Document.

If an Employee is eligible for medical benefits, they may elect any of the medical plan options as the medical premium payment benefit.

If you elect medical coverage under the Kaiser HMO Medical Plan and are otherwise eligible, Nutanix, Inc. will make a contribution to a Health Reimbursement Arrangement (Medical) for you.

If you elect medical coverage under any United Healthcare or Kaiser Permanente Medical plans and are otherwise eligible, Nutanix, Inc. will make a contribution to a Health Reimbursement Arrangement (Family Forming) for you.

B. Dental Premium Payment Benefit

Covered Persons shall have the right to the dental benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Incorporated Document. A description of such benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Document.

If an Employee is eligible for dental benefits, they may elect any of the dental plan options as the dental premium payment benefit.

C. Vision Premium Payment Benefit

Covered Persons shall have the right to the vision benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Incorporated Document. A description of such benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Document.

If an Employee is eligible for vision benefits, they may elect any of the vision plan options as the vision premium payment benefit.

D. Health Care Spending Account Premium Payment Benefit

Employees who are Covered Persons shall have the right to the health care spending account benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions and limitations set forth in such Incorporated Document. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Document.

If an Employee is eligible for the health care spending account benefits, they may elect any whole dollar annual contribution amount of not less than $100 and not more than an amount to be communicated annually by the Plan Administrator, which amount shall not exceed the maximum amount allowed under Section 125(i) of the Code, as the health care spending account premium payment benefit.

E. Limited Purpose Health Care Spending Account Premium Payment Benefit

Employees who are Covered Persons shall have the right to the limited purpose health care spending account benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions and limitations set forth in such Incorporated Document. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Document.

If an Employee is eligible for the limited purpose health care spending account benefits, they may elect any whole dollar annual contribution amount of not less than $100 and not more than an amount to be communicated annually by the Plan Administrator, which amount shall not exceed the maximum amount allowed under Section 125(i) of the Code, as the limited purpose health care spending account premium payment benefit.

F. Supplemental Life Premium Payment Benefit

Employees who are Covered Persons shall have the right to the supplemental life insurance benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Document. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions, the procedure for naming beneficiaries and consequences for failure to name a beneficiary, shall be as set forth in the applicable Incorporated Document.

If an Employee is eligible for supplemental life benefits, they may elect any of the supplemental life coverage options as the supplemental life premium payment benefit.

G. Dependent Life Premium Payment Benefits

Covered Persons shall have the right to the dependent life insurance benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Document. A description of such benefits, including the amount payable, maximums, conditions

precedent to payment, limitations and exclusions, the procedure for naming beneficiaries and consequences for failure to name a beneficiary, shall be as set forth in the applicable Incorporated Document.

If an Employee is eligible for dependent life benefits, they may elect any of the dependent life options as the dependent life premium payment benefit.

H. Supplemental AD&D Premium Payment Benefit

Employees who are Covered Persons shall have the right to the supplemental AD&D insurance benefits described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Document. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions, the procedure for naming beneficiaries and consequences for failure to name a beneficiary, shall be as set forth in the applicable Incorporated Document.

If an Employee is eligible for supplemental AD&D benefits, they may elect any of the supplemental AD&D coverage options as the supplemental AD&D

4.5 Non-Elective Benefits

A. Basic Life Benefits

Employees who are Covered Persons shall have the right to the basic life benefits provided under the applicable Incorporated Documents. Such benefits shall be subject to the terms conditions, and limitations set forth in such applicable Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations, exclusions, and the procedure for naming beneficiaries and consequences for failure to name a beneficiary, shall be as set forth in the applicable Incorporated Document.

B. Basic AD&D Benefits

Employees who are Covered Persons shall have the right to the basic AD&D benefits provided under the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations, and exclusions shall be set forth in the applicable Incorporated Documents.

C. Business Travel Accident Benefits

Employees who are Covered Persons shall have the right to the business travel accident benefits provided under the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Incorporated Document. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations, and exclusions shall be set forth in the applicable Incorporated Document.

D. Employee Assistance Plan Benefits

Covered Persons shall have the right to the employee assistance plan benefits provided under the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Incorporated Document. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations, and exclusions shall be set forth in the applicable Incorporated Document.

E. Short-Term Disability Benefits

Employees who are Covered Persons shall have the right to the short-term disability benefits provided under the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations, and exclusions shall be set forth in the applicable Incorporated Documents.

F. Long-Term Disability Benefits

Employees who are Covered Persons shall have the right to the long-term disability benefits provided under the applicable Incorporated Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Incorporated Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations, and exclusions shall be set forth in the applicable Incorporated Documents.

4.6 Limits for Certain Employees

Benefits payable under the Plan to each highly compensated participant, as defined in Code Section 125(e)(1) or highly compensated individual, as defined in Code Section 125(e)(2), shall be limited to the extent necessary to avoid violating Code Section 125(b)(1), as applicable.

Benefits payable under the Plan to each key employee, as defined in Code Section 416(i)(1), shall be limited to the extent necessary to avoid violating Code Section 125(b)(2), as applicable.

Benefits payable under the Plan to each highly compensated individual, as defined in Code Section 105(h)(5) shall be limited to the extent necessary to avoid violating Code Section 105(h)(l) as applicable.

4.7 Notification of Premium Payment Amounts

The Company shall provide written notification to eligible Employees of the amount of the premium payment benefits prior to the initial and annual enrollment/election period. The amount of the premium payment benefits shall be the contributions required of the Employee to participate in the group health or welfare benefit plan(s) for which a premium payment benefit is available under the Plan. Any such written notification is hereby incorporated by reference and made part of the Plan.

4.8 Application of Other Plans

Notwithstanding any other provision of the Plan, Covered Employees electing one or more premium payment benefits under the Plan shall be subject to the provisions, conditions, limitations, and exclusions of each Benefit listed in Article IV for which they elect the premium payment benefit.

ARTICLE V

ELECTIONS

5.1 Enrollment for Non-Elective Benefits

All Employees meeting the eligibility requirements of Section 3.1 shall be automatically covered for Benefits described in Section 4.5 and such benefits shall not be subject to the provisions of this Article V.

5.2 Enrollment for Elective Benefits

A. Initial Enrollment/Election

Employees meeting the eligibility requirements of Section 3.1 shall be eligible to elect Benefits described in Section 4.4.

B. Annual Enrollment/Election

Approximately 60 days before each Plan Year begins, the Plan Administrator shall conduct an enrollment during which Employees may make new elections or change existing ones for the next Plan Year.

5.3 Salary Reduction/Deduction Agreements

During the applicable election period determined by the Employer, an Employee shall enter into a Salary Reduction Agreement with the Employer if such Employee selects Benefits requiring Employee pre-tax contributions. The Salary Reduction Agreement shall authorize the Employer to reduce the Employee's salary by the amount of required Employee contributions. All elections of Benefits shall be null and void if the Covered Employee fails to execute a Salary Reduction Agreement as provided for herein.

During the applicable election period determined by the Employer, an Employee shall enter into a Salary Deduction Agreement with the Employer if such Employee selects Benefits requiring Employee after-tax contributions. The Salary Deduction Agreement shall authorize the Employer to deduct the amount of required Employee contributions from the Employee's pay on an after-tax basis. All elections of Benefits shall be null and void if the Covered Employee fails to execute a Salary Deduction Agreement as provided for herein.

5.4 Forms and Agreements

Employees may enroll, make elections, and direct their Employer to make Salary Reduction Contributions and/or Salary Deduction Contributions only by filing the appropriate, completed forms or agreements with the Plan Administrator before the deadline described in Section 5.6.

5.5 Default Benefits

The Plan Administrator shall conduct an enrollment during which Employees may make new elections or change existing ones for the next Plan Year.

An Employee enrolling for the first time who fails to submit a valid enrollment/election and Salary Reduction Agreement and/or Salary Deduction Agreement, as required in Section 5.4, is deemed to have made the following applicable elections:

-United Healthcare Medical POS Plan (employee-only coverage)

-Hawaii employees will be automatically enrolled in state approved medical coverage. If you wish to waive this coverage and are eligible to do so under Hawaii state law, you must complete a HC-5 waiver form for the current calendar year and provide a signed copy to hr@nutanix.com.

Contributions required for the default coverage shall be deducted from the Employee's pay as Salary Reduction Contributions, as permitted under the Code, or as Salary Deduction Contributions.

5.6 Deadlines

A. Initial Enrollment/Election

For Employees who become eligible after the Effective Date but before the annual enrollment described in Section 5.2(B), the deadline for enrolling and making initial elections is 30 days from the Employee's date of hire. Salary Reduction Agreements and/or Salary Deduction Agreements completed by Eligible Full-time Employees shall be effective as of the Employee's date of hire. Salary Reduction Agreements and/or Salary Deduction Agreements completed by Eligible Part-time Employees shall be effective the first of the month following 60 days of employment.

B. Annual Enrollment/Election

For Covered Employees and Employees who become eligible as of the first day of a Plan Year, the deadline for enrolling and making elections is the date the Plan Administrator specifies, but no later than the day preceding the first day of the Plan Year to which the enrollment, elections, and Salary Reduction Agreement and/or Salary Deduction Agreement apply.

5.7 Validity of Election Forms

A. Plan Administrator Approval

Enrollments and elections and Salary Reduction Agreement and/or Salary Deduction Agreements take effect only if valid, as determined by the Plan Administrator. Except for supplemental elections described in Section 5.8(B), the Plan Administrator shall substitute the unreduced compensation benefit, described in Section 4.3, for any invalid premium payment benefit election.

B. Remedial Modification or Rejection

The Plan Administrator may modify or reject any enrollment or election and/or Salary Reduction Agreement and/or Salary Deduction Agreement or take other action the Plan Administrator deems appropriate under rules uniformly applicable to similarly situated persons to satisfy nondiscrimination requirements of Code Section 125(b). Any remedial modification, rejection, or other action the Plan Administrator takes must be on a reasonable basis that does not discriminate in favor of highly compensated individuals or participants, as defined in Code Section 125(e)(1) and (2), respectively, or key employees, as defined in Code Section 416(i)(1).

5.8 Changing Elections

A. General Rule

All elections and Salary Reduction Agreements and/or Salary Deduction Agreements stay in force during the entire Plan Year to which they apply unless changed or revoked as provided in this Section 5.8. During annual enrollment, however, Covered Employees may make new benefit elections or change existing ones for the forthcoming Plan Year.

B. Supplemental Elections

Section 5.8(A) notwithstanding, the Plan Administrator may approve a supplemental election to correct an enrollment or election form or Salary Reduction Agreement or Salary Deduction Agreement that is invalid for any reason if approval would not violate Code Section 125.

C. Revocation of Elections

Covered Employees may revoke elections (including default elections) and Salary Reduction Agreements and Salary Deduction Agreements during a Plan Year only in accordance with the provisions described in the Section 125 change in election rules and the HIPAA special enrollment rules.

ARTICLE VI

COORDINATION OF BENEFITS

6.1 Applicability

Except as provided in Section 6.10, the following Coordination of Benefits ("COB") provisions apply to this Plan, as outlined in this Article VI, when a Covered Person has health care coverage under more than one Health Care Arrangement.

6.2 COB Definitions

A. "Health Care Arrangement" means any of the following coverages which provides benefits or services to the Covered Person for, or because of, medical, dental, surgical or hospital care treatment:

1. Group or nongroup coverage, whether insured or uninsured, including HMOs;

2. The medical care component of long-term care contracts, such as skilled nursing care

3. Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan, or an employee benefits plan;

4. Coverage under federal government programs, except that coverage under a federal government program may be limited to hospital, medical and surgical benefits of the governmental program. Coverage does not include Medicare supplemental policies or Medicaid policies;

5. The medical benefits coverage in group or individual automobile "fault" or "no-fault" coverage.

The term Health Care Arrangement shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Health Care Arrangements into consideration in determining its benefits and that portion which does not.

B. "Allowable Expense" means an expense for health care, when the item of expense is covered at least in part by one or more Health Care Arrangements covering the individual for whom the claim is made.

When a Health Care Arrangement provides benefits in the form of services instead of cash payments, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

6.3 Order of Benefit Determination Rules

This Plan determines its order of paying benefits using the first of the following rules which applies:

A. COB/Non-COB Provision

The benefits of a Health Care Arrangement which does not contain a COB provision always shall be determined before the benefits of a Health Care Arrangement which does contain a COB provision.

B. No Fault Auto Insurance

The benefits of the Health Care Arrangement which covers the person as a beneficiary under a no-fault automobile insurance policy required by law shall be determined prior to this Plan, regardless of whether the no-fault policy has been selected as secondary.

C. Non-Dependent/Dependent

Subject to paragraph I, the benefits of the Health Care Arrangement which covers the person as an employee, member, or subscriber (that is, other than as a dependent) shall be determined before those of the Health Care Arrangement which covers the person as a dependent.

D. Dependent Child/Parents not Separated or Divorced

Except as stated in Paragraph (E) below, when this Plan and another Health Care Arrangement cover the same child as a dependent of different persons, called “parents”:

1. the benefits of the Health Care Arrangement of the parent whose birthday falls earlier in a year are determined before those of the Health Care Arrangement of the parent whose birthday falls later in that year; but

2. if both parents have the same birthday, the benefits of the Health Care Arrangement which covered the parent longer are determined before those of the Health Care Arrangement which covered the other parent for a shorter period of time.

However, if the other Health Care Arrangement does not have the rule described in (1) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Health Care Arrangements do not agree on the order of benefits, the rule in the other Health Care Arrangement will determine the order of benefits.

For a dependent who has coverage under either or both parents and also has coverage as a dependent under a spouse’s plan, the rule in paragraph H applies.

E. Dependent Child/Separated or Divorced Parents

If two or more Health Care Arrangements cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

1. first, the Health Care Arrangement of the parent with custody of the child;

2. then, the Health Care Arrangement of the spouse of the parent with custody of the child;

3. then, the Health Care Arrangement of the parent not having custody of the child; and

4. finally, the Health Care Arrangement of the spouse of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Health Care Arrangements of that parent has actual knowledge of those terms, the benefits of that Health Care Arrangement are determined first. This paragraph does not apply with respect to any Plan Year starting before the Plan is given notice of the court decree.

This Plan will not cover the expenses of any child who does not meet the Plan's definition of Dependent as defined in Article II, except as may be required pursuant to a qualified medical child support order under Section 609(a) of ERISA.

F. Active/Inactive Employee

The benefits of a Health Care Arrangement which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Health Care Arrangement which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Health Care Arrangement does not have this rule, and if, as a result, the Health Care Arrangements do not agree on the order of benefits, this rule is ignored.

G. Continuation Coverage

If an individual is covered under a continuation plan as a result of the purchase of coverage as provided under federal or state law, and also under another group plan, the following shall be the order of benefit determination:

1. First, the benefits of a plan covering the person as an employee or retiree (or as the dependent or employee or retiree);

2. Second, the benefits of coverage under the continuation plan.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

H. Longer-Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the Health Care Arrangement which has covered the person longer are determined before those of the Health Care Arrangement which has covered that person for the shorter time.

The start of a new plan does not include:

1. A change in the amount or scope of a plan's benefits;

2. A change in the entity that pays, provides, or administers the plan's benefits; or

3. A change from one type of plan to another, such as from a single employer plan to a multiple employer plan.

I. Medicare Coordination

1. Employees and/or Spouses Entitled to Medicare Due to Age

Unless an active Employee entitled to Medicare due to age gives the Plan notice, in the form and manner requested by the Plan Administrator, waiving his or her right to Plan benefits, the Plan is Primary. With respect to the spouse of an active employee who is entitled to Medicare due to the spouse's age, unless the Employee gives the Plan notice, in the form and manner requested by the Plan Administrator, waiving Plan benefits, the Plan is primary.

2. Medicare Disabled Covered Persons

If required by law, the Plan is primary with respect to a Covered Person who is also entitled to Medicare because of disability. Otherwise, the Plan is secondary.

3. Covered Persons with End-Stage Renal Disease

For the period required by law, if any, the Plan is primary with respect to a Covered Person entitled to Medicare because of end-stage renal disease. Otherwise, the Plan is secondary.

6.4 Effect on the Benefits of this Plan

A. When this Section Applies

This Section 6.4 applies when, in accordance with Section 6.3, "Order of Benefit Determination Rules," this Plan is a secondary payor of benefits to one or more other Health Care Arrangements. In that event, the benefits of this Plan may be reduced under this Section. Such other Health Care Arrangement or Arrangements are referred to as "the other Arrangements" in (B) immediately below.

B. Reduction in this Plan's Benefits

The benefits that would be payable under this Plan in the absence of the COB provisions specified in this Article VI will be reduced by the benefits payable under the other Arrangements for the expenses covered in whole or in part under this Plan. This applies whether or not claim is made under a Health Care Arrangement.

When a Health Care Arrangement provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an expense incurred and a benefit payable.

C. This Plan shall credit against its plan deductible any amounts it would have credited to its deductible in the absence of the other Health Care Arrangement.

6.5 Disagreement on Order of Benefits

If the Plan and other Health Care Arrangement(s) cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the Plan shall immediately pay half of the claim and will determine its liability following payment, except that the Plan shall be required to pay no more than it would have paid had it been the primary plan.

6.6 Limitation of Benefits

In applying this Article's provisions, the Plan does not pay health care benefits in an amount greater than it would have if it were primary.

6.7 Right to Receive and Release Necessary COB Information

The Company has the right to obtain any information necessary to apply the COB provisions of this Article VI. The Company has the right to obtain COB information from or give that information to any other organization or person involved in the administration of the COB provisions of this Plan or any other Health Care Arrangement. The Company need not tell, or get the consent of, any person prior to obtaining that information. Each person claiming benefits under this Plan must give the Company any information it needs to process the claim.

6.8 Facility of Payment

A payment made under another Health Care Arrangement may include an amount which should have been paid under this Plan. If it does, the Company may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

6.9 Right of Recovery

If the amount of the payments made by the Company is more than it should have paid under the COB provisions specified in this Article VI, it may recover the excess from one or more of:

A. the persons it has paid or for whom it has paid;

B. insurance companies; or

C. other Health Care Arrangements, including Workers' Compensation.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

6.10 Governing Provisions

When the provisions describing coordination of benefits are set forth in an applicable Incorporated Document, such Incorporated Document shall govern except to the extent the provisions fail to establish order of responsibility, in which case the provisions of this Article VI shall govern.

ARTICLE VII

COBRA CONTINUATION COVERAGE

7.1 Eligibility for Continuation Coverage

The provisions contained in this Article VII apply only to the Medical (including the HRA), Dental, Vision, Employee Assistance Plan, health care Flexible Spending Account and Limited Purpose Health Care Spending Account benefits provided under the Plan. The provisions of this Article VII do not govern to the extent provided in Section 7.9.

Certain Employees and Dependents shall have the right to purchase continuation coverage under this Plan in accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, Title X (COBRA), provided such individuals were Covered Persons under the Plan on the date immediately preceding the date of a Qualifying Event or become Covered Persons during the continuation period because such Dependent is born to or placed for adoption with the Employee.

7.2 Definitions

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

A. "Employee" means a person who is (or was) covered under the Plan by virtue of the person's performing services for the Employer on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage.

B. "Dependent" means, with respect to an Employee as defined in this Section 7.2, any individual who, on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage, is covered under the Plan as (1) the Spouse of such Employee or (2) the Dependent child of such Employee. Domestic Partners and their children covered under the Plan on the day before the event giving rise to the COBRA-equivalent coverage, although not a Dependent under COBRA, will be offered COBRA-equivalent coverage and will be treated as Dependents under this Article VII. The term Dependent shall include any child born to or placed for adoption with the Employee during the continuation period.

C. "Qualified Beneficiary" means an Employee or Dependent as defined in this Section 7.2 but shall not mean Dependents defined in Section 7.7(B), except that the term Qualified Beneficiary shall include Dependents born to or placed for adoption with the Employee during the continuation period.

D. "Qualifying Event" means any of the following, the occurrence of which would result in loss of coverage under the Plan were it not for the right to purchase COBRA continuation coverage:

    1. for Employees, termination of employment for any reason other than gross misconduct, or loss of eligibility due to reduction in hours worked by the Employee;

2. for Dependents:

   a. death of the Employee;

   b. divorce or legal separation of the Employee and Spouse or dissolution of a domestic partnership;

   c. reduction in hours worked by the Employee or termination of employment by the Employee for any reason other than gross misconduct;

   d. entitlement of the Employee to benefits under Title XVIII of the Social Security Act (relating to Medicare); or

   e. ceasing to qualify as a Dependent child under the Plan.

The Qualifying Event shall be deemed to occur on the date of the Qualifying Event — not on the date coverage ends because of the Qualifying Event.

7.3 Loss of Eligibility for Continuation Coverage

A Qualified Beneficiary shall not be eligible for COBRA continuation coverage unless:

A. the Company or Plan Administrator is notified of the election of COBRA continuation coverage, on a form provided for that purpose, within 60 days of the later of:

   1. the date the Qualified Beneficiary's coverage under the Plan would otherwise terminate by reason of an event described in Section 7.2(D); or

   2. the date notice of eligibility is sent to the individual in accordance with Section 7.5(C); and

B. the Qualified Beneficiary pays the initial required premium, as set forth in Section 7.8, no later than the date 45 days after the date on which COBRA continuation coverage was elected.

Until expiration of the election period, a Qualified Beneficiary may change or revoke any election. Failure to elect COBRA continuation coverage within the prescribed election period shall result in a waiver of the right to COBRA continuation coverage.

7.4 Termination of COBRA Continuation Coverage

COBRA continuation coverage shall terminate on the date on which the earliest of the following occurs:

A. the last day of the month preceding the date the Qualified Beneficiary fails to pay a subsequent required premium within 30 days of the date it is due;

B. the date the Qualified Beneficiary first becomes, after the date of making a COBRA election, entitled to Medicare;

C. the date the Qualified Beneficiary first becomes, after the date of making a COBRA election, covered under another group health plan, as defined in Code Section 5000(b)(1), not containing a limitation or exclusion as to any pre-existing condition of such individual (other than such an exclusion or limitation which does not apply to, or is satisfied by, such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996);

D. 36 months from the date on which a Qualifying Event described in Sections 7.2(D)(2)(a), 7.2(D)(2)(b), 7.2(D)(2)(d), or 7.2(D)(2)(e) occurs;

E. 18 months from the date on which a Qualifying Event described in Sections 7.2(D)(1) or 7.2(D)(2)(c) occurs. If a Qualifying Event described in Sections 7.2(D)(2)(a), 7.2(D)(2)(b), or 7.2(D)(2)(e) occurs subsequent to a Qualifying Event described in Section 7.2(D)(2)(c), an additional period of coverage shall be allowed for Dependents who have properly and timely elected and paid for COBRA continuation coverage; but, in no event shall the sum of the first and second periods of coverage exceed 36 months from the date of the first Qualifying Event giving rise to the Qualified Beneficiary's eligibility for COBRA continuation coverage;

F. the date the Company terminates all group health plans;

G. in the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act to have been disabled (i) at the time of the Qualifying Event or (ii) at any time during the first 60 days of continuation coverage, the 18-month period set forth in Section 7.4(E) shall be extended to 29 months; provided that such individual notifies the Plan Administrator of such determination in accordance with Section 7.5(D) before the end of such 18-month period; and provided further that if the Qualified Beneficiary does not remain disabled during the extended period, coverage shall cease with the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled;

H. in the case of a Qualifying Event described in Section 7.2(D)(2)(c) that occurs less than 18 months after the date the Employee becomes entitled to Medicare, 36 months from the date the Employee becomes entitled to Medicare; or

I. for the Health Care Spending Account Plan or Limited Purpose Health Care Spending Account Plan, the last day of the Plan Year in which the Qualifying Event occurs (subject to any applicable grace period). Notwithstanding the preceding sentence, a Qualified Beneficiary shall carry over up to the Maximum Carryover Amount or, if less, the unused balance in his or her Health Care Spending Account at the end of the Plan Year, to a subsequent Plan Year. The carryover shall only be available for the duration of the period of COBRA continuation coverage. No premium will be charged for the subsequent Plan Year.

7.5 Notice Requirements

A. The Employer shall notify the Plan Administrator of the occurrence of an event described in Sections 7.2(D)(1), 7.2(D)(2)(a), 7.2(D)(2)(c), and 7.2(D)(2)(d), within 30 days of the date of the described event.

B. The Qualified Beneficiary shall be responsible for notifying the Plan Administrator of the occurrence of an event described in Sections 7.2(D)(2)(b) or 7.2(D)(2)(e) within 60 days of the date of the described event.

C. The Plan Administrator shall provide notice to Qualified Beneficiaries of their COBRA continuation coverage rights within 14 days of the date it receives the notice described in Sections 7.5(A) and (B).

D. A Qualified Beneficiary, who is determined under Title II or XVI of the Social Security Act to have been disabled at any time within the first 60 days of the continuation period, shall be responsible for notifying the Plan Administrator of such determination within 60 days after the date of such determination, but in no event later than the end of the 18-month period set forth in Section 7.4(E). Such Qualified Beneficiary further shall be responsible for notifying the Plan Administrator of any final determination under such Title(s) that they are no longer disabled, within 30 days of the date of such determination.

E. At the commencement of coverage under the Plan, the Plan Administrator shall provide each Employee or Spouse or Domestic Partner who is a Covered Person with notice of their rights under COBRA.

F. The Plan Administrator shall provide notice to each Qualified Beneficiary of any termination of COBRA continuation coverage that takes effect earlier than the end of the maximum period of COBRA continuation coverage applicable to the Qualified Beneficiary.

G. The Plan Administrator shall provide notice to each Employee, Spouse or Domestic Partner or Dependent of the unavailability of COBRA continuation coverage if the Plan Administrator determines after receiving notice of a Qualifying Event that the Employee, Spouse or Domestic Partner or Dependent is not entitled to COBRA continuation coverage.

7.6 Coverage Available for Continuation

A Qualified Beneficiary may elect to continue receiving the health care coverage (as defined in COBRA regulations) they were receiving immediately before the event giving rise to the right to elect COBRA continuation coverage. If coverage provided to similarly situated active Employees is changed or eliminated, COBRA continuation coverage also shall be changed or eliminated. If the Company terminates the Plan but continues to maintain one or more other group health plans, as defined in Code Section 5000(b)(l), COBRA continuation coverage recipients may elect coverage under one of those other group health plans. A Qualified Beneficiary may elect to continue to receive coverage for the level of reimbursement, if any, that the individual had in effect under his or her Health Care Spending Account or Limited Purpose Health Care Spending Account immediately before the Qualifying Event after reflecting debits for health care reimbursements made up to the Qualifying Event.

7.7 Election Rules

A. Scope of Election

Each affected Qualified Beneficiary generally shall have an independent right to elect or reject COBRA continuation coverage under this Article VII; provided, however, that in the event an Employee or his or her Spouse or Domestic Partner makes an election to continue coverage on behalf of the other or on behalf of any other Qualified Beneficiary, such election shall be binding on such other party; and provided further, that in the event the Qualified Beneficiary is a minor or an incapacitated person, the parent or legal guardian of such minor or the legal representative of such incapacitated person shall have the right to elect or reject continuation coverage on behalf of such minor or incapacitated person, and any such election or rejection of coverage shall be binding on such minor or incapacitated person. Each Qualified Beneficiary is entitled to a separate election with respect to any choice of coverages available under the Plan.

B. After Acquired Dependents

A Qualified Beneficiary eligible for COBRA continuation coverage may elect to cover Dependents (as defined in Section 7.2(B)) acquired after the date of eligibility described under Section 7.3 to the same extent as Covered Persons, provided the Company or Plan Administrator is notified of the election to cover such Dependent(s) in the manner and within the time set forth in an applicable document incorporated by reference under the Plan, except that in no event shall notice be required within a period of less than 30 days. Such newly acquired Dependent(s), other than Qualified Beneficiaries defined in Section 7.2(C), shall have no independent right to COBRA continuation coverage. Failure to notify the Company or Plan Administrator within the prescribed time shall result in a waiver of the right to elect COBRA continuation coverage for such newly acquired Dependent(s).

C. Open Enrollment Periods

During an open enrollment period occurring during the COBRA coverage period, a Qualified Beneficiary may elect to cover Dependents not previously covered, subject to the terms and conditions set forth in the applicable document incorporated by reference under the Plan. This subsection (C) shall not apply to Health Care Spending Account or Limited Purpose Health Care Spending Account benefits.

7.8 Required Premium

In order to receive COBRA continuation coverage, Qualified Beneficiaries shall agree, on forms furnished by the Plan Administrator, to pay any required premiums to the Plan and shall make such premium payments when and as required. All premiums other than the initial premium shall be due on the first day of the calendar month. The amount of the premium shall be no more than 102 percent of the cost of coverage. In the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act to have been disabled at any time within the first 60 days of continuation coverage, the cost of coverage for the 19th month through the 29th month of coverage shall be no more than

150 percent of the cost of coverage. Notwithstanding the foregoing, the cost of coverage shall not exceed the maximum, nor be changed more frequently than permitted by law.

7.9 Governing Provisions

When the provisions for COBRA continuation coverage are set forth in an applicable Incorporated Document, such applicable Incorporated Document shall govern except to the extent such language fails to comply with requirements of applicable law or fails to determine the right or liability of the party, in which case the provisions of this Article VII shall govern.

ARTICLE VIII

CONTRIBUTIONS, FUNDING AND PLAN ASSETS

8.1 Contributions

A. Employer Contributions

The Employer shall pay premiums for Benefits listed in Section 4.4 to the Employer-sponsored plans to which such benefits are payable provided that the Covered Employee shall authorize Salary Reduction Contributions and/or Salary Deduction Contributions in a corresponding amount pursuant to Section 8.1(B)(2).

The Employer shall make Employer contributions for benefits listed in Section 4.5 to the Employer-sponsored plans to which such benefits are payable.

Notwithstanding any contrary Plan provision, an Employer is not obligated to contribute to the Plan after it is terminated except to the extent required to pay benefits outstanding on the date the termination is adopted or, if later, effective.

B. Salary Reduction and/or Salary Deduction Contributions

As a condition of Plan participation, Employees must agree to direct the Employer to:

1. not reduce their compensation and not provide premium payment benefits pursuant to Section 4.4, or

2. reduce their compensation and make Salary Reduction Contributions and/or Salary Deduction Contributions to the plan(s) governing their selected premium payment benefits.

Any election of premium payment benefits shall be null and void unless the Employee authorizes a Salary Reduction Agreement and/or a Salary Deduction Agreement as provided for herein. An Employer must take Salary Reduction Contributions and/or Salary Deduction Contributions and apply them as directed, except that the Employer may not apply a Salary Reduction Contribution or a Salary Deduction Contribution for a selected premium payment benefit to any other premium payment benefit nor may a Salary Reduction Contribution or a Salary Deduction Contribution be applied during a subsequent Plan Year to any participating plan that provides benefits or coverage. Any such Salary Reduction Agreements and/or a Salary Deduction Agreements are hereby incorporated by reference into the Plan as if set forth in full herein.

C. Priority of Contributions

Contributions shall be deemed to come first from amounts contributed by Covered Employees and then from amounts contributed by the Employer.

D. COBRA Contributions

To the extent a former Covered Employee, Dependent or Spouse has exercised his or her continuation rights under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) with respect to benefits described in Section 7.1, the Plan shall accept contributions from such individuals as COBRA premiums.

8.2 Funding

A. Funding Policy

The Employer shall establish and carry out, and may revise from time to time, the funding policy for the Plan.

B. Funding Mechanism

Contributions from the Employer and/or Employees may be held under or paid to one or more of the following vehicles: insurance policies or arrangements, arrangements with health maintenance organizations, or trust funds established by the Employer. In addition, benefits may be paid directly from the general assets of the Employer. Benefits provided through insurance or pursuant to an arrangement with a health maintenance organization shall be only paid by the Insurance Company issuing the insurance policy or by the health maintenance organization. The Employer shall have no liability for benefits provided through insurance or pursuant to an agreement with a health maintenance organization.

8.3 Plan Assets

The Employer shall make payments provided for in Section 8.1(A) from its general assets. The Employer shall make payments provided for in Section 8.1(B) and (D) by collecting Employee contributions and COBRA contributions and transmitting such amounts to the applicable benefits described in Article IV.

8.4 Treatment of Certain Policy Payments

Where an insurance policy provides for payment of premiums directly from the Employer, unless the insurance policy states otherwise, payable dividends, retroactive rate adjustments, rebates or experience refunds are not plan assets. These dividends, retroactive rate adjustments, rebates or experience refunds are Employer property, which the Employer may retain to the extent they do not exceed the Employer's aggregate contributions to Plan cost made from its own funds, except as required by law.

ARTICLE IX

CLAIM AND PAYMENT PROCEDURES

9.1 General Claims Procedures

Except as hereinafter provided, the provisions of this Section shall apply to every claim for a benefit under the Plan regardless of the basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred.

These provisions shall not apply to the extent that claims and appeals procedures are set forth differently in an Incorporated Document, except to the extent that claims and appeals procedures set forth in an Incorporated Document fail to comply with requirements of applicable law, in which case the provisions of this Article IX shall govern. In addition, the provisions of this Article IX shall not be interpreted so as to override applicable state laws that are more protective of Covered Persons' rights with respect to claims and appeals under ERISA plans, to the extent such state laws are not preempted by ERISA.

Solely with respect to the Benefits described in Section 4.4(A), notwithstanding any other Plan provision to the contrary, the Plan intends to comply with Section 2719 of the Public Health Service Act, as set forth in the Patient Protection and Affordable Care Act, and all regulations and guidance issued thereunder.

9.2 Claim Administrator

The Plan Administrator and/or the Company shall have the authority to appoint, remove, and replace one or more Claim Administrators. A Claim Administrator shall have the duties, powers, and responsibilities set forth herein. In the absence of such an appointment and except as hereinafter provided, the Plan Administrator shall also be the Claim Administrator.

Claims with respect to benefits provided on an insured basis shall be determined by the insurance company issuing the policy or agreement as Claim Administrator, except that, if the Employer and insurance company so agree in writing, the Plan Administrator shall retain final authority over the disposition of any review pursuant to Section 9.9.

With respect to claims for benefits provided on a self-funded basis, the Plan Administrator shall retain final authority over the disposition of any review pursuant to Section 9.9 unless otherwise delegated to a Claim Administrator in an Incorporated Document.

9.3 Claims Administration

The Claim Administrator shall have the duty to receive and review claims for benefits under the Plan; to determine what amount, if any, is due and payable under the terms and conditions of the Plan; to make or authorize appropriate disbursements of benefit payments to persons entitled thereto; to inform the Company or any other third party, as appropriate, of the amount of such benefits; to make claims decisions under the terms of the Plan; and to provide a full and fair review to any individual whose claim for benefits has been denied in whole or in part, except as described in Section 9.2 as applied to self-funded benefits.

9.4 Claimants and Designation of Authorized Representative

A Covered Person may file a claim for benefits to which such claimant believes they are entitled. A Covered Person may designate an authorized representative for the initial claim, an appeal of an adverse benefit determination, or both. An "authorized representative" means a person authorized by the Covered Person, in writing, to act on his or her behalf. To designate an authorized representative, the Covered Person must submit a written request on a form approved by the Plan Administrator, which the Covered Person signs and which authorizes the representative to act on their behalf with respect to the benefit claim. If a party is not properly designated as an authorized representative under the Plan, the Plan Administrator will not communicate with that party with respect to any benefit claim or other exercise of a Covered Person's rights under the Plan. With respect to any urgent, pre-service, or concurrent care claim (discussed in Section 9.8(C) below), a Covered Person's treating physician or other health care professional may act as an authorized representative in exercising a Covered Person's rights under the Plan. The Plan will also recognize a court order giving a person authority to submit claims on a Covered Person's behalf. Any attempt to assign benefits by a Covered Person to a health care provider is void pursuant to Article XII and does not constitute a designation of an authorized representative for purposes of the Plan.

9.5 Claim Forms

The Claim Administrator shall furnish to a claimant, upon request, the form(s) required for filing a claim for benefits under the Plan.

9.6 Deadline for Filing a Claim

No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation of services or supplies received, is received by the Plan Administrator within the timeframe set forth in the applicable Incorporated Document. Failure to submit a properly completed claim form within the prescribed period shall neither invalidate nor reduce a claim if it is shown that it was not reasonably possible to furnish the claim form within that time and that the claim form was submitted as soon as reasonably possible.

9.7 Proof of Claim

As a condition of receiving a Plan benefit and as often as the Plan Administrator determines is reasonably necessary, a claimant must submit such evidence as the Plan Administrator shall require that a claim is reimbursable under the terms of the Plan.

9.8 Decision on the Claim

The following rules shall apply to claims filed with respect to an ERISA-covered Benefit under the Plan. An "adverse benefit determination" is a denial, reduction or termination of a benefit, failure to provide or pay for (in whole or in part) a benefit, a denial to participate in the Plan, or a claim adverse benefit determination on the grounds that the treatment is experimental, investigational or not medically necessary. This also includes concurrent care determinations. With respect to claims for disability benefits and claims for benefits under Section 4.4(A), certain retroactive terminations of coverage will be considered adverse benefit determinations, whether or not there is an adverse effect on any particular

benefit at that time, to the extent required by applicable regulations and by guidance from the relevant government agencies.

A. Any time a claimant receives an adverse benefit determination for benefits, other than group health plan and disability benefits as described in paragraphs B and C below, the claimant shall be given written notice of such action within a reasonable period of time but not later than 90 days after the claim is received by the plan, unless special circumstances require an extension of time for processing. If there is an extension, the claimant shall be notified of the extension and the reason for the extension within the initial 90-day period. The extension shall not exceed 180 days after the claim is filed.

   If a claim is denied, in whole or in part, the claimant shall be notified of the adverse benefit determination in writing. The notice of adverse benefit determination shall contain the following information:

   1. the specific reason(s) for the adverse benefit determination;

   2. a reference to the specific provision(s) in the Plan on which the adverse benefit determination is based;

   3. a description of additional material or information necessary to perfect the claim and an explanation of why the material or information is needed;

   4. a description of the Plan's claim and appeal procedures and applicable timeframes; and

   5. a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA after the Plan's appeal procedure (set forth below) has been exhausted.

B. Any time a claimant receives an adverse benefit determination for disability benefits, the claimant shall be given written notice of such action within a reasonable period of time, no later than 45 days after the claim is received by the plan, unless the Claim Administrator determines that an extension of up to 30 days is necessary due to matters beyond the Plan's control. If there is an extension, the claimant shall be notified, before the initial 45-day period of time expires, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The 30-day extension period is tolled until the claimant responds to any information request. A second 30-day extension is also permitted if the Claim Administrator determines that, due to matters beyond the Plan's control, a decision cannot be rendered within the first extension period. In that case, the claimant shall be notified, before the end of the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. Such extension notices shall specifically explain 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 claimant shall be afforded at least 45 days within which to provide the specified information.

If a claim is denied, in whole or in part, the claimant shall be notified of the adverse benefit determination in writing. The notice of adverse benefit determination shall contain the following information:

1. the specific reason(s) for the adverse benefit determination;

2. a reference to the specific provision(s) in the Plan on which the adverse benefit determination is based;

3. a description of additional material or information necessary to perfect the claim and an explanation of why the material or information is needed;

4. a description of the Plan's claim and appeal procedures and applicable timeframes;

5. a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA after the Plan's appeal procedure (set forth below) has been exhausted;

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

    a. the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

    b. the views of medical or vocational experts obtained by the plan, without regard to whether the advice was relied upon for the adverse benefit determination; and

    c. any Social Security Administration disability determination regarding the claimant presented to the Plan;

7. for adverse benefit determinations based on medical necessity, experimental treatment, or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request;

8. either the specific rule, guideline, protocol, standards, or other similar criteria relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist; and

9. a statement that reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits are available free of charge, upon request.

C. The following rules shall apply to medical, dental, vision, employee assistance plan, health care spending account or limited purpose health care spending account benefits except that claims for health care spending account shall be considered "post-service" only.

1. Urgent Care Claims – Claims for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or, in the judgment of a physician, would subject the patient to severe pain that cannot be adequately managed otherwise. The Plan shall defer to an attending provider to determine if a medical claim under Section 4.4(A) is urgent.

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

2. Pre-service Claims – Claims which must be decided before a patient will be afforded access to health care (e.g., preauthorization requests).

   The Claim Administrator shall notify the claimant of the Plan's determination not later than 15 days after receipt of the claim. This period may be extended by 15 days, provided the Claim Administrator or its delegate determines that an extension is necessary due to matters beyond the control of the Plan and notifies the claimant within the initial period of the circumstances requiring the extension and the date by which the Plan expects to render a decision. If such an extension is necessary due to the claimant's failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information. The claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

   If the claim is improperly filed, the Claim Administrator shall notify the claimant as soon as possible, but not later than five (5) days after receipt of the claim by the Plan, of the specific information necessary to complete the claim.

3. Post-service Claims – Claims involving the payment or reimbursement of costs for medical care which has already been provided.

   For non-urgent post-service health claims, the Plan has up to 30 days to evaluate and process claims for benefits covered by ERISA. The 30-day period begins on the date the claim is first filed. This period may be extended by 15 days provided the Claim Administrator or its delegate determines that an extension is necessary due to matters beyond the control of the Plan and notifies the claimant within the initial period, of the circumstances requiring the extension and the date by which the Plan

expects to render a decision. The claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

4. Concurrent Care Claims – Claims where the Plan has previously approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments.

   Concurrent care claims may fall under any of the other three categories, depending on when the appeal is made. However, the Plan must give the claimant sufficient advance notice to appeal the claim before a concurrent care decision takes effect.

5. Notification of Adverse Benefit Determination - applicable to all health claims

   In the event of an adverse benefit determination, the claimant will receive notice of the determination.

   If a claim is denied, in whole or in part, the claimant shall be notified of the adverse benefit determination in writing. The notice of adverse benefit determination shall contain the following information:

   a. the specific reason(s) for the adverse benefit determination;

   b. a reference to the specific provision(s) in the Plan on which the adverse benefit determination is based;

   c. a description of additional material or information necessary to perfect the claim and an explanation of why the material or information is needed;

   d. a description of the Plan's claim and appeal procedures and applicable timeframes;

   e. a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA after the Plan's appeal procedure (set forth below) has been exhausted;

   f. if any internal rules, guidelines, protocols, or similar criteria were used as a basis for the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;

   g. for adverse benefit determinations based on medical necessity, experimental treatment, or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and

h. For adverse determinations involving urgent care (for medical claims only), the notice will also include a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.

For medical claims only, the notice of adverse benefit determination shall include information sufficient to identify the claim involved, including:

i. the date of service;

j. the health care provider;

k. the claim amount (if applicable);

l. the denial code and its corresponding meaning;

In addition, for medical claims only, the notice of adverse benefit determination shall include the following information:

m. a statement that diagnosis and treatment codes (and their meanings) shall be provided upon request;

n. description of the Plan's standard used in denying the claim;

o. a description of the external review processes; and

p. the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

9.9 Right to Appeal

A claimant who has received an adverse benefit determination, shall have the right to appeal the adverse benefit determination.

The following rules shall apply to claims filed with respect to an ERISA-covered benefit under the Plan.

A. A claimant who has received an adverse benefit determination for benefits, other than the group health plan and disability benefits as described in paragraphs B and C below, or is otherwise adversely affected by action of the Claim Administrator, shall have the right to request review of the claim. Such request must be in writing and must be made within 60 days after such claimant is advised of the Claim Administrator's action. The requested review must take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. If written request for review is not made within the 60-day period, the claimant shall forfeit his or her

right to review. The claimant or a duly authorized representative of the claimant may review all relevant information and submit issues, comments, documents, records, and other information in writing.

The Claim Administrator or Plan Administrator or its delegate, as applicable, shall then review the claim. It may hold a hearing if it deems it necessary and shall issue a written decision reaffirming, modifying, or setting aside its former action within a reasonable period of time, but not later than 60 days after receipt of the written request for review, unless the Plan Administrator determines that special circumstances, such as a hearing, require an extension. The claimant shall be notified in writing of any such extension within 60 days following the request for review, and such extension shall not exceed 60 days from the end of the initial period.

A copy of the review determination shall be furnished to the claimant. If the claim is denied, the review determination notice shall contain the following information:

1. the specific reason(s) for the adverse benefit determination;

2. a reference to the specific provision(s) in the Plan on which the adverse benefit determination is based;

3. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access, and copies of all relevant information;

4. a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA;

5. a description of any voluntary appeals procedures offered by the Plan, if any; and

6. a statement that the claimant has the right to obtain information about the voluntary appeals process, if any.

The decision shall be final and binding upon the claimant and all other persons or entities involved, except to the extent that the Plan provides for a voluntary appeals procedure subsequent to this appeals process, or the decision is subject to judicial review.

B. A claimant who has received an adverse benefit determination for disability benefits or is otherwise adversely affected by the action of the Claim Administrator shall have the right to request review of the claim. Such request must be in writing and must be made within 180 days after such claimant is advised of the Claim Administrator's action. If written request for review is not made within the 180-day period, the claimant shall forfeit his or her right to review. The claimant or a duly authorized representative of the claimant may review all relevant information and submit issues and comments in writing.

The Claim Administrator or Plan Administrator or its delegate, as applicable, shall then review the claim. It shall issue a written decision reaffirming, modifying, or setting aside its former action within a reasonable period of time, but not later than

45 days after receipt of the written request for review, or an additional 45 days if the Plan Administrator determines that special circumstances require an extension. The claimant shall be notified in writing of any such extension before the initial period of time expires, and such notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review. The extension period is tolled until the claimant responds to any information request.

A copy of the review determination shall be furnished to the claimant. If the claim is denied, the review determination notice shall contain the following information:

1. the specific reason(s) for the adverse benefit determination;

2. a reference to the specific provision(s) in the Plan on which the adverse benefit determination is based;

3. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access, and copies of all relevant information;

4. a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA;

5. a description of any voluntary appeals procedures offered by the Plan, if any;

6. a statement that the claimant has the right to obtain information about the voluntary appeals process, if any;

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

    a. the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

    b. the views of medical or vocational experts obtained by the plan, without regard to whether the advice was relied upon for the adverse benefit determination; and

    c. any Social Security Administration disability determination regarding the claimant presented to the Plan;

8. a description of any applicable contractual limitations period, including the date on which the claim expires;

9. either the specific rule, guideline, protocol, standards, or other similar criteria relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist; and

10. for adverse benefit determinations based on medical necessity, experimental treatment, or other similar exclusions or limits, an explanation

of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

The Plan will provide for the identification of experts whose advice was obtained on behalf of Plan in connection with an adverse determination, without regard to whether the advice was relied on in making the determination.

In deciding an appeal of any adverse benefit determination based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and such individual shall not have been consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual. In deciding an appeal, no deference will be afforded to the initial adverse benefit determination and the review of the appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual.

The Claim Administrator will ensure that all claims and appeals for disability benefits are handled impartially. The Claim Administrator shall ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support an adverse benefit determination of benefits. The Claim Administrator shall ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

A claimant shall be able to review his or her file and present information as part of the appeal. Before making a benefit determination on review, the Claim Administrator shall provide the claimant with any new or additional evidence considered or generated by the Plan, as well as any new or additional rationale to be used in reaching the decision. The claimant shall be given this information in advance of the date on which the notice of final appeal decision is made to give such claimant a reasonable opportunity to respond.

If the Plan fails to strictly adhere to the requirements in this subsection with respect to the claim, the claimant is deemed to have exhausted the Plan's administrative remedies and may pursue any remedies under Section 502(a) of ERISA. However, this shall not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. If a court rejects the claimant's demand for immediate review based on the exceptions above, the claim will be considered as refiled on appeal upon receipt of the court's decision, and the plan will notify the claimant of the resubmission.

The decision shall be final and binding upon the claimant and all other persons or entities involved, except to the extent that the Plan provides for a voluntary

appeals procedure subsequent to this appeals process, or the decision is subject to judicial review.

C. A claimant who has received an adverse benefit determination for medical, dental, vision, employee assistance plan, health care spending account, and limited purpose health care spending account benefits or is otherwise adversely affected by action of the Claim Administrator, shall have the right to request review of the claim. Such request must be in writing and must be made within 180 days after such claimant is advised of the Claim Administrator's action. If written request for review is not made within the 180-day period, the claimant shall forfeit his or her right to review. The claimant or a duly authorized representative of the claimant may review all relevant information and submit issues and comments in writing.

The Claim Administrator or Plan Administrator or its delegate, as applicable, shall then review the claim. It shall issue a written decision reaffirming, modifying, or setting aside its former action within a reasonable period of time, but not later than:

1. for urgent health claims, as soon as possible considering the medical situation, but no later than 72 hours,

2. for pre-service claims, within a reasonable period of time given the medical situation, but no later than 30 days (or 15 days following each appeal if there are two mandatory appeals),

3. for post-service claims, within a reasonable period of time, but not later than sixty (60) days after receipt of the request for review (or 30 days following each appeal if there are two mandatory appeals).

If a claim for medical benefits is an urgent health claim or a claim requiring an ongoing course of treatment, the claimant may begin an expedited external review, as described in Section 9.10, before the Plan's internal appeals process has been completed.

Medical coverage as described in Section 4.4(A) shall continue pending the outcome of an internal appeal.

A copy of the review determination shall be furnished to the claimant. If the claim is denied, the review determination notice shall contain the following information:

4. the specific reason(s) for the adverse benefit determination;

5. a reference to the specific provision(s) in the Plan on which the adverse benefit determination is based;

6. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access, and copies of all relevant information;

7. a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA;

8. a description of any voluntary appeals procedures offered by the Plan, if any;

9. a statement that the claimant has the right to obtain information about the voluntary appeals process, if any, and information as to how the claimant may obtain information about alternative dispute resolution options from the Department of Labor or state regulators;

10. if any internal rules, guidelines, protocols, or similar criteria were used as a basis for the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;

11. for adverse benefit determinations based on medical necessity, experimental treatment, or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and

12. for adverse determinations involving urgent care, the notice will also include a description of the expedited review process for such claims (for medical claims only). This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.

For claims for medical benefits, the notice of adverse benefit determination shall include information sufficient to identify the claim involved, including:

13. the date of service;

14. the health care provider;

15. the claim amount (if applicable);

16. the denial code and its corresponding meaning;

17. In addition, for medical claims only, the notice of adverse benefit determination shall include the following information:

18. a statement that diagnosis and treatment codes (and their meanings) shall be provided upon request;

19. description of the Plan’s standard used in denying the claim;

20. a description of the external review processes; and

21. the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

Upon request by the claimant, the Plan will provide for the identification of experts whose advice was obtained on behalf of Plan in connection with an adverse

determination, without regard to whether the advice was relied on in making the determination.

In deciding an appeal of any adverse benefit determination based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and such individual shall not have been consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual. In deciding an appeal, no deference shall be afforded to the initial adverse benefit determination and the review of the appeal shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual.

The Claim Administrator will ensure that all claims and internal appeals for medical benefits are handled impartially. The Claim Administrator shall ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support an adverse benefit determination of benefits. The Claim Administrator shall ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

In connection with an internal appeal of a medical claim, a claimant shall be able to review his or her file and present information as part of the review. Before making a benefit determination on review, the Claim Administrator shall provide the claimant with any new or additional evidence considered or generated by the Plan, as well as any new or additional rationale to be used in reaching the decision. The claimant shall be given this information in advance of the date on which the notice of final appeal decision is made to give such claimant a reasonable opportunity to respond.

For medical claims only, if the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to the claim, the claimant is deemed to have exhausted the internal claims and appeals process and may request an expedited external review before the Plan's internal appeals process has been completed. However, this shall not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, the claimant may resubmit the claim for internal review and the claimant may ask the Plan to explain why the error is minor and why it meets this exception.

The decision shall be final and binding upon the claimant and all other persons or entities involved, except to the extent that the Plan provides for a voluntary appeals procedure subsequent to this appeals process, or the decision is subject to judicial review.

9.10 Right to an External Review of Claims

To the extent required by PPACA, as amended by HCERA, as required by the No Surprises Act provisions of the CAA, and as interpreted by applicable guidance and regulations from the relevant government agencies, the following rules shall apply to claims filed for benefits under Section 4.4(A) of the Plan. This Section 9.10 shall not be interpreted to give claimants any rights to external review beyond what is expressly required under these laws and as interpreted by applicable guidance and regulations from the relevant government agencies. This Section 9.10 is not applicable to any other benefits offered under the Plan.

The claimant shall be entitled to request an external review of a medical claim involving medical judgment, as determined by the external reviewer; a coverage rescission; or in the event there is a question as to whether the claim should have been subject to surprise billing protections, as required by the No Surprises Act provisions of the CAA, provided the claimant requests the external review within four (4) months of the date of receipt of an adverse benefit determination. If the claimant's request for an external review is determined eligible for such a review, an independent organization shall review the Claim Administrator's decision and provide the claimant with a written determination, as described in the Incorporated Documents.

The external review decision is binding on the claimant and the Plan, except to the extent that other remedies are available under federal law.

The external review process does not apply to an adverse benefit determination or final internal adverse benefit determination beyond those listed herein.

9.11 Legal Remedy

Before pursuing a legal remedy, a claimant shall first exhaust all claims, review, and appeals procedures required under the Plan.

9.12 Subrogation, Reimbursement and Recovery for Third Party Liability

A. This Section shall govern with respect to Plan benefits for injuries or illnesses of Covered Persons related to a third party's actions or inactions.

With respect to benefits provided on an insured basis, to the extent that conflicting subrogation, reimbursement, or recovery provisions exist in an Incorporated Document, such provisions in the Incorporated Document shall govern.

With respect to benefits provided on a self-insured basis, to the extent that any Incorporated Document also contains subrogation, reimbursement, or recovery provisions, this subsection and the applicable Incorporated Document will both apply so as to grant the Plan the greatest possible rights with respect to subrogation, reimbursement, and recovery.

B. Subrogation

If a Covered Person becomes injured or ill because of the actions or inactions of a third party, the Plan shall have the right to pursue a claim against the third party for

expenses paid by the Plan related to such injury or illness The Plan's right of recovery applies to the extent the Plan has paid expenses related to the injury or illness, regardless of whether any related settlement or other third-party payment states that the payment (all or part of it) is for health care expenses or of any allocation or itemization of such recovery to specific types of injuries.

By accepting Plan benefits to pay for treatments, devices or other products or services related to such injury or illness, the Covered Person agrees to place such third-party payments in Covered Person's separate identifiable account (in an amount equal to related expenses paid by the Plan or, if less, the full third-party payment amount) and that the Plan has an equitable lien on such funds, without regard to whether the Covered Person has been made whole or fully compensated for the injury or illness. The Covered Person also agrees to serve as a constructive trustee over the funds until the time they are paid to the Plan. The Covered Person further agrees to cooperate with the Plan's recovery efforts and do nothing to prejudice the Plan's recovery rights.

The Plan's right of subrogation will apply to the first dollar of any recovery obtained from the third-party, without regard to whether the Covered Person has been made whole or fully compensated for the injury or illness, and shall not be subject to the principles of unjust enrichment, assertion of a "common fund" doctrine or its equivalent or any other equitable defenses. At its option, the Plan may file suit or intervene in any pending lawsuit to secure and protect its rights on any third-party recovery. The Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) incurred in obtaining the funds.

C. Plan's Right of Recovery

If a Covered Person becomes injured or ill because of the actions or inactions of a third party, the Plan shall have the right to recover related Plan expenses out of any payments made by (or on behalf of) the third party (whether by lawsuit, settlement, no-fault automobile insurance statute or otherwise) to or on behalf of a Covered Person. The Plan's right of recovery applies to the extent the Plan has paid expenses related to the injury or illness, regardless of whether any related settlement or other third-party payment states that the payment (all or part of it) is for health care expenses, regardless of the label assigned to the recovery and regardless of the allocation or itemization of such recovery to specific types of injuries. The Plan may require the Covered Person to sign a reimbursement agreement in a form acceptable to the Plan Administrator, but whether or not such an agreement is executed, in the event that the Plan provides benefits and the Covered Person receives a third-party payment as described in this paragraph, the Covered Person shall immediately reimburse the Plan for the lesser of the amount of the third-party payment or the full amount of all benefits paid by the Plan.

By accepting Plan benefits to pay for treatments, devices or other products or services related to such injury or illness, the Covered Person agrees to place such third-party payments in Covered Person's separate identifiable account (in an amount equal to related expenses paid by the Plan or, if less, the full third-party payment amount) and that the Plan has an equitable lien on such funds, without regard to whether the Covered Person has been made whole or fully compensated for the injury or illness. The Covered Person also agrees to serve as a constructive

trustee over the funds until the time they are paid to the Plan. Covered Person further agrees to cooperate with the Plan's recovery efforts and do nothing to prejudice the Plan's recovery rights.

The Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) incurred in obtaining the funds.

D. Cooperation

If so requested by the Claim Administrator, the Covered Person (or if a minor, his or her parent or legal guardian) shall:

1. provide proof, satisfactory to the Claim Administrator, that no right, claim, interest, or cause of action against a third party has been, or will be, discharged, or released without the written consent of the Claim Administrator;

2. execute a written agreement assigning to the Plan all rights, claims, interests, and causes of action that the Covered Person has against a third party in connection with the expenses paid by the Plan;

3. notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of an intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness;

4. provide all information requested by the Plan, the Claim Administrator, or their representatives;

5. authorize the Plan, in writing, to sue, compromise or settle, in the Covered Person's name or otherwise, all rights, claims, interests, or causes of action to the extent of benefits paid by the Plan and shall do nothing to prejudice the rights given to the Plan under this section; and

6. agree, in writing, to assist the Plan in prosecuting any rights, interests, claims, or causes of action that have been assigned to the Plan against a third party, including, if requested by the Claim Administrator or Plan Administrator, the institution of a formal proceeding against a third party.

E. Enforcement of Plan's Subrogation and Recovery Rights

Should it be necessary for the Plan to institute proceedings against the Covered Person for failure to reimburse the Plan or to otherwise honor the Plan's equitable interest in obtaining amounts described in this Section, the Covered Person shall be liable for the costs of collection relating to such failure, including reasonable attorney's fees.

The Plan shall have the right to terminate a Covered Person's participation in the Plan or offset future benefits to which a claimant (or a Covered Person through whom the claimant derives his or her claim) may be entitled, until the amount

otherwise due the Plan under this Section, plus interest, has been received by the Plan.

The Plan's rights under this Section shall be enforceable regardless of whether the third party admits liability for the injury or illness to a Covered Person, and shall remain enforceable against the heirs and estate of any Covered Person.

9.13 Payment Procedures

A. Payment of Claim

Subject to Section 12.4, benefits shall be payable to the claimant upon establishment of the right thereto.

B. Facility of Payment

If a claimant dies before all amounts payable under the Plan have been paid, or if the Plan Administrator determines that the claimant is a minor or is incompetent or incapable of executing a valid receipt and no guardian or legal representative has been appointed, or if the claimant fails to provide the Plan with a forwarding address, the amount otherwise payable to the claimant may be paid to any other person or institution reasonably determined by the Plan Administrator to be entitled equitably thereto and without prejudice therefor. Any payment made in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

C. Forfeiture

The Plan Administrator shall take reasonable steps to ascertain the whereabouts of a claimant so as to affect delivery of benefits payable under the Plan. If a claimant has not collected benefits payable to him or her within 15 months from the date the claim was filed, the Plan Administrator may, three months after sending by certified mail a written notice of benefits to the last known address of such claimant as shown on the records of the Administrator, deem the claimant's right to such benefit waived. Upon such waiver, the Plan shall have no liability for payment of the benefit otherwise payable.

ARTICLE X

ADMINISTRATION

10.1 Plan Administrator

The Company shall appoint a person, entity, or committee to serve as Plan Administrator. In the absence of such appointment, the Company shall be the Plan Administrator. The Plan Administrator shall be the "named fiduciary" for purposes of ERISA.

10.2 Plan Administrator's Duties

The Plan Administrator shall:

A. manage and carry out the Plan's operation and administration according to the Plan's terms and for Covered Employees' exclusive benefit;

B. maintain:

1. whatever records and data are necessary or desirable for the Plan's proper operation and administration, and

2. the Plan's governing documentation for inspection by anyone who participates or is eligible to participate in the Plan;

C. notify Employees eligible to participate in the Plan of:

1. the Plan's availability and terms,

2. the premium payment benefits available for election,

3. the maximum annual Salary Reduction Contribution and/or Salary Deduction Contribution amounts for each available premium payment benefit, and

4. the procedures for enrolling and making and changing elections;

D. supply eligible Employees with any forms and agreements they must complete;

E. prepare and file all annual reports or returns, plan descriptions, financial statements, and other documents required by law or under the Plan's terms; and

F. record its and the Employer's acts and determinations regarding the Plan and preserve these records in its custody.

10.3 Plan Administrator's Powers

Except as expressly limited or reserved in the Plan to the Company, the Plan Administrator shall have the right to exercise, in a uniform and nondiscriminatory manner, full discretion with respect to the administration, operation, and interpretation of the Plan.

Without limiting the generality of the foregoing rights, the Plan Administrator shall have full power and discretionary authority to:

A. require any person to furnish such information as the Plan Administrator may request from time to time and as often as the Plan Administrator determines reasonably necessary for the purpose of proper administration of the Plan and as a condition to the individual's receiving benefits under the Plan;

B. make and enforce such rules and prescribe the use of such forms as the Plan Administrator determines reasonably necessary for the proper administration of the Plan;

C. interpret the Plan and decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions;

D. determine all questions concerning the eligibility of any individual to participate in, be covered by, and receive benefits under the Plan pursuant to the provisions of the Plan;

E. determine whether objective criteria set forth in the Plan have been satisfied respecting any term, condition, limitation, exclusion, and restriction or waiver thereof;

F. determine the amount of benefits payable, if any, to any person or entity in accordance with the provisions of the Plan; to inform the Employer or any other third party, as appropriate, of the amount of such benefits; to make claim decisions under the terms of the Plan; and to provide a full and fair review to any individual whose claim for benefits has been denied in whole or in part;

G. delegate to other person(s) any duty that otherwise would be a fiduciary responsibility of the Plan Administrator under the terms of the Plan;

H. engage the services of such person(s) and entity or entities as it deems reasonably necessary or appropriate in connection with the administration of the Plan;

I. make such administrative or technical amendments to the Plan as may be reasonably necessary or appropriate to carry out the intent of the Company, including such amendments as may be required or appropriate to satisfy the requirements of the Code and ERISA and the rules and regulations from time to time in effect under any such laws, or to conform the Plan with other governmental regulations or policies; and

J. pay all reasonable and appropriate expenses incurred in connection with the management and administration of the Plan including, but not limited to, premiums or other considerations payable under the Plan and fees and expenses of any actuary, accountant, legal counsel, or other specialist engaged by the Plan Administrator.

10.4 Finality of Decisions

The Plan Administrator shall have full power, authority, and discretion to enforce, construe, interpret and administer the Plan. All decisions and determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on Covered Persons and all other interested parties.

10.5 Compensation and Bonding of Plan Administrator

Unless otherwise agreed to by the Company, the Plan Administrator shall serve without compensation for services as such, but all reasonable expenses incurred in the performance of the Plan Administrator's duties shall be paid as specified in Article XII. Unless otherwise determined by the Company or unless required by federal or state law, the Plan Administrator shall not be required to furnish bond or other security in any jurisdiction.

10.6 Liability Insurance

The Company may obtain liability coverage at the Company’s expense to insure any Employee serving as Plan Administrator against legal liability that may arise from being the Plan Administrator or performing the Plan Administrator's duties.

10.7 Reserved Powers

The Company reserves the powers, among others:

A. to adopt the Plan;

B. to amend, terminate, or merge the Plan according to Article XI; and

C. to appoint and remove any Claim Administrator or Plan Administrator.

ARTICLE XI

AMENDMENT, TERMINATION OR MERGER OF PLAN

11.1 Right to Amend the Plan

Except as provided in Section 11.3, the Company reserves the unlimited right to amend the Plan in any way. Any amendment to the Plan shall be in writing and shall be adopted by the Company **in** accordance with its normal procedures. However, the Plan Administrator shall have the authority to amend the Plan to comply with applicable law or regulation or to reflect the Company's intent.

11.2 Right to Terminate or Merge the Plan

Notwithstanding that the Plan is established with the intention that it be maintained indefinitely, the Company (or its duly authorized representative) reserves the unlimited right to terminate or merge the Plan. Any termination or merger of the Plan shall be in writing and shall be adopted by the duly authorized representative of the Company acting in accordance with its regular duties for the Company.

11.3 Effect of Amendment, Termination or Merger

Any amendment, termination or merger of the Plan shall be effective at such date as the Company shall determine. If no date is specified by the Company in the written instrument amending, terminating, or merging the Plan, the amendment, termination, or merger shall be effective upon the date that the written instrument is adopted or executed.

In the event that the Plan is terminated, plan assets will be used for the benefit of participants and beneficiaries or to defray reasonable administrative expenses, as applicable.

ARTICLE XII

MISCELLANEOUS

12.1 No Employment Rights

The Plan is a voluntary undertaking of the Employer and does not constitute a contract with any person. The Plan is not an inducement or condition of an Employee's employment with any Employer. Neither the establishment of the Plan, nor any modification thereof, nor any payments hereunder, shall be construed as giving to any Employee or any other person, any legal or equitable rights against his or her Employer, the Company or their shareholders, directors, officers, employees or agents, or as giving any person the right to be retained in the employ of the Employer.

12.2 Exclusive Rights

No individual shall have a right to benefits under the Plan except as specified herein; and in no event shall any right to benefits under the Plan be or become vested. This Plan is not a guarantee of continuation of any benefits or coverage offered through the Plan.

12.3 No Property Rights

No one has any right, title, or interest in the property of the Company or the Employer by virtue of the Plan, nor is any person entitled to interest on any benefit amounts that may be allocated or available to him or her.

12.4 No Assignment of Benefits

Except when the Plan is required by law or applicable guidance to recognize an assignment of Benefits to a State Medicaid program, Benefits payable under the Plan and the right to assert legal or equitable rights, including but not limited to bringing an administrative claim for benefits, action under state law or filing a lawsuit against the Plan, the Plan Administrator, a Claim Administrator, or any Plan fiduciary, or the Company and Participating Employers, or officers, shareholders or employees thereof, shall not be subject in any manner to liability, anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to effect same shall be void. This includes, but is not limited to, any attempt by a Covered Person to assign his or her right to receive Plan benefits and legal rights relating to the Plan—including any rights to bring an administrative claim or lawsuit—to any other party, including any health care provider; such assignment is not permitted under the Plan and is void. The Plan reserves the right to make payment directly to the Covered Person, or, solely at the discretion of the Plan Administrator or the Claim Administrator, directly to a doctor, hospital, or other provider of health care. Where payments are made directly to a doctor, hospital, or other provider of health care, such direct payments are provided at the discretion of the Plan Administrator or Claim Administrator and do not imply or create an enforceable assignment of benefits or the right to receive such benefits or the right to assert any legal or equitable rights (including but not limited to claims for breach of fiduciary duty or the right to bring an injunction), or to bring any administrative claim, action under state law or lawsuit against the Plan, the Plan Administrator, a Claim Administrator, or any Plan fiduciary, or the Company and Participating Employers, or officers, shareholders or employees thereof, under any federal or state law, including ERISA.

12.5 Right to Offset Future Payments

In the event a payment or the amount of a payment is made erroneously to an individual, the Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous or excess payment. This right to offset shall not limit the right of the Plan to recover an erroneous or excess payment in any other manner.

12.6 Right to Recover Payments

Whenever a payment has been made by the Plan, including erroneous payments, in a total amount in excess of the amount payable under the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from the person to or for whom the payment was made.

12.7 Misrepresentation or Fraud

A Covered Person who receives benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. The Plan Administrator shall decide such matters on a case-by-case basis. An Employee may be asked to provide proof of eligibility for his or her Dependents. If a Covered Person makes any intentional misrepresentation or uses fraudulent means concerning eligibility for coverage, changing existing coverage, or benefits under the Plan, the Employee’s and his or her Dependents’ coverage may be terminated irrevocably (retroactively to the extent permitted by law), and could be grounds for Employee discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

12.8 Legal Action

Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan must first exhaust the Plan's claim, review, and appeal procedures. Unless otherwise provided by law, the Company and the Plan Administrator are the only necessary parties to any action or proceeding that involves the Plan or its administration. No Employee, Employer, or other person or entity is entitled to notice of any legal action, unless a court with appropriate jurisdiction orders otherwise.

Unless an Incorporated Document specifies a shorter timeframe, no action at law or in equity in any court or agency shall be brought to recover benefits under the Plan prior to the exhaustion of the claims and appeals procedures set forth in Article IX, nor shall an action be brought at all unless within one year after the date a claim is incurred under the Plan.

12.9 Governing Law

The provisions of the Plan shall be administered, and all questions pertaining to the validity or construction of the Plan and the acts and transactions of the parties shall be determined, construed, and enforced, in accordance with applicable and, to the extent not preempted, the laws of the State of California.

12.10 Governing Instrument

This document, together with any documentation incorporated by reference herein, is the legal instrument governing the Plan. In case of conflict between this document and any other writing or evidence, the terms of this document shall govern.

12.11 Savings Clause

If a provision of the Plan or the application of a provision of the Plan to any person, entity, or circumstance is held invalid under governing law by a court of competent jurisdiction, the remainder of the Plan and the application of the provision to any other person, entity, or circumstance shall not be affected.

12.12 Captions and Headings

The captions and headings of an Article, Section or provision of the Plan are for convenience and reference only and are not to be considered in interpreting the terms and conditions of the Plan.

12.13 Notices

No notice or communication in connection with the Plan made by a claimant or an Employee shall be effective unless duly executed on a form provided or approved by, and filed with, the appropriate Plan Administrator (or his or her representative).

12.14 Waiver

No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in a writing signed by the party to be charged. No written waiver shall be deemed a continuing waiver unless so specifically stated in the writing, and only for the stated period, and such waiver shall operate only as to the specific term, condition, or provision waived.

12.15 Parties' Reliance

The Company, the Employer, the Plan Administrator, and anyone to whom the Plan's operation or administration is delegated may rely conclusively on any advice, opinion, valuation, or other information furnished by any actuary, accountant, appraiser, legal counsel, or physician the Plan engages or employs. A good faith action or omission based on this reliance is binding on all parties, and no liability can be incurred for it except as the law requires. No liability shall be incurred for any other action or omission of the Company, the Employer, or their employees, except for willful misconduct or willful breach of duty to the Plan.

12.16 Disclaimer

The Company makes no assertion or warranty about:

A. health care services and supplies that Covered Persons obtain reimbursement for as Plan benefits, or

B. whether Plan benefits are or will be excludable from a Covered Employee's gross income for federal or state income tax purposes, or

C. whether any other tax treatment is or will be applicable.

12.17 Expenses

All expenses of the Plan shall be paid from forfeitures, Employee contributions, or by the Plan, unless otherwise paid by the Employer. The Employer may advance expenses to the Plan, subject to reimbursement, without obligating itself to pay such expenses.

12.18 Indemnification

The Employer, to the extent permitted by law, shall indemnify and hold harmless the board of directors, any employee or officer or shareholder of the Company or the Employer from and against all loss, damages, liability and reasonable costs and expenses incurred in carrying out his or her responsibilities under the Plan, unless due to the bad faith or willful misconduct of such person, provided that such individual's attorney's fees and any amount paid in settlement shall be approved by the Company.

12.19 Employees' Tax Obligations

A. Excludability Determination

Covered Employees themselves must determine whether Plan benefits are excludable for tax purposes and must notify the Plan Administrator if they have reason to believe a payment is not excludable.

B. Liability and Payment

If the Plan Administrator determines at any time after a Plan Year's end that Employees' Salary Reduction Contributions or Salary Deduction Contributions or other Employer contributions exceeded limits allowed by law for any reason including, but not limited to, erroneous information, or administrative error, then Covered Employees must:

1. pay any local, state, and federal income taxes and related penalties and interest due with respect to the excess Salary Reduction Contributions or other Employer contributions for which the Covered Employee is liable, and

2. reimburse the Employer for the Employee's share of any local, state, and federal tax contributions the Employer would have withheld or other applicable deductions the Employer would have taken had the excess Salary Reduction Contributions or other Employer contributions been treated as taxable income.

ARTICLE XIII

HIPAA PRIVACY AND SECURITY

13.1 Scope

The provisions of this Article XIII shall apply to any self-insured group health plan Benefit and any insured group health plan Benefit from which the Plan Sponsor receives Protected Health Information.

13.2 Definitions

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

A. "Business Associate" means a person or entity that performs a function or activity regulated by HIPAA on behalf of the group health plans provided under the Plan and involving individually identifiable health information. Examples of such functions or activities are claims processing, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation and financial services. A Business Associate may be a Covered Entity. However, Insurers and HMOs are not Business Associates of the plans they insure. A person or entity that transmits PHI to a covered entity (or its business associate) and routinely requires access to that PHI may also be a business associate. Examples of such entities include health information exchange organizations, regional health information organizations and e-prescribing gateways. Vendors that contract with covered entities offering certain personal health records to individuals may also be considered business associates, and vendors that contract with Business Associates ("subcontractors") and require or have access to PHI or ePHI on a routine basis may also be Business Associates with respect to the Plan.

B. "Covered Entity" means a group health plan (including an employer plan, Insurer, HMO and government coverage such as Medicare); a health care provider (such as a doctor, hospital or pharmacy) that electronically transmits any health information in connection with a transaction for which the U.S. Department of Health and Human Services has established an electronic data interchange standard; and a health care clearinghouse (an entity that translates electronic information between nonstandard and HIPAA standard transactions).

C. "Protected Health Information or PHI" means individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. Information is "individually identifiable" if it names the individual person or there is a reasonable basis to believe components of the information could be used to identify the individual. "Health Information" means information, including genetic information, whether oral or recorded in any form or medium, that (i) is created by a health care provider, health care plan, employer, life insurer, public health authority, health care clearinghouse, or school or university; and (ii) relates to the past, present, or future physical or mental health or condition of a person, the provision of health care to a person; or the past, present or future payment for health care.

13.3 Uses and Disclosures of PHI

The Plan may disclose a Covered Employee's PHI or ePHI to the Plan Sponsor (or to the agent of the Plan Sponsor) for the plan administration functions under 45 CFR 164.504(a), to the extent not inconsistent with the HIPAA regulations. The Plan will not disclose PHI or ePHI to the Plan Sponsor except upon receipt of a certification by the Plan Sponsor that the Plan incorporates the agreements of Sections 13.4 and 13.5, except as otherwise permitted or required by law.

13.4 Privacy Agreements of the Plan Sponsor

As a condition for obtaining PHI from the Plan and its Business Associates the Plan Sponsor agrees it will:

A. Not use or further disclose such PHI other than as permitted by Section 13.3, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;

B. Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

C. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

D. Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware, including reporting any breach of unsecured PHI;

E. Make the PHI of a particular participant available for purposes of the participant's requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulations 45 CFR 164.524 and 164.526;

F. Make the PHI of a particular participant available for purposes of required accounting of disclosures by the Plan Sponsor pursuant to the participant's request for such an accounting in accordance with HIPAA regulations 45 CFR 164.528;

G. Make the Plan Sponsor's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

H. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

I. Ensure that there is adequate separation between the Plan and the Plan Sponsor by implementing the terms of subparagraphs (1) through (3), below:

1. Employees with Access to PHI: The employees, classes of former employees or other individuals under the control of the Plan Sponsor listed in Appendix B and/or in a separately maintained access control list are the only individuals that may access PHI received from the Plan.

2. Use Limited to Plan Administration: The access to and use of PHI by the individuals described in (1), above, is limited to plan administration functions as defined in HIPAA regulations 45 CFR 164.504(a) that are performed by the Plan Sponsor for the Plan.

3. Mechanism for Resolving Noncompliance: If the Plan Sponsor or the persons listed in Appendix B who are responsible for monitoring compliance determine that any person described in (1), above, has violated any of the restrictions of this Article XIII, then such individual shall be disciplined in accordance with the policies of the Plan Sponsor established for purposes of privacy and security compliance, up to and including dismissal from employment. The Plan Sponsor shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

J. Notify participant(s) of an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information (a "Breach") without unreasonable delay in a report which includes the following information:

1. the circumstances surrounding the Breach;

2. the date of the Breach and the date of its discovery;

3. the information Breached;

4. any steps the impacted individuals should take to protect themselves;

5. the steps the Plan Sponsor is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and

6. a contact person who can provide additional information about the Breach.

The Plan Sponsor will cooperate with participant(s) in the investigation of, and response to, the Breaches it reports to participant(s). For this purpose, the term "Breach" means an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information.

Notwithstanding the foregoing, the terms of this Article XIII shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504(f)(1)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations.

13.5 Security Agreements of the Plan Sponsor

As a condition of obtaining e-PHI from the Plan, its Business Associates, Insurers and HMOs, the Plan Sponsor agrees it will:

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

B. Ensure that the adequate separation between the Plan and the Plan Sponsor as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

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

D. Report to the Plan any security incident of which it becomes aware. For purposes of this Amendment, security incident shall mean successful unauthorized access, use, disclosure, modification, or destruction of, or interference with, the e-PHI; and

E. Upon request from the Plan, the Plan Sponsor agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification, or destruction of the e-PHI to the extent such information is available to the Plan Sponsor.

EXECUTION

IN WITNESS WHEREOF, the Plan Sponsor has caused the Plan to be executed by its duly authorized officer this 5th day of May 2025.

Nutanix, Inc.

By: Jennifer Lepird

Title: SVP, Chief People Officer

Signature: Signed by: Jennifer Lepird 0086EE75F188499...

APPENDIX A

APPLICABLE INCORPORATED DOCUMENTS

APPLICABLE BENEFIT	APPLICABLE BENEFIT
Medical POS	Group Policy #905005 and summary plan description issued by United Healthcare effective January 1, 2023
Medical HDHP	Group Policy #905005 and summary plan description issued by United Healthcare effective January 1, 2023
Medical PPO	Group Policy #499606 and booklet certificate issued by Aetna International effective January 1, 2023
Medical HMO	Group Policy #604564 (Northern CA) and #232258 (Southern CA) and evidence of coverage issued by Kaiser effective January 1, 2023
Hawaii Medical PPO	Group Policy #905005 and summary plan description issued by United Healthcare effective September 1, 2023
Dental Benefits	Group Policy #16325 and evidence of coverage issued by Delta Dental effective January 1, 2023
Vision Benefits	Group Policy #30070902 and evidence of coverage issued by Vision Service Plan effective January 1, 2023
Employee Assistance Plan	Group Policy and evidence of coverage issued by Concern effective January 1, 2023
Group Term Basic Life Benefits	Group Policy # G-71041-CA and booklet-certificate issued by Prudential Financial Insurance Company effective May 1, 2022

Accidental Death & Dismemberment Benefits	Group Policy # G-71041-CA and booklet-certificate issued by Prudential Financial Insurance Company effective May 1, 2022
Short Term Disability Benefits	Group Policy # G-71041-CA and booklet-certificate issued by Prudential Financial Insurance Company effective May 1, 2022
Long Term Disability Benefits	Group Policy # G-71041-CA and booklet-certificate issued by Prudential Financial Insurance Company effective May 1, 2022
Business Travel Accident	Group Policy # MTA 9153125 and certificate of coverage issued by AIG effective May 1, 2021.
Health Care Spending Accounts	Health Nutanix, Inc. Flexible Benefit Plan
Health Reimbursement Arrangement (Medical)	Health Reimbursement Arrangement Summary Plan Description
Infertility Health Reimbursement Arrangement (Family Forming)	Carrot Infertility HRA Summary Plan Description issued April 1, 2022
All Benefits	Nutanix, Inc. Employee Welfare Benefit Plan Wraparound Summary Plan Description

This Appendix shall be subject to modification without formal amendment of the Plan.

APPENDIX B

EMPLOYEES OF THE EMPLOYER APPROVED TO HAVE ACCESS TO HIPAA PROTECTED HEALTH INFORMATION

This list of Employees with access to PHI shall be subject to modification without formal amendment of the Plan.
(PHI):

- VP, Total Rewards
- Sr. Manager, Benefits AMER
- Benefits Program Manager
- Benefit Analyst
- VP of Labor & Employment
- Director, Americas Employment Law
- Employment Counsel, Americas