Masons of California DBA Masonic Homes of California DBA Acacia Creek and Masonic Center for Youth and Family

MEDICAL EXPENSE REIMBURSEMENT PLAN

BASIC

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION (SPD)

Effective Date January 1, 2027

NONSTOP ADMINISTRATION & INSURANCE SERVICES, INC. · nonstophealth.com · 877.626.6057
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MEDICAL EXPENSE REIMBURSEMENT PLAN

Masons of California DBA Masonic Homes of California DBA Acacia Creek and Masonic Center for Youth and Family is pleased to introduce the Masons of California DBA Masonic Homes of California DBA Acacia Creek and Masonic Center for Youth and Family Medical Expense Reimbursement Plan (the "Plan" or the "MERP"), which is part of the Masons of California DBA Masonic Homes of California DBA Acacia Creek and Masonic Center for Youth and Family Group Health Benefit Plan (the "Health Plan"), which provides medical and prescription drug, benefits to Covered Persons.

The Plan is an employee welfare benefit plan and a group health plan under ERISA. Further, the Plan is an account-based group health plan as described in Treas. Reg. §54.9815-2711(d) that provides for reimbursement of certain medical expenses. The Plan is intended to meet the requirements for qualification under Section 106 of the Code, so that the Plan Sponsor's contributions to the Plan on behalf of Participants will be excludable from gross income for federal income tax purposes, and Section 105 of the Code, so that benefits paid to Participants under the Plan will be excludable from gross income for federal income tax purposes. It is further intended that the Plan be "integrated" with the Health Plan for purposes of Section 2711 of the PHS Act (and the guidance issued thereunder, including IRS Notice 2013-54).

ARTICLE I

Plan Purpose

The purpose of the Plan is to reimburse you, subject to certain limitations as prescribed herein, for certain medical expenses incurred by you which are not reimbursed in any other manner and meet the definition of Qualifying Medical Expenses as defined under the terms of this Plan. As set forth above, the Employer intends that this Plan qualify as an accident and health plan and that benefits paid to employees hereunder be excludable from their gross income pursuant to Sections 105 and 106 of the Code.

This plan document and summary plan description ("SPD") describes the provisions of the MERP, which reimburses certain medical care expenses that are not reimbursed under the Health Plan, and a separate plan document and SPD describes the medical and prescription drug benefits available to you through the Health Plan.

ARTICLE II

Definitions

As used herein, the following words, phrases and terms shall have the following meanings, unless the facts and context clearly require otherwise:

2.1 "Accumulator year" shall mean the date the plan deductible and out-of-pocket maximum reset.

2.2 "Administrator" or "Plan Administrator" shall mean the Employer and Plan Sponsor.

2.3. "Adverse Benefit Determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

2.4 "Appeals Fiduciary" means the person, persons or entity designated by the Claims Administrator to review appeals of claims initially denied by the Claims Fiduciary. The Appeals Fiduciary shall not be the Claims Fiduciary, or a subordinate to the Claims Fiduciary.

2.5 "Claimant" means a Participant and/or his or her spouse (or the authorized representative of any such person) claiming a Benefit under the Plan.

2.6 "Claims Administrator" means the entity designated by the Administrator in Section V hereof to receive and review all claims and appeals under this Plan.

2.7 "Claims Fiduciary" means the person, persons, or entity designated by the Claims Administrator to receive and review claims under this Plan.

2.8. "Code" shall mean the Internal Revenue Code of 1986, as amended, or any U.S. internal revenue statute enacted as successor thereto.

2.9. "Dependents" shall mean only those persons who qualify as dependents within the meaning of Code section 152 as modified by Code Section 105(b), and any child (as defined in Section 152(f)(I)) of the Participant until his or her 26th birthday, covered under the Health Plan. Coverage may be available for a mentally or physically disabled child who is age 26 or older if such coverage is available under the Health Plan and pursuant to the terms or conditions set forth under the Health Plan.

2.10. "Effective Date" shall mean the original effective date of this Plan which shall be January 1, 2027.

2.11. "Employee" shall mean any common law or statutory employee of the Employer paid on a W-2 basis, specifically excluding individual providing services to the Employer (or to a firm or entity providing goods or services to the Employer) and classified under the Employer's policies and procedures by the Employer as (a) an independent contractor, or (b) a leased employee, within the meaning of Section 414(n) of the Code (in either case irrespective of

whether such individual is later classified as a common law employee of the Employer for labor, tax or other purposes by any governmental agency or authority or in any judicial or administrative proceeding); provided that for purposes of determining whether the Plan complies with the requirements of Section 105(h) of the Code, all employees of all Affiliated Employers shall be treated as employed by the Employer. An Employee shall not include any partner in a partnership, or more-then 2% shareholder in a Subchapter S corporation.

2.12. "Employer" shall mean Masons of California DBA Masonic Homes of California DBA Acacia Creek and Masonic Center for Youth and Family and any affiliates thereof which shall hereafter adopt this Plan for the benefit of their respective Employees.

2.13. "ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

2.14. "FMLA" means the Family and Medical Leave Act of 1993, as amended.

2.15. "FMLA Leave" means a leave of absence that the Plan Sponsor is required to extend to an Employee under the provisions of the FMLA.

2.16. "Health Plan" shall mean the Masons of California DBA Masonic Homes of California DBA Acacia Creek and Masonic Center for Youth and Family group health benefit plan identified in Appendix A which provides group medical and prescription drug benefits to Covered Persons.

2.17 "Health Care Professional" means a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with applicable state law.

2.18. "Incurred" shall mean the point in time when the Medical Expense was received by, an individual, not the date an individual is required to pay for such medical care or is billed after the receipt of medical care.

2.19. "Medical Care" shall mean amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, including amounts paid for Medicines and Drugs and such other expenses as meet the requirements of Section 213(d) of the Code and the Regulations thereunder, or any other guidance by the U.S. Department of Treasury.

2.20. "Medical Expense Reimbursement Plan" ("MERP") means an account-based group health plan as described in Treas. Reg. §54.9815-2711(d) that provides for reimbursement of certain medical expenses.

2.21. "Medicines and Drugs" shall mean only drugs or biologicals which are legally procured, which are generally accepted as falling within the category of medicines and drugs, which require the prescription of a Health Care Professional who is a Health Plan service

provider for their use by an individual, which are covered under the Health Plan, and which are prescribed by a Health Care Professional who is a Health Plan service provider.

2.22. "Participant" shall mean an Employee of the Employer who is eligible to participate and is in fact participating in this Plan in accordance with its terms.

2.23. "Plan" shall mean this self-insured accident and health reimbursement plan.

2.24. "Plan Sponsor" shall mean the Employer.

2.25."Plan Year" the Plan Year for the Plan is the twelve-month period beginning January 1 ending on December 31.

2.26. "Qualifying Medical Expenses" shall mean those In-Network Health Plan expenses for Medical Care which are approved by the carrier for the Health Plan, are covered expenses under the terms of the Health Plan, and are incurred by a Participant during the Plan Year at a time when he or she was a Health Plan Participant, but are not reimbursable thereunder.

2.27. "Regulations" shall mean regulations issued by the U.S. Department of Labor pursuant to ERISA or by the U.S. Department of the Treasury pursuant to the Code.

2.29. "Uniformed Services" means the United States Army, Navy, Air Force, Marine Corps, Coast Guard, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated as such by the President of the United States in time of war or emergency.

ARTICLE III

Participation

3.1 Participation in General.

If you are an Employee who is eligible to participate in, and in fact participating in the Employer's Health Plan, or a Spouse or Dependent of an Employee who is eligible for and in fact participating in the Employer's Health Plan with the Employee, you shall become a participant in this Plan on the same day your enrollment in the Health Plan begins, for as long as you continue to participate in the Health Plan. You are automatically enrolled in this Plan when you enroll in the Health Plan and no additional steps are needed to enroll in this Plan.

3.2 Termination and Resumption of Participation

If you terminate employment (for active Employees) or participation in the Health Plan, or otherwise become ineligible to participate in this Plan during a plan year, your participation in this Plan shall cease as of the termination of such employment or eligibility. If you terminate employment (for active Employees) and then resume such employment or eligibility, you may immediately resume participation in the Plan at such time as you again satisfy the applicable eligibility requirements provided for above.

3.3 Participation During FMLA or Similar State Leaves

The Employer will continue to maintain yours (and your Spouse's or Dependent's, as applicable) benefits under the Plan on the same terms and conditions as Eligible Employees who are actively at work if you are absent from work due to (i) a period of duty in the Uniformed Services, (ii) an FMLA leave, or (iii) a state leave similar to FMLA that requires benefits continuation, to the extent required under the USERRA, the FMLA, or the state leave law, as applicable.

If you are on FMLA or a similar state leave requiring benefits continuation, your coverage under this Plan will terminate at the end of your FMLA (or similar state) leave period if you do not return from leave, or on the date you give notice that you will not be returning from FMLA (or a similar state) leave, and you may then be eligible for COBRA continuation coverage (as described below). To receive group health plan coverage during unpaid FMLA (or similar state) leave, you must continue to pay your share of the premium. If you do not continue your group health plan coverage or other types of coverage during unpaid FMLA (or similar state) leave, your coverage will be reinstated when you return from FMLA (or similar state) leave.

For additional information about coverage under the Plan during FMLA or similar state leave, contact the Employer.

3.4 Uniformed Services Reemployment Rights

Your right to continued participation in a group health plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Accordingly, if you are absent from work due to a period of active duty in the military you may elect to continue your group health plan coverage. If you are absent for less than 31 days, you will pay the regular member share of the cost of the health coverage. If the absence is for 31 or more days, the cost of continuation coverage may not exceed 102% of the full cost of your health coverage.

Continuation coverage will terminate on the earlier of:

- The last day of the 24 month period beginning on the first day of military leave, or

- The date you fail to apply for reemployment, as required under USERRA, after returning from military leave.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

3.5 Participation During Other Leaves of Absence

For leave that is not FMLA, USERRA, or similar state leave laws described in Section 3.3 or 3.4 above, your benefits under the Plan may continue if your benefits under the Health Plan continue for a period of time during a leave of absence, subject to the leave policies and procedures adopted by the Employer. Contact the Employer for information on the different types of leaves of absences available, the maximum length of coverage available during such leave of absence, any contribution requirements, and procedures for paying your share of monthly premium costs. If you elect not to continue your benefits or if you fail to timely pay for your benefits during your approved leave of absence, your benefits under this Plan may terminate for the duration of your leave.

3.6 Transfers

If a change in job classification or a transfer results in you no longer qualifying as an Eligible Employee, you shall cease to be a Participant for purposes of this Plan (or shall not become eligible to become a Participant) as of the effective date of such change of job classification or transfer. Any balance remaining in your Medical Expense Reimbursement Plan on the effective date of such change of job classification or transfer shall be forfeited and shall remain the property of the Employer. However, no forfeiture shall occur until all payments and reimbursements have been made on claims submitted within the time period specified in Section 4.3 of this Plan. Should you again qualify as an Eligible Employee or if you were not previously an Eligible Employee and you become an Eligible Employee, you will become a Participant on the first entry date following the later of the effective date of such subsequent change of status or the date you meet the eligibility requirements of this Article 3.

ARTICLE IV

4.1 Benefits

Reimbursement of Qualifying Medical Expenses. Reimbursement of Qualifying Medical Expenses. Subject to the provisions hereof, the Employer shall from time to time reimburse participants for Qualifying Medical Expenses incurred and paid by the participants, provided that the same are not reimbursed to the participants or their spouses or dependents in any other manner, including, but not limited to, the Health Plan or any other fully or partially insured or self-insured plans or programs requiring the payment of a premium or other outlay by the Employer. If any participant or his or her spouse or dependent is partially reimbursed from any

other sources with respect to amounts otherwise eligible for reimbursement hereunder, that portion which is not so reimbursed may be reimbursed hereunder, subject to the provisions hereof. Reimbursement claims shall be filed and processed as provided below.

The amount of *Qualifying Medical Expenses* eligible for reimbursement is listed in Appendix A and may be amended from time to time by the Employer.

The entire, applicable annual limit described in the Appendix A shall be available to reimburse Qualifying Medical Expenses as of the first day of the Plan Year, or the first day you begins participating pursuant to Section 3.1 if you first become eligible for the Plan during the Plan Year.

You may be reimbursed for Qualifying Medical Expenses you (incur up to the amount credited or available to you at the time the reimbursements are paid by the Employer pursuant to the "*Payment of Benefits"* section below provided that these expenses are not reimbursed in any other manner. The amount credited or available includes any amounts credited to you in the amount and manner specified in this Section. Any unused reimbursement limits remaining at the end of the Plan Year shall be forfeited and shall remain the property of the Company.

4.2 Excluded Expenses

This Plan specifically excludes expenses for the following:

(a) Any Medical Care expenses that are not covered under, or approved by the carrier of, the Health Plan;
(b) Any Qualifying Medical Expenses you incurred in a prior Plan Year or before you were participating in this Plan or the Health Plan;
(c) Any Qualifying Medical Expenses you incur after you cease being eligible under this Plan or the Health Plan;
(d) Any Qualifying Medical Expenses that are incurred during the Plan Year that exceed the Maximum Annual Benefit identified in Appendix A for the Plan Year; and
(e) Any Qualifying Medical Care Expenses that are incurred while the Employee is on a leave of absence that includes a period of time during which no benefits are paid by the Plan Sponsor and COBRA coverage is not elected.

4.3 Payment of Benefits

Payment of benefits under the Plan shall be made as soon as administratively feasible, but not more frequently than on a monthly basis, after the required forms and documentation have been received by the Employer, including any receipts, certificates and other information described in this summary under *"Filing a Claim."*

Except as otherwise provided herein, claims pertaining to Qualifying Medical Expenses incurred during a plan year must be filed with the Administrator on or prior to 90 days following

the end of the Accumulator Year. If your participation ceases due to termination of employment or loss of eligibility under the Health Plan, claims pertaining to Qualifying Medical Expenses incurred during the Plan Year prior to your termination must be filed with the Administrator within 90 days of the date participation in the plan ended. Reimbursement shall be made by the Administrator directly to the participant, subject to the limitations prescribed herein with respect to the Plan Year in questions.

While reimbursement claims may be processed more frequently, the Administrator reserves the right to process claims on a monthly basis with respect to all Participants. A Participant applying for reimbursement under this Plan shall submit to the Administrator his or claim as well as documented proof acceptable to the Administrator of the Qualifying Medical Expenses incurred (such as paid bills, receipts, canceled checks, the service provider's signature on the claim form or the Health Plan insurer's Explanation of Benefits, as provided above), for verification by the Administrator prior to payment. Failure to comply with this procedure shall terminate the participant's right to reimbursement.

4.4 Direct Benefit Payments. The Employer may, in its discretion, pay any or all of the Qualifying Medical Expenses directly to the health care provider in lieu of making reimbursement thereof. In such event, the Employer shall be relieved of all further responsibility with respect to that particular medical expense.

4.5 Cost of Coverage. The Employer shall fund coverage provided hereunder from its general assets. The Employer is not required to maintain a fund or segregate any amounts for you, your spouse, or your dependents.

ARTICLE V

Administration

5.1. Designation of Plan Administrator.

The Employer shall be the Plan Administrator and Named Fiduciary of this Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan by written agreement with the person or persons to whom such responsibilities are so delegated. The Plan Administrator is hereby designated as the agent of the Plan for purposes of service of legal process. The Plan Administrator and all other Plan fiduciaries shall discharge their duties with respect to the Plan solely in the interests of the Participants and for the exclusive purpose of providing benefits to them and defraying reasonable expenses of administering the Plan; with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims, in accordance with the documents and instruments governing the Plan insofar as the same are consistent with applicable law.

5.2. Enrollment and Claims Procedures.

(a) Claims Submission

A Participant shall make a claim for benefits and have his or her claim reviewed under the following procedure:

You have received a Nonstop Visa card that has been preloaded with appropriate funds. You may use this card to pay for all eligible In-Network Qualifying Medical Expenses. The Nonstop Visa card provides for reimbursement by paying a provider directly for your eligible Qualifying Medical Expenses. The debit card is funded with the amount of funds from your Medical Expense Reimbursement account, and the account balance will be reduced in amounts equal to reimbursed Qualifying Medical Expenses. Except as otherwise provided herein, if a provider does not accept payment with a debit card or the debit card is used for items sold, or services provided, by a provider or merchant not approved by the Claims Administrator pursuant to applicable IRS guidance, then a Participant shall generally make a claim for Plan benefits as follows:

Except as otherwise provided herein, a Participant shall generally make a claim for Plan benefits by filing a written request with the Plan Administrator's delegated Claims Administrator, Nonstop Administration and Insurance Services, Inc. ("Claims Administrator") by submitting a claim as follows:

(i) By submitting the claim via the Nonstop Exchange portal, by logging into the portal located at *www.nonstophealth.com/claims* and clicking "New Claim",

(ii) Via facsimile at 1-877-463-1175,

(iii) Via e-mail at claims@nonstophealth.com, or

(iv) Via Regular mail at the below address:

Nonstop Health Claims
1800 Sutter Street, Suite 730
Concord, CA 94520

To complete a non-debit card request you must submit your completed Claims/Reimbursement Request Form, the receipt or bill showing payment, the paid receipt/bill, and all pages of the Explanation of Benefits (EOB).

In any case, subject to the following provisions for debit card purchases, reimbursement will generally be made within thirty (30) days after the claim has been filed and approved for payment by the Claims Fiduciary.

i. You must certify upon enrollment, and at each annual enrollment thereafter, that (a) any debit card provided to you pursuant to this Plan will be used only for Qualifying Medical Expenses you and spouse or Dependents, as applicable, (b) any Qualifying

Medical Expenses for which the debit card is used have not been reimbursed in any other manner, (c) you will not seek reimbursement under any other plan, (d) you understand that such certification is reaffirmed each time the card is used, and (e) you will retain sufficient documentation for any Qualifying Medical Expenses paid with the card, including invoices, receipts, bills, or other similar statements that show the date the sale or service was rendered, a description of the item sold or service rendered, and the amount of the item or service as such may be required.

ii. Upon your termination from the Plan your debit card service will be deactivated. At such time you must submit any remaining claims, as applicable, for Qualifying Medical Expenses using one of the other methods for submitting claims provided for in this Section.

iii. Consistent with applicable Internal Revenue guidance and regulations, if the Claims Administrator determines that you have used a debit card to reimburse ineligible expenses, to reimburse expenses for individuals who are not Health Plan participants and/or not eligible for reimbursement under the terms of the Plan, or that you have already been reimbursed for the same expenses from another source, the Claims Administrator will suspend the debit card and, in addition to any action taken by the Plan Administrator described in Section 7.4 of this Plan, you will be required to use one of the other methods for submitting any additional claims provided for in this Section.

(b) Claims pertaining to Qualifying Medical Expenses incurred during a Plan Year must be filed with the Claims Administrator on or before 90 days following the end of the Accumulator Year to be eligible for reimbursement. Reimbursement shall be made by the Claims Administrator directly to you, subject to the limitations prescribed by Section 4.3 hereof with respect to the Plan Year in question. If you terminate employment or lose eligibility under the Health Plan prior to the end of the Plan Year, claims pertaining to Qualifying Medical Expenses incurred prior to terminating or losing eligibility must be filed with the Claims Administrator within 90 days of the date your participation in the plan ends. While reimbursement claims may be processed more frequently, the Claims Administrator reserves the right to process claims on a monthly basis with respect to all Participants. If you are applying for reimbursement under this Plan you must submit to the Claims Administrator (along with, and at the time of submitting, your claim) documented proof acceptable to the Claims Administrator of the Qualifying Medical Expenses incurred (such as paid bills, receipts, canceled checks, the service provider's signature on the claim form or the Health Plan insurer's Explanation of Benefits, as provided above), for verification by the Claims Administrator prior to payment. Failure to comply with this procedure shall terminate your right to reimbursement.

(c) Notification of Claims Decision

If you have filed a claim for reimbursement, you will be notified of the Claims Administrator's designated Claim's Fiduciary's decision on your claim if it is denied in whole or in part. This notification will be issued no more than 30 days after the Claims Fiduciary receives the claim. The Plan may extend this 30-day period for up to 15 days if the extension is required

due to matters beyond the Plan's control. If this period is extended, you will be notified by the Claims Fiduciary. You will have at least 45 days to provide any additional information requested of you by the Claims Fiduciary, if the need for the extension is due to the Claims Fiduciary's request for additional information from you or your health care providers.

If you are not notified of the Claims Fiduciary's decision on your claim within the above time periods, your claim is denied.

(d) Claim Denial

The Claims Fiduciary will provide you with written notice of the denial of your claim. Such notice will include the following:

- the specific reason or reasons for your adverse benefit determination;
- reference to the specific plan provisions on which the determination is based;
- a description of any additional material or information necessary for you to fix your claim and an explanation of why such material or information is necessary;
- a description of the review procedures, including a statement of your right to bring a lawsuit following an adverse benefit determination on review; and
- either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request.

(e) Appealing a Denied Claim

You have at least 180 days after the receipt of the denial notice to request a review of the denial. Your request for a review must be in writing.

In connection with your right to appeal the Claims Administrator's initial determination regarding your claim, you also:

- may review pertinent documents and submit issues and comments in writing;
- will be given the opportunity to submit written comments, documents, records, or any other material relevant to your claim;
- will, at your request and free of charge, receive reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and

- be given a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination.

The Claims Administrator's designated Appeals Fiduciary will review your appeal and must issue a decision on your appeal no later than 60 days after receiving your request for a review unless the Appeals Fiduciary determines that special circumstances (such as the need to hold a hearing) requires an extension of time of not more than sixty (60) days, in which case written notice of such extension shall be furnished to you prior to the termination of the initial sixty (60) day period. Such notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render a decision on review.

Similar to the initial claim determination period, the review period may be extended. If this period is extended, you will be notified by the Appeals Fiduciary. If you are not notified of the Plan's decision on your appeal within the above time periods, your claim is denied.

Your review decision from the Appeals Fiduciary will include the following:

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provisions on which the benefit determination is based;
- a statement that you are entitled to receive without charge reasonable access to any document (i) relied on in making the determination, (ii) submitted, considered or generated in the course of making the benefit determination, (iii) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (iv) that constitutes a statement of policy or guidance with respect to the Plan concerning the claim denial without regard to whether the statement was relied on;
- a statement describing your right to receive information about such procedures, as well as your right to bring a lawsuit; and
- the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

The review shall take into account all comments, documents, records, and other information submitted by the Participant relevant to the claim, without regard to whether such information was submitted or considered in the original benefit determination. The review shall not afford deference to the initial claim denial and shall be conducted by a named fiduciary of the

Plan who is not the individual who made the initial claim denial, nor a subordinate of such individual. If the claim denial was based on a medical judgment, the fiduciary shall consult with a health care professional with appropriate training and experience in the field of medicine involved in the judgment. Such professional shall not be an individual consulted in connection with the initial claim denial, nor a subordinate of any such individual. The review process shall identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial claim denial, regardless of whether the advice was relied on in making the denial.

(f) Notwithstanding the foregoing, with respect to Health Plan benefits the Participant, the Plan Administrator, and the Claims Administrator shall comply with and be bound by any lawful claims procedures from time to time established by the Health Plan insurer in accordance with the terms and conditions of such Plan, to the extent relevant to the determination of benefits payable under this Plan (for example, for purposes of determining if expenses alleged to be incurred for medical care are actually Qualifying Medical Expenses for purposes hereof, by reference to the definitions of covered and excluded expenses under the Health Plan).

5.3. Records and Reports.

The Administrator shall exercise such discretionary authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of the Participants and the benefits which are payable under this Plan.

5.4. Other Powers and Duties of the Administrator.

The Plan Administrator shall have all discretionary power and authority to make all determinations under the Plan including without limitation determinations regarding eligibility to participate and eligibility for payment of claims, and shall have the authority to discharge its duties hereunder, including, but not by way of limitation, the following:

(a) To construe and interpret this Plan, decide all questions of eligibility and determine the amount, manner and time of payment of any benefits hereunder;

(b) To prescribe procedures to be followed by Participants filing applications for benefits;

(c) To prepare and distribute, in such manner as the Administrator determines to be appropriate, information explaining the Plan;

(d) To gather within the Employer and from Participants such information as shall be necessary for the proper administration of the Plan;

(e) To furnish the Employer, upon request, such reports with respect to the administration of the Plan as are reasonable and appropriate;

(f) To receive, review and keep on file (as it deems convenient and proper) reports of benefit payments by the Employer and reports of disbursements for expenses directed by the Administrator; and

(g) To appoint individuals to assist in the administration of the Plan and any other agents it deems advisable, including legal and actuarial counsel.

The Claims Administrator shall have no independent power to add to, subtract from or modify any of the terms of the Plan, or to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under the Plan.

5.5. Rules and Decisions.

The Administrator shall have the sole discretion to interpret the Plan and decide any matters arising under the Plan. The Administrator may adopt any rules and procedures as it deems necessary, desirable or appropriate in the administration of the Plan, provided that such determinations do not conflict with the Plan or applicable law. All rules and decisions of the Administrator shall be uniformly and consistently applied to all Participants in similar circumstances and shall be conclusive and binding on all persons having an interest in the Plan. When making any decision or determination, the Administrator shall be entitled to rely upon such information as may be furnished to it by a Participant, the Sponsor or legal counsel to this Plan.

Participants or any other persons making claims for benefits under this Plan shall only be entitled to benefits under the Plan if the Claims Administrator, in its discretion, determines that such Participants or other persons making such claims are entitled to such benefits. Any final determination by the Claims Administrator shall be binding on all parties. If challenged in court, such determination shall not be subject to de novo review and shall not be overturned unless proven to be arbitrary and capricious upon the evidence presented to the Claims Administrator at the time of its determination.

5.6. Procedures.

The Administrator may act at a meeting or in writing without a meeting. The Administrator may adopt such rules and procedures as it deems desirable for the conduct of its affairs.

5.7. Authorization of Benefit Payments.

The Administrator shall issue directions concerning all benefits which are to be paid from the Employer's general assets in accordance with the Plan.

5.8. Application and Forms for Benefits.

The Administrator may require a Participant to complete and file with the Claims Administrator an application for a benefit and all other forms approved by the Claims Administrator, and to furnish all pertinent information requested by the Claims Administrator. The Claims Administrator may rely upon, all such information so furnished it, including the Participant's current mailing address.

5.9 Facility of Payment.

Whenever, in the Administrator's or Claims Administrator's opinion, a person entitled to receive any payment of a benefit or installment thereof hereunder is under a legal disability or is incapacitated in any way so as to be unable to manage the person's financial affairs, the Administrator may direct the Employer to make payments to such person or the person's legal representative or to a relative or friend of such person for such person's benefit, or the Administrator may direct the Employer to apply the payment for the benefit of such person in such manner as the Administrator considers advisable. Any payment of a benefit or installment thereof in accordance with the provisions of this Section shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

5.10. Employee Notification.

All present Employees who as of the Effective Date would qualify as Participants shall as soon as administratively feasible be provided reasonable notification by the Plan Administrator of the existence of the Plan and of benefits available thereunder. Similarly, as soon as administratively feasible after employment any new Employee who would qualify as a Participant shall be provided such notice. Any Participant shall have the right, upon request, to review a copy of the Plan and secure a copy of the same from the Plan Administrator.

ARTICLE VI

COBRA Continuation Coverage

6.1 Covered Individuals and Qualifying Events

You will be provided an initial notice from the Plan Administrator or its delegated COBRA Administrator describing in detail your right to elect COBRA coverage if your employment terminates (other than for gross misconduct) or you incur a reduction in your hours of employment that makes you ineligible for coverage under the Plan as an active employee.

If you are the spouse of an employee and are covered under the Plan, you have an independent right to elect COBRA coverage if coverage is lost for any of the following qualifying events:

- the death of your covered spouse;
- termination of your covered spouse's employment (other than for gross misconduct);
- a reduction in your covered spouse's hours of employment that makes him or her ineligible for coverage as an active employee;
- divorce or legal separation; or
- your covered spouse becomes entitled to Medicare.

If you have dependent children who are currently covered under the Plan, he or she may elect COBRA coverage if coverage is lost for any of the following qualifying events:

- the death of the covered parent;
- termination of the covered parent's employment (other than for gross misconduct);
- a reduction in the covered parent's hours of employment that makes him or her ineligible for coverage as an active employee;
- divorce or legal separation of the parents;
- the covered parent becomes entitled to Medicare; or
- the dependent ceases to be a "dependent child" under the plan.

A child who is born or placed for adoption with you during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA continuation coverage upon proper notification to the Administrator of the birth or adoption.

6.2 How to Elect COBRA Coverage

If you, your spouse or dependents experience a qualifying event, the Plan Administrator or its delegee will provide you with a COBRA Notice which will discuss the COBRA election procedures. To elect COBRA coverage, you must complete and submit the election form attached to the COBRA Notice to the Plan Administrator or its delegee within the later of 60 days from the date you receive such notice or your loss of coverage under the Plan. The same notice will be sent separately to your spouse, if any, however, only one of you needs to elect

continuation coverage for your spouse and dependent children who wish to continue coverage. Furthermore, because COBRA gives you the right to elect coverage independently, you, your spouse or dependent children, if any, may elect single coverage and not include those individuals who do not wish to continue coverage. **You or your spouse or dependents must elect continuation coverage under the Health Plan in order to obtain continuation coverage under this Plan**.

6.3 Period of COBRA Coverage

18-Month Coverage. When the COBRA qualifying event is the end of your employment or a reduction of your hours of employment, COBRA continuation coverage lasts for up to l8 months, subject to extension as set forth below.

36-Month Coverage. When the COBRA qualifying event is your death, your enrollment in Medicare, your divorce or legal separation from your spouse, or a dependent child losing eligibility as a dependent child under a group medical plan, COBRA continuation coverage lasts for up to 36 months.

Disability Extension. If you or any of your qualified beneficiaries covered under the Plan is determined by the Social Security Administration (the "SSA") to be disabled at any time during the first 60 days of COBRA continuation coverage and you or your spouse notifies the Plan Administrator or its delegee in a timely fashion, you and your qualified beneficiaries can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You or your spouse must make sure that the Plan Administrator or its delegee is notified of the SSA's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Note that you or your spouse must make sure that the Plan Administrator or its delegee is notified within 30 days of the date of the SSA's determination that any such qualified beneficiary is no longer disabled, and disability extension coverage will terminate upon such determination.

Second Qualifying Event. If you and your qualified beneficiaries covered under the Plan experience another qualifying event while receiving COBRA continuation coverage, your spouse and dependent children are eligible additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available if you die, enroll in Medicare, or get divorced or legally separated from your spouse. The extension is also available to your dependent child when that child stops being eligible to participate under the Plan as a dependent child. In all of these cases, you or your spouse must make sure that the Plan Administrator or its delegee is notified of the second qualifying event within 60 days of the second qualifying event.

6.4 Early Termination of COBRA Coverage

COBRA coverage may terminate early if:

- You do not pay the required premium for COBRA coverage under the Plan when such payment is due.
- You and your spouse or dependent children, if any, become covered under another group health plan after the date COBRA coverage is elected that does not contain any exclusion or limitation for any of your preexisting conditions.
- You, your spouse or dependent children, if any, become entitled to Medicare benefits after the date COBRA coverage is elected.
- The Plan is terminated, as well as any and all other similar Employer group health plans.

6.5 Cost of COBRA Coverage

If a covered individual wishes to continue coverage under the Plan, he or she is required to contribute an amount equal to 102% of the cost of coverage under the Plan for similarly situated participants, as determined on an actuarial basis; provided, however, if for any reason a covered individual becomes disabled (as determined by the SSA) within the first 60 days of his or her COBRA continuation coverage, thereby extending his or her eligibility for COBRA continuation coverage from 18 months to 29 months, then such disabled individual will be required to contribute an amount equal to 150% of the cost of coverage under the Plan for similarly situated participants, as determined on an actuarial basis. This amount must be paid on an after tax basis. The first contribution due will be applied retroactively back to the date of your loss of coverage and must cover all amounts due for that period. Your first contribution will be due within 45 days of your election. Each payment thereafter will be due within 30 days of the first day of each month during which you continue COBRA coverage under the Plan.

6.6 Health Insurance Marketplace

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. For more information about the Marketplace, visit www.healthcare.gov.

6.7 Medicare

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you and https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

6.8 Other Coverage Options

You may also be eligible for Medicaid or Children's Health Insurance Program (CHIP), which, if eligible, may be a coverage option in lieu of COBRA and may cost less than COBRA continuation coverage. You can learn more about these options at: www.healthcare.gov or https://www.healthcare.gov/medicaid-chip/childrens-health-insurance-program/.

6.9 Notice to Plan Administrator or Its Delegee

It is your responsibility to notify the Plan Administrator or its delegee of a divorce, legal separation or other change in marital status, change in a spouse's address, or a child losing dependent status under your spouse's employer's group medical plan during the COBRA coverage period, within 60 days of the event. Failure to timely notify the Plan Administrator or its delegee of any of these events could prejudice your rights to COBRA coverage. It is your employer's responsibility to notify the Plan Administrator or its delegee of your death, termination of employment or reduction in hours, or Medicare eligibility.

6.10 No State Continuation Rights

As a self-funded group health plan, you do not have continuation rights under state law for the benefits offered under this Medical Expense Reimbursement Plan even if state continuation rights may apply to your Health Plan benefits.

ARTICLE VII

General Provisions

7.1. Enforceable Rights; Denial of Guaranty.

The Employer intends that the terms of this Plan, including those relating to coverage and benefits, and Employees' rights thereunder, shall be legally enforceable against the Employer for as long as the Plan shall remain in effect. However, neither the Employer nor any trustee, officer or employee thereof in any way guarantees to any Employee the payment to any Employee of any benefit or amount which may become due and payable in accordance with the terms of this Plan.

7.2 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 or correction methods permitted under applicable IRS guidance.

7.3 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 using any method permitted under applicable IRS guidance.

7.4 Misrepresentation or Fraud

A Participant who receives benefits under the Plan on behalf of him/herself and/or any other person 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 with respect to such individual(s) and may be liable for all costs of collection, including attorney's fees and court costs, to the extent permitted by law. The Plan Administrator shall decide such matters on a case by case basis.

7.5. Exclusive Benefit of Employees.

This Plan is maintained for the exclusive benefit of Employees of the Employer; provided, however, that this agreement shall not be considered a guarantee of employment for any period of time whatsoever, and the inclusion of any Participant under the Plan does not ensure his or her retention as an Employee of the Employer. The Administrator, subject to approval of the Plan Sponsor, may employ the services of such persons as it may deem necessary or desirable in connection operation of the Plan.

7.6. Right to Terminate or Amend.

This Plan is established with the intention of being maintained for an indefinite period of time. However, the Employer reserves the right at any time and from time to time to terminate or amend in whole or in part any or all of the provisions of this Plan and/or of the Health Plan. No such amendment or termination shall operate or be construed so as to deny or abridge any Participant's rights to benefits accrued hereunder prior to the date requisite action is taken by the Employer with respect to said amendment or termination.

7.7. Limitation of Employer Liability.

Neither the Plan, the Employer, the Administrator, nor any trustee, officer, employee or agent thereof, shall have any responsibility hereunder for (a) the nature, quality or compliance with applicable law of any services or care rendered to or for any Employee, spouse or Dependent; or (b) any financial or tax consequences of the Plan to any Employee, spouse or Dependent which result from matters which are the responsibility of the Employee, spouse, or Dependent, of any insurer under the Health Plan and/or of any provider of care or services including, but not limited to, adverse financial or tax consequences resulting from any failure to observe those legal or tax requirements applicable to programs such as this Plan for which the Employee, spouse or Dependent, any insurer under the Health Plan or any provider of care or services is responsible (for example, by submitting erroneous information to the Administrator or exceeding the prescribed benefit limitations hereunder or under the Health Plan.)

7.8. Discrimination.

Nothing herein contained shall be deemed to allow the Employer or the Administrator to treat any Participant under the Plan differently than any other similarly-situated Participant under the Plan in similar circumstances, it being the intention that this Plan shall be administered uniformly with respect to all Participants.

7.9. Other Benefits; No Contract of Employment.

Nothing contained herein shall in any way limit any Employee’s right to participate in or benefit from any employee pension or welfare benefit plan for which the Employee is or may become eligible by reason of his or her employment. This Plan shall not be

deemed to constitute, replace or supplant any contract of employment between the Employer and Employees, whether oral or written.

7.10. Insurance and Other Corporate Assets.

If the Employer shall acquire an insurance policy or contract, or any other asset for the purpose of funding benefits provided for hereunder, no Participant shall have any right with respect to, or claim against, such policy, contract, or asset, except as expressly provided by the terms of such policy or contract or in the title to such other asset. Such policy, contract, or asset shall not be deemed to be held under any trust for the benefit of any Participant, or to be held in any way as collateral security for the fulfillment of the obligations of the Employer under this Plan, except as may be expressly provided by the terms of such policy, contract, or in the title to such other asset, all of which shall otherwise be and remain general, unpledged and unrestricted assets of the Employer.

7.11. Governing Law.

This Plan shall be governed and construed in accordance with the laws of the United States of America and, insofar as the same are not pre-empted by applicable federal law, the laws of the state of California.

7.12. Binding Effect.

This Plan shall be binding upon the Employer and its successors and assigns, and upon each participating Employee or his or her spouse or Dependents and his or her estate, heirs, assigns and beneficiaries, unless and until terminated or amended by the Employer as provided herein. In the event the Employer becomes a party to any merger, consolidation, reorganization, or other transaction resulting in any change in the ownership or control of the Employer, this Plan shall remain in full force and effect as an obligation of the Employer or its successors in interest unless and until so terminated or amended.

7.13. Severability.

In the event any provision of this Plan shall be held invalid, unenforceable or illegal by any administrative body or by a court of competent jurisdiction, as sustained on appeal; or by any governmental, legislative or other action; or if any such provisions shall result in the Plan failing to fulfill the requirements applicable hereto under Sections 105 or 106 of the Code and the Regulations thereunder, then said provision shall be null, void and of no effect in its application hereto and such action shall not invalidate or render unenforceable any other provision hereof.

7.14. Gender and Number.

All words herein denoting gender shall be deemed to refer to the feminine, masculine or neuter, singular or plural, as the context and the facts require such construction.

7.15. Missing Payees; Notices, Statements and Payments.

Each Participant must file with the Administrator from time to time in writing his or her residence address and each change of residence address. Neither the Employer nor the Administrator shall be required to search for or locate a current or former Participant, spouse or Dependent. All notices, statements, payments, or other communications required or permitted to be given pursuant hereto shall be in writing and shall be hand delivered or mailed by U.S. mail or private express carrier, postage prepaid, addressed to the party in question at his or her last known residence address; and when so given shall be deemed delivered for all purposes on the date of delivery, if hand delivered, or on the date of mailing, if mailed.

7.16. Nonalienation of Benefits.

(a) In general, benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, prior to actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder, shall be void. The Employer shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person entitled to benefits hereunder.

(b) Notwithstanding subsection (a) above, payments may be made in accordance with the terms of a "Qualified Child Support Order." Upon receipt of any Qualified Child Support Order, the Administrator shall notify, in writing, you and each alternate recipient named in the medical child support order (at the address included in the medical child support order) of the receipt of such order and the procedures for determining the "qualified" status of such medical child support order. Within a reasonable period after receipt of a medical child support order, the Administrator shall determine whether such order is a "qualified" medical child support order and shall notify, in writing, you and each alternate recipient named in such order of such determination. If the Administrator shall determine that the medical child support order is a "qualified" medical child support order, the Administrator shall ensure that any payment of benefits pursuant to such order in reimbursement for expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian shall be made directly to the alternate recipient or the alternate recipient's custodial parent or legal guardian, as the case may be.

(c) For purposes of this Section, the following terms have the following meanings:

(A) "Alternate recipient" means any child of a Participant who is recognized by a medical child support order as having a right to enrollment under the Plan with respect to the Participant.

(B) "Medical child support order" means any judgment, decree or order (including approval of a settlement agreement) that (1) provides for child support with respect to a child of a Participant under the Plan or provides for health benefit coverage for such child, is made pursuant to a State domestic relations law (including a community property law), and relates to benefits under the Plan; or (2) enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to the Plan, if such judgment, decree or order is issued by a court of competent jurisdiction or through an administrative process established under State law that has the force and effect of law under the applicable State law.

(C) "Qualified Medical Child Support Order" means a medical child support order that:

(1) creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive group health benefits to which a Participant or beneficiary is eligible under the Plan; and

(2) clearly specifies (a) the name and the last known mailing address (if any) of the Participant and the name and mailing address of each alternate recipient covered by the order; (b) a reasonable description of the type of coverage to be provided under the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined; (c) the period to which such order applies; and (d) each plan to which such order applies; and

(3) does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided thereunder, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act.

7.17 No Right to Continued Employment.

Participation in this Plan does not provide you any right to continued employment, nor does it affect the Employer's right to conduct business with you regarding your employment.

7.18 Headings.

All Article and Section headings in the Plan are intended merely for convenience and shall in no way be deemed to modify or supplement the actual terms and provisions set forth.

7.19 Plan Provisions Control.

To the extent any terms or provisions set forth in any other document or instrument, conflict, or are interpreted as conflicting, with the provisions set forth in this Plan Document and SPD, the terms of this Plan Document and SPD shall control.

ARTICLE VIII

HIPAA PRIVACY AND SECURITY

8.1 Disclosure of Information

(a) The Plan Sponsor may only use and/or disclose Protected Health Information (as such term is defined in 45 C.F.R. §160.103) as permitted by the "Standards for Privacy of Individually Identifiable Health Information" under the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, and applicable guidance (the "Privacy Rule").

(b) The Plan will disclose Protected Health Information to the Plan Sponsor only upon its receipt of a certification by the Plan Sponsor that the Plan Sponsor agrees to:

(i) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(ii) Ensure that any agents, including subcontractors, to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(iii) Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(iv) Report to the Plan any use or disclosure of the Protected Health Information that is inconsistent with the uses or disclosures permitted by the Privacy Rule of which it becomes aware;

(v) Make available Protected Health Information based on HIPAA's access requirements in accordance with 45 C.F.R. §164.524;

(vi) Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. §164.526;

(vii) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;

(viii) Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule;

(ix) If feasible, return or destroy all Protected Health Information 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, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(x) Ensure that adequate separation of the Plan and the Plan Sponsor is established as required by 45 C.F.R. 164.504(f)(2)(iii) as described below.

8.2 Certification of the Plan Sponsor

The Plan (or a health insurance issuer or HMO with respect to the Plan, if applicable) will disclose Protected Health Information to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 C.F.R. §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 8.1. The Plan will not disclose and may not permit a health insurance issuer or HMO to disclose Protected Health Information to the Plan Sponsor as otherwise permitted herein unless the statement required by 45 C.F.R. §164.520(b)(1)(iii)(C) is included in the appropriate notice.

8.3 Separation of Plan and the Plan Sponsor

(a) Only designated employees in the human resources department of the Plan Sponsor ("Permitted Employees") will be given access to the Protected Health Information. Despite the foregoing, any employee or person not described above who receives Protected Health Information relating to payments under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business, will also be included in the definition above of Permitted Employees.

(b) The Permitted Employees may only use the Protected Health Information for Plan administrative functions that the Plan Sponsor performs for the Plan.

8.4. Security of Electronic Protected Health Information

In accordance with 45 C.F.R. §164.314(b)(2), to the extent as may be required by law, the Plan Sponsor agrees to:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that the Plan Sponsor may create, receive, maintain, or transmit on behalf of the Plan;

(b) Ensure that the adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(c) Ensure that any agents, including subcontractors, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) Report to the Plan any security incident of which it becomes aware with respect to electronic Protected Health Information.

ARTICLE IX

ERISA Rights and Plan Information

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if any. The Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit under the Plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S.

Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, including COBRA, HIPAA and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. You may also visit their website at www.dol.gov/ebsa.

Facts About the Plan

General Information

The name of the Plan is the Masons of California DBA Masonic Homes of California DBA Acacia Creek and Masonic Center for Youth and Family Medical Expenses Reimbursement Plan.

The Employer has assigned plan number 503 to the Plan.

The Plan is a welfare benefit plan and a group health plan under ERISA.

This Plan is integrated with the Employer's Health Plan, which is a group health plan, offered to employees from time to time.

This Plan is adopted effective January 1, 2027.

The Plan Year for the Plan is the twelve-month period beginning January 1 ending on December 31.

Accumulator Year: Your medical plan deductible and out-of-pocket maximum reset each year on January 1.

Employer Information

The name, address and tax identification number of your employer is:

Masons of California DBA Masonic Homes of California DBA Acacia Creek and Masonic Center for Youth and Family
1111 California Street
San Francisco, CA 94587
EIN: 94-1156564

Plan Administrator Information

The name, address and telephone number of the Plan Administrator is:

Masons of California DBA Masonic Homes of California DBA Acacia Creek and Masonic Center for Youth and Family
1111 California Street
San Francisco, CA 94587
Telephone: (510) 429-6451

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions Participants have about the Plan. Participants may contact the Plan Administrator for any further information about the Plan.

The Plan Administrator has delegated claims administrative duties for the Plan to the following third-party administrator:

Nonstop Administration & Insurance Services, Inc.
1800 Sutter Street, Suite 730
Concord, CA 94520
Telephone: (877) 626-6057

Service of Legal Process

The name and address of the Plan's agent for service of legal process is:

Masons of California DBA Masonic Homes of California DBA Acacia Creek and Masonic Center for Youth and Family
1111 California Street
San Francisco, CA 94587

Masons of California DBA Masonic Homes of California DBA Acacia Creek and Masonic Center for Youth and Family
MEDICAL EXPENSE REIMBURSEMENT PLAN

Appendix A

The following Welfare Program shall be treated as comprising the MERP:

- Kaiser Maximum Benefit: $5,500 for employee plans and $11,000 for employee + dependent plans.

Masons of California DBA Masonic Homes of California DBA Acacia Creek and Masonic Center for Youth and Family
MEDICAL EXPENSE REIMBURSEMENT PLAN

Schedule A – Affiliated Employers

As of January 1, 2027, unless otherwise noted

Each entity listed below has sufficient common ownership with the Employer so as to constitute a member of a commonly controlled group as described in Code §§414(b), (c), (m), and (o) and has adopted the Plan with the consent of the Employer.

- Grand Lodge of Free and Accepted Masons of California – EIN: 94-0487790
- California Masonic Foundation – EIN: 23-7013074