CONFLUENT, INC.

SHORT TERM DISABILITY BENEFIT PLAN

Effective Date of Plan: January 1, 2023

Unless otherwise stated, the provisions of this restatement of the Plan apply to periods of Disability beginning on or after January 1, 2026.

This Plan Comprises Part of the Confluent, Inc.
Welfare Benefits Plan

Plan No. 501

CONFLUENT, INC.

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TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

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I. DEFINITIONS

A. *Active Employment* "Active Employment" means performance by the Employee of the regular duties of their work on any day that is one of the Company's scheduled work days. A period of Active Employment will also include (i) day(s) of vacation that have been scheduled by an Employee and (ii) days that are not the Company's scheduled work days provided the Employee is in Active Employment on the preceding scheduled work day.

B. *Claims Administrator* "Claims Administrator" means the entity appointed by the Company for the purposes of processing and adjudicating claims under the Plan in accordance with the terms of the Plan and the Department of Labor claims procedure regulations.

C. *Company* "Company" means Confluent, Inc and any successor thereto. In addition, for the purpose of determining eligibility to participate in the Plan, "Company" also means any subsidiary of Confluent, Inc. that the officers of Confluent, Inc., in their sole discretion, authorize to participate in the Plan.

D. *Disability* "Disability" means any physical or mental condition arising from an illness, injury, or pregnancy (including childbirth or related medical conditions) which renders a Participant incapable of performing their regular and customary occupation or any reasonably related occupation. A Participant will also be considered to have sustained a Disability if:

1. they are ordered not to work by written order from a state or local health officer because they are infected with, or suspected of being infected with, a communicable disease; or

2. they have been referred or recommended by competent medical authority to participate as a resident in either an alcohol abuse treatment program or a drug abuse treatment program, or to participate in an approved outpatient program for the treatment of alcohol or drug abuse which requires attendance for a minimum of five (5) days per week for a minimum of eight (8) hours per day; however, such Disability will be considered to continue only during the first ninety (90) days while the Participant is receiving treatment for alcohol or drug abuse in a residential facility or outpatient program.

A Participant will not be considered disabled if (i) they are performing work of any kind for remuneration or profit unless with the prior approval of the Plan

Administrator, or (ii) they decline alternative employment by the Company which is within the Participant's capabilities and, as determined solely by the Company, has status and compensation comparable to the Participant's previous occupation.

E. *Earnings* "Earnings" means gross base pay in effect on the date immediately preceding the commencement of the period of Disability. Bonuses, commissions, differentials, overtime and other forms of additional compensation are excluded.

"Earnings" with respect to a Participant who sustains a Disability while on an approved leave of absence (LOA) under the Company's leave policies or a federal, state or local jurisdiction mandated leave law, means gross base pay in effect just prior to the date their leave began. Bonuses, commissions, differentials, overtime and other forms of additional compensation are excluded.

An increase in Earnings during a period of Disability will increase the benefit amount.

F. *Effective Date* "Effective Date" of the Plan means January 1, 2023. "Effective Date" of this restatement of the Plan is January 1, 2026.

G. *Employee* "Employee" means a person who is a regular employee of Confluent, Inc., working twenty (20) or more hours per week, assigned to or attached to a geographic location within the United States of America or its territories. Excluded from the definition of "Employee" is any individual who:

1. is performing services for the Company through an employment or leasing agency, or

2. is performing services for the Company as an independent contractor or consultant, or

For the purpose of this Plan: A person that meets the above requirements who is a citizen of the U.S.A. but assigned to a Company location outside the U.S.A. or its territories and is paid by U.S.A. payroll will also be considered an Employee.

H. *ERISA* "ERISA" means the Employee Retirement Income Security Act of 1974, as amended, or as it may be amended from time to time, and rules and regulations promulgated thereunder.

I. *Objective Medical Evidence* "Objective Medical Evidence" means a measurable abnormality which is evidenced by one or more standard medical diagnostic procedures including laboratory tests, physical examination findings, X-rays, MRIs, EEGs, ECGs, CAT scans or similar tests that support the presence of a Disability or indicate a functional limitation. Objective Medical Evidence does not include Physician's or Practitioner's opinions based solely on the acceptance of subjective complaints (e.g. headache, fatigue, pain, and nausea), age transportation, local labor market and other non-medical factors. To be considered an abnormality, the test result must be clearly recognizable as out of the range of normal for a healthy population; the significance of the abnormality must be understood and accepted in the medical community.

J. ***Participant*** "Participant" means an Employee who satisfies the requirements for participation in the Plan as hereinafter specified.

K. ***Physician*** "Physician" means a physician or surgeon holding an MD or DO degree, Psychologist, optometrist, dentist, podiatrist, or chiropractic practitioner who is duly licensed or certified in the state or foreign country in which he or she practices and is acting within the scope of his or her practice. "Psychologist" means a licensed psychologist with a doctoral degree in psychology and who either (i) has at least two (2) years of clinical experience in a recognized health setting, or (ii) has met the standards of the National Register of the Health Service Providers in Psychology. "Physician" does not include the Participant or the Participant's child (biological, adopted, foster child, stepchild, legal ward, or child of a domestic partner), domestic partner, grandchild, grandparent, parent, parent-in-law, sibling, or spouse.

L. ***Plan*** "Plan" means the Confluent Inc. Short Term Disability Benefit Plan, as herein set forth and as it may be amended from time to time.

M. ***Plan Administrator*** "Plan Administrator" means the Company. The Plan Administrator will also serve as the "named fiduciary" as required by ERISA. The Plan Administrator will serve without compensation.

N. ***Plan Year*** "Plan Year" means the twelve (12) month period ending December 31st.

O. ***Practitioner*** "Practitioner" means a Nurse Practitioner or physician assistant (provided the or physician assistant has performed a physical examination and collaborated with a Physician or surgeon) duly licensed or certified by the state or foreign country in which he or she is practicing and acting within the scope of their license or certification. With regard to Disability resulting from pregnancy, childbirth, or postpartum conditions, Practitioner will also include a midwife, Nurse Practitioner, or nurse midwife acting within the scope of his or her license. "Nurse Practitioner" means a licensed nurse practitioner who has completed a transition to practice in their licensed state of a minimum of three (3) full-time equivalent years of practice or 4,600 hours. "Practitioner" does not include the Participant or the Participant's child (biological, adopted, foster child, stepchild, legal ward, or child of a domestic partner), domestic partner, grandchild, grandparent, parent, parent-in-law, sibling, or spouse.

P. ***Regular and Continuous Care*** "Regular and Continuous Care" means that you personally consult with a Physician or Practitioner at a frequency that is medically necessary to effectively manage and treat your disabling condition(s), in accordance with generally accepted medical standards; and receive appropriate treatment from a Physician and/or Practitioner whose specialty or experience is suited to your disabling condition(s), with such care conforming to generally accepted medical standards.

II. PARTICIPATION

A. *Eligibility for Participation* A person who is an Employee on the Effective Date of the Plan is eligible to participate on such Effective Date. A person who becomes an Employee after the Effective Date of the Plan is eligible to participate on the date on which they become an Employee.

B. *Effective Date of Participation* An Employee becomes a Participant on the date they become eligible, provided, however, that if an Employee is not in Active Employment on the date that their participation would otherwise become effective, their participation will be deferred until the date on which they return to Active Employment.

C. *Cessation of Participation* A Participant will automatically cease to participate on the earliest of the following:

1. the date on which the Participant ceases to be an Employee;

2. six (6) months after the date on which the Participant commences a leave of absence (LOA);

3. the date on which the Participant is placed on layoff status (except this provision shall not apply in the case of a temporary shut-down initiated by the Company); or

4. the date on which this Plan terminates.

III. ELIGIBILITY FOR BENEFITS

A. *Elimination Period* A Participant who sustains a Disability will, subject to the provisions of the Plan, be eligible to receive benefits on the first (1st) day of Disability, provided the Participant (i) has been continuously Disabled for a period of eight (8) consecutive days and (ii) has been examined by a Physician or Practitioner during some portion of that eight-day period. Except, provided if an eligible employee has been medically certified to work a restricted or partial work schedule consisting of periods of 50% or less of normal work hours, each medically certified partial schedule (50% or less) work day will count as one (1) day towards satisfying the waiting period, provided the partial work days are consecutive.

Successive periods of Disability separated by sixty (60) or fewer calendar days of continuous Active Employment at the Participant's normal work schedule will be considered one period of Disability, unless the subsequent Disability is due to an illness or injury found by the Claims Administrator to be entirely unrelated to the cause of the previous Disability and commences after return to Active Employment with the Company for at least one (1) day.

B. *Disability Determination* The Claims Administrator will determine whether a Disability exists with respect to a Participant on the basis of information which the Claims Administrator, in its sole discretion, deems relevant to such determination, including, but not limited to (i) Objective Medical Evidence, and (ii) a certificate from the Participant's Physician or Practitioner.

Certificates from the Participant's Physician or Practitioner must contain (i) a diagnosis and diagnostic code prescribed in the International Classification of Diseases, or, where no diagnosis has yet been obtained, a detailed statement of symptoms, (ii) a statement of the medical facts within the Physician's or Practitioner's knowledge, based on a physical examination and a documented medical history of the Participant by the Physician or Practitioner, (iii) the Physician's or Practitioner's conclusion as to the Participant's disability, and (iv) a statement of the Physician's or Practitioner's opinion as to the expected duration of the disability.

C. *Exclusions* No Participant will be entitled to a benefit under this Plan if:

1. their Disability arises out of, relates to, is caused by or results from an intentionally self-inflicted illness or injury unless the Participant's underlying injury or illness is otherwise covered by the plan and results from a documented medical condition (such as depression or mental illness).

2. their Disability arises out of, relates to, is caused by or results from an illness or injury to which a contributing cause was the Participant's commission or attempted commission of a felony, or the Participant's engagement in an illegal occupation;

3. their Disability arises out of, relates to, is caused by or results from an illness or injury due to war or any act of war, declared or undeclared, insurrection, rebellion, participation in a riot, or service in the armed forces of any country or international authority;

4. the Participant is not under the Regular and Continuous Care and treatment of a Physician or Practitioner, unless the Claims Administrator determines that such Regular and Continuous Care and treatment are not medically indicated given the nature of the Disability;

5. the Participant is incarcerated in any federal, state or municipal penal institution, jail, medical facility, hospital (public or private) or in any other place because of a criminal conviction under a federal, state or municipal law or ordinance;

6. the period of Disability begins when the Employee is not a Participant in the Plan;

7. the Participant is receiving unemployment compensation under any federal or state program;

8. the Participant is receiving Company-paid sick leave, PTO used as sick leave or salary continuation during their period of Disability, except that a benefit will be payable which, when added to such Company-paid sick leave or salary continuation, does not exceed the Participant's weekly Earnings;

9. their Disability is caused by or results from gainful self-employment or employment elsewhere;

10. the Participant makes false, fraudulent, or misleading statements related to their Disability claim, or the Participant submits false or fraudulent information or documentation related to their Disability or claim; or

11. the Participant is receiving pay under the Worker Adjustment and Retraining Notification (WARN) Act or in-lieu-of-notice pay.

IV. DISABILITY BENEFITS

A. *Amount of Benefit* Subject to reduction as hereinafter provided, the amount of weekly benefit for which a Participant covered under the Plan for a Disability will be equal to (i) one hundred percent (100%) of weekly Earnings through week eight (8) and sixty-seven percent (67%) of your weekly Earnings subject to a maximum weekly benefit of $3,500 thereafter for the duration of the benefit period set forth in Section IV.F. below.

For each day of any period of Disability for which benefits are payable and which is less than a full week, the amount of benefit payable will be 1/5th of the amount of the weekly benefit for each business day of paid leave.

B. *Benefits During Partial Disability* A Participant who has returned to work for the Company or any other employer (including self-employment) on a part-time basis, and who is working fewer hours than they are regularly scheduled to work, may, with the approval of the Plan Administrator, receive benefits under the Plan equal to the weekly benefit otherwise payable under this Plan, reduced by 80% of the weekly income derived from part-time employment. Benefits paid under this provision are subject to reduction as herein provided.

C. *Redirection of Benefits* An employee eligible to receive benefits under this Plan may choose to redirect a portion of their weekly benefit to cover all or part of the cost of employee-paid benefits. To execute this option, the employee must designate in writing on a form available from the Company, the semi-monthly amount to be so redirected. This redirection may be initiated at any time while receiving Plan benefits. The employee may terminate, or change the terms of, the redirection at any time while receiving Plan benefits.

D. *Reductions to the Amount of Benefit* The Disability benefit will be reduced by any of the following which are available to the Participant, for the same period for which the Disability benefit is payable hereunder:

1. temporary and permanent disability payments (whether total or partial), vocational rehabilitation payments, and any other amounts awarded to or allocated for the Participant under any workers' compensation law, occupational disease law, or any other legislation or law of similar purpose; and

2. benefits under a state disability plan, paid family and medical leave law, or a Company plan established in lieu thereof; and

3. benefits under any other plan, fund, arrangement, by whatever name known, providing disability benefits pursuant to a compulsory act or law of any government.

If a Participant is or might be entitled to any of the above-itemized benefits, the full Plan benefit will be paid upon receipt by the Claims Administrator of (i) evidence that the Participant has applied for such benefits and (ii) an executed agreement to reimburse the Plan, up to the amount of payments made, immediately upon receipt of such benefits.

If a Participant fails to apply for any of the above-itemized benefits to which they might be entitled, the Plan benefit will be reduced by the amount of the benefit which the Participant would have received had application been made. Determination of the amount of such benefit will be made by the Claims Administrator.

E. *Commencement and Duration of Benefits* Benefits will be payable as of the first day that a Participant becomes eligible to receive benefits and applies therefor. Thereafter, benefits will be payable until the earliest of the following:

1. the date following a period of ninety (90) days of Disability;

2. the date of the Participant's death; or

3. the date the Disability ceases to exist.

With respect to a Disability that commenced while the Participant was covered under this Plan, benefits will not terminate solely because the Participant ceased to be employed by the Company.

F. *Discontinuance and Resumption of Benefits* Benefits will be discontinued on the date, as determined by the Claims Administrator, that any of the following has occurred:

1. the Participant has refused to undergo a medical examination; failure by the Participant to undergo a scheduled medical examination following a written request by the Claims Administrator to do so will be considered a refusal;

2. the Participant has refused to provide information requested in writing by the Claims Administrator for the purpose of determining whether the Participant is entitled to benefits under the Plan; failure to furnish such information within thirty (30) days after such information has been requested will be considered a refusal;

3. the Participant has refused to follow or has rejected the treatment plan recommended by their Physician or Practitioner, unless the Participant disputes such treatment plan in good faith and on the advice of another Physician or Practitioner; or

4. the Participant is no longer under the Regular and Continuous Care and treatment of a Physician or Practitioner, unless such Regular and Continuous Care and treatment are not medically indicated, given the nature of the Disability.

5. the Participant has made a false, fraudulent, or misleading statement, whether by misrepresenting or omitting a material fact, or by submitting false or fraudulent information or documentation in connection with this Plan or any claim for benefits under the Plan. A Participant who makes false, fraudulent, or misleading statements or who submits false or fraudulent information or documentation in connection with this Plan or any

claim for benefits under the Plan, may also be subject to disciplinary action. Such action may include, but is not limited to:

a. denial or revocation of any benefits related to the false or fraudulent statement;

b. recovery of any benefits improperly paid; and

c. pursuit of all available civil and criminal remedies by the Plan Administrator.

Benefits that have been discontinued in accordance with the above may resume if the reason for discontinuance ceases to apply. In no event, however, will benefits be paid for the period during which the Participant was not in compliance with the Plan unless the Claims Administrator determines that the Participant's failure to comply was due to reasonable cause.

The Participant will not be required to reimburse the Plan for benefits which may have already been paid between the date on which the reason for discontinuance occurred and the date of the Claims Administrator's determination.

G. *Suspension and Reinstatement of Benefits* Benefits will be suspended as of the date of any medical examination conducted pursuant to Section V.G. If the Claims Administrator, on the basis of the results of such examination, determines that eligibility for benefits continues, benefits will be reinstated as of the date of the medical examination.

V. PAYMENT OF BENEFITS

A. *Application for Benefits* To be entitled to any benefits under the Plan, a Participant must comply with such procedures and requirements as the Claims Administrator may have prescribed with respect to the completion and filing of an application for such benefits and submission of evidence that the Participant is entitled to such benefits. The Claims Administrator may require information with respect to the Participant's age, address, marital status, dependents, employment record, medical history and evidence that the Participant has applied for any benefits which would serve to reduce benefits under this Plan.

The Claims Administrator may require any other information reasonably relevant to a determination of whether the Participant is eligible to receive benefits and may also require written authorization to obtain:

1. information from the Participant's Physician(s) or Practitioner(s) with respect to their physical condition, diagnosis, prognosis, date of expected return to work and related matters;

2. relevant medical records on file in any hospital, Physician's or Practitioner's office, or government office; and

3. such other records from any company having information reasonably relevant to a determination.

B. *Time Limit for Application for Benefits* An application for benefits must be filed no later than forty-five (45) days after the date benefits may become payable under the Plan unless it is not reasonably possible for the Participant or their representative to do so. In no event will an application be accepted by the Claims Administrator if such application is filed more than six (6) months after the date benefits may become payable.

C. *Claim Processing* Upon receipt of the Participant's application, the Claims Administrator will make a determination as to the eligibility of the Participant for benefits not later than forty-five (45) days after receipt of the claim. If, due to circumstances beyond the Claims Administrator's control, a decision cannot be made within that period, the Claims Administrator may extend that period up to sixty (60) additional days (in thirty (30) day increments) provided the Claims Administrator notifies the Participant, in writing

1. of the delay prior to the expiration of the deadline(s) (e.g., prior to the expiration of the first forty-five (45) days, or the first thirty (30) day extension period);

2. of the date by which it intends to make a decision;

3. of the circumstances that caused the delay;

4. of the standards on which entitlement is based;

5. of the unresolved issues and the additional information needed to resolve those issues; and

6. that the Participant is entitled to at least forty-five (45) days within which to provide additional information to resolve the issues.

If the time for making a decision is extended due to a Participant's failure to submit information necessary to decide the claim, the time for making a decision will be tolled from the date notification of an extension is sent to the Participant until the Participant provides the required information.

D. *Notification of Benefit Determination* If the Claims Administrator determines that a Participant is not eligible for benefits, the Participant will be notified, in writing, of the adverse benefit determination (denial). The notification will be written in a culturally and linguistically appropriate manner designed to be understood by the Participant, and it will set forth the following:

1. the specific reason or reasons for the denial;

2. reference to the specific Plan provisions on which the denial is based;

3. a description of any additional material or information necessary for the Participant to perfect the claim and an explanation as to why such material or information is necessary;

4. a description of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of the Participant's right to bring a civil action following an adverse benefit determination on review;

5. the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the decision or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist;

6. if the decision is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment used in making the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such an explanation is available, on request, free of charge;

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

   (a) the views presented by the Participant's Physician or Practitioner or the views of the medical or vocational experts whose advice was obtained on behalf of the Plan;

   (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse decision, without

regard to whether the advice was relied upon in making the benefit decision; or

(c) a disability determination made by the Social Security Administration regarding the Participant and presented to the Plan by the Participant, and

8. a statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits.

E. *Claim Review Procedure* The claims procedures set forth in this section will provide all Participants with a full and fair opportunity for review of any claim that is denied. Each Participant will have the right to appoint a representative to pursue any claim or appeal on the Participant's behalf. Such request must:

1. be in writing;

2. be filed with the Claims Administrator within one hundred eighty (180) days after receipt of the written decision;

3. set forth all of the grounds upon which the request for review is based and any facts, documents, records or any other information in support thereof; and

4. set forth any issues or comments which the Participant deems relevant to their claim.

Any Participant or representative of the Participant whose claim has been denied will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Upon receipt of the request for review of the decision, the Claims Administrator will consider the request and provide the Participant with a written decision, written in a culturally and linguistically appropriate manner, within forty-five (45) days after receipt of the request for review. This review: (i) will not afford deference to the initial adverse benefits determination, (ii) will include a review of the entire file, including any new materials and arguments submitted since the initial adverse benefits determination, (iii) will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or other person making the benefit determination in connection with the claim as soon as possible and sufficiently in advance of the end of the aforementioned forty-five (45) day period, (iv) will be rendered by an appropriately named individual or individuals who neither made the adverse benefits determination that is subject of the appeal, nor is a subordinate of that individual, and (v) will be rendered with the consultation of a health care professional (who has appropriate training and experience in the field of medicine involved with the particulars of the claim under review) who was not the health care professional consulted during the adverse benefit determination that is the subject of the appeal, nor the subordinate of that health care professional, if the initial adverse benefit determination was made in consultation

with a health care professional or was based in whole or in part on a medical judgment.

If, for reasons beyond the Claims Administrator's control, additional time is required in which to review the Participant's request, the Participant will be notified, in writing, on or before the date the forty-five (45) day period expires. The notice of extension will include the reason for the delay and the date that the Claims Administrator expects to render a decision; however, in no event, will the written decision be issued more than ninety (90) days after the request for review is received.

If, after rendering an adverse determination, the Claims Administrator receives new or additional evidence that is considered, relied upon, or generated in connection with the claim, the Participant will be provided, free of charge, with the new or additional evidence as soon as possible and sufficiently in advance of the date on which the notification of benefit determination on review is due, and the Participant will be afforded an opportunity to respond.

F. *Notification of Benefit Determination on Review* If, on review, the Claims Administrator determines that a Participant is not eligible for benefits, the Participant will be notified, in writing of the adverse benefit determination (denial). The notification will be written in a culturally and linguistically manner designed to be understood by the Participant and will set forth the following:

1. the specific reason or reasons for the denial;

2. reference to the specific Plan provisions on which the denial is based;

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

4. a statement of the Participant's right to bring a civil action pursuant to ERISA section 502(a) no later than six (6) months after the date on which notification of the final determination is made, including the calendar date on which the six (6) month period will expire;

5. the rule, guideline, protocol or similar criterion on which the denial was based or a statement that a copy of such is available, on request, free of charge, or, if the denial was not based on a rule, guideline, protocol or similar criterion, a statement that these were not used;

6. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment that the Claims Administrator used in making the determination, applying the terms of the Plan to the Participant’s medical circumstances, or a statement that such an explanation is available, on request, free of charge;

7. if applicable, the identity of any medical or vocational expert(s) whose advice was obtained on behalf of the Claims Administrator in connection with the adverse

benefit determination, whether or not the advice was relied upon in making the determination;

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

   a. the views presented by the Participant to the Claims Administrator of the Physician(s) or Practitioner(s) treating the Participant and vocational professionals who evaluated the Participant;

   b. the views of medical or vocational experts whose advice was obtained on behalf of the Claims Administrator in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

   c. a disability determination regarding the Participant presented by them to the Plan made by the Social Security Administration.

   If an adverse benefit determination on review is based on a new or additional rationale, the Claims Administrator will provide the Participant, free of charge, with the rationale. To allow the Participant a reasonable opportunity to respond, the rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required.

G. *Medical Examinations* The Claims Administrator may require that a Participant applying for benefits submit to an examination by a Physician or Practitioner designated by the Claims Administrator, for their medical opinion as to whether the Participant is disabled so as to meet the eligibility requirements under the Plan for benefits. Re-examinations of a Participant receiving benefits may be directed by the Claims Administrator from time to time for the purpose of assisting the Claims Administrator in determining whether continued eligibility for such benefits exists. The fees of such Physician or Practitioner and the expenses of such examination will be paid by the Plan.

H. *Non-Alienation of Benefits* To the extent permitted by law, no benefit payable at any time under the Plan will be assignable or transferable, or subject to any lien, in whole or in part, either directly or by operation of law or otherwise, including, but not limited to, execution, levy, garnishment, attachment, pledge, bankruptcy, or in any other manner. No benefit payable under the Plan will be liable for, or be subject to, any obligation or liability of any Participant.

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

J. *Payment In the Event of Death* In the event of the death of the Participant, any payments due under this Plan as a result of the Participant's Disability will be made to their beneficiary as noted in the Participant's group life insurance policy or, if no

such policy exists, to the Participant's spouse. If payments cannot be made under either of the above methods, payment will be made to the Participant's estate.

VI. PLAN FINANCING

A. *Participant Contributions* Participants will not be required to make contributions to the Plan.

B. *Company Contributions* Disability benefit payments and such other costs as are determined necessary to properly maintain and operate the Plan will be paid out of the Company's general assets.

VII. ADMINISTRATION AND RESPONSIBILITY

A. *Duties of the Plan Administrator* The Plan Administrator will have exclusive authority and responsibility for all matters in connection with the operation and administration of the Plan. Specifically, the Plan Administrator will:

1. be responsible for the compilation and maintenance of all records necessary in connection with the Plan;

2. determine eligibility for benefits under the Plan, and compute and authorize the payment of such benefits as they become payable;

3. decide questions relating to the eligibility of Employees to become Participants;

4. engage such legal, actuarial, accounting and other professional and clerical services as may be necessary or proper; and

5. interpret this instrument and make and publish such uniform and non-discriminatory rules for administration of the Plan as are not inconsistent with the provisions of this instrument.

B. *Delegation of Duties* The Plan Administrator may, from time to time, delegate any of the rights, powers, and duties of the Plan Administrator (including fiduciary responsibilities) with respect to the operation and administration of the Plan to one or more committees, individuals or entities. If the Plan Administrator delegates any rights, powers or duties to any person, such person may from time to time further delegate such rights, powers and duties to any other person. If any right, power or duty is delegated to more than one person, such persons may from time to time allocate among themselves any such right, power or duty. Any allocation or delegation of fiduciary responsibilities under the Plan will be terminable upon such notice as the Plan Administrator, in its sole discretion, deems reasonable and prudent.

C. *Decisions and Rules* The decisions of the Plan Administrator made in good faith upon any matter within the scope of its authority will be final, but the Plan Administrator at all times in carrying out its decisions will act in a uniform and nondiscriminatory manner.

D. *Fiduciary Duties* In performing its duties, the Plan Administrator will act solely in the interest of the Participants:

1. for the exclusive purpose of providing benefits to Participants and defraying reasonable expenses of administering the Plan;

2. 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; and

3. in accordance with the documents and instruments governing the Plan, insofar as such documents and instruments are consistent with the provisions of ERISA.

E. *Liability; Indemnification* The Plan Administrator will not be liable for any act, omission, determination, or construction made by itself or by its designated counsel, agents, or other employees, except for willful misconduct. Nothing herein, however, will be construed as purporting to relieve the Plan Administrator or any other fiduciary under the Plan, or any officer or director of the Company, or any agent thereof, from responsibility or liability for any responsibility, obligation, or duty imposed by ERISA. The Company will indemnify and hold harmless any person to whom any fiduciary duty is delegated from and against any and all liabilities, claims, demands, costs and expenses (including attorneys' fees) arising out of an alleged breach in the performance of its fiduciary duties under the Plan, other than such liabilities, claims, demands, costs and expenses as may result from the gross negligence or willful misconduct of such person. The Company will have the right, but not the obligation, to conduct the defense of such person in any proceeding to which this Section applies.

VIII. MISCELLANEOUS

A. *Permanence of the Plan* The Company intends to continue the Plan indefinitely but will not be under any obligation or liability whatsoever to continue to maintain the Plan for any given length of time. The Company may, in its sole discretion, terminate the Plan any time without any liability whatsoever for such action. If the Plan is terminated, the termination will not affect the rights of any Participant to claim benefits with respect to a Disability incurred prior to such termination.

B. *Right to Amend* The Company reserves the power and right, at any time or times to amend any or all of the provisions of the Plan to any extent and in any manner it will deem advisable.

C. *Nonguarantee of Employment* The adoption and maintenance of the Plan will not be considered to be a contract between the Company and any Employee. Therefore, no provision of the Plan will give any Employee the right to be retained in the employ of the Company or to interfere with the right of the Company to discharge any Employee at any time, irrespective of the effect such discharge may have upon an Employee as a Participant or prospective Participant under the Plan. In addition, no provision of the Plan will be considered to give the Company the right to require any Employee to remain in its employ or to interfere with any Employee's right to terminate their employment at any time.

D. *Titles* Titles are for reference only. In the event of a conflict between a title and the content of a Section, the content will control.

E. *Governing Law* The Plan will be construed, administered and governed in all respects in accordance with ERISA and other pertinent federal laws and in accordance with the laws of the State of California to the extent not preempted by ERISA. If any provision of this Plan will be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions of the Plan will continue to be fully effective.

F. *Gender and Number* Wherever used in this Plan, *their* and *they* will include the singular, unless the context indicates otherwise.

G. *Overpayments* In the event the Participant has been paid benefits by the Plan in excess of those to which they are entitled, the Plan has a right to recover the overpayment. The Claims Administrator will make reasonable arrangements with the Participants or their legal representative(s) for the repayment to the Plan. The Plan will not recover more money than the amount paid to the Participant.