PAISBOA HEALTH BENEFIT PLAN

INTEGRATED HEALTH REIMBURSEMENT ARRANGEMENT PROGRAM

SUMMARY PLAN DESCRIPTION

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I. INTRODUCTION

The PAISBOA Health Benefit Trust (HBT) is the Plan Sponsor and has established the PAISBOA Health Benefit Plan Integrated Health Reimbursement Arrangement (the "Plan") effective November 1, 2023 to reimburse employees for certain eligible fertility expenses.

The Plan provides reimbursements to Eligible Employees and eligible spouses or partners for eligible expenses on a tax-favored (i.e., non-taxable) basis. To the extent the Plan provides reimbursements of "medical care," the Plan is intended to be a health reimbursement arrangement as defined under IRS Notice 2002-45 and an employer-provided medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended (the "Code") and the regulations issued thereunder. Any reimbursements for surrogacy and stepchild adoptions are not tax-favored, and although these will be reimbursed via the Health Reimbursement Arrangement, employees will receive a 1099 for these reimbursements to recognize the miscellaneous income in their personal tax return.

The Plan is intended to be integrated with the Employer's medical plan(s) in order to comply with the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Patient Protection and Affordable Care Act, as amended ("PPACA") and the applicable regulations.

This document, together with any summaries, booklets, notices, enrollment materials and attachments issued in connection with the Plan and as in effect from time to time (each of which are fully incorporated herein by this reference), is intended to serve as the summary plan description for the Plan. If there are any conflicts between this document, the summaries, booklets, notices, enrollment materials or attachments and the legal Plan document, the legal Plan document will govern.

Nothing in this document states or implies that any person has a guaranteed right to participate in the Plan, or that the Plan will remain unchanged in future years. The HBT has the right and sole discretion to suspend, amend or terminate the Plan and/or any of the benefits provided thereunder at any time in any manner, in whole or in part, to the extent permitted by law. The Plan Administrator, or its designee, has sole discretionary authority to interpret and construe the provisions of the Plan, to determine eligibility for benefits under the Plan, and to resolve any disputes that arise under the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides, in its discretion, that an Eligible Employee is entitled to them.

Receipt of this document does not necessarily mean that you are eligible to participate in the Plan or that you are entitled to any benefits from the Plan. Your rights, if any, are governed by the provisions of the Plan document as in effect from time to time.

If you have any questions regarding enrollment, eligibility, or a claim, contact the "Claim Administrator", Maven Clinic Co., at support@mavenclinic.com. If you have any questions regarding other information in this Summary Plan Description, contact the "Plan Administrator" whose name and address are included in this summary.

II. ELIGIBILITY FOR PARTICIPATION

A. Who is an Eligible Employee?

You are an "Eligible Employee" if you are a regular U.S. employee of a PAISBOA Health Benefit Trust member school and you are enrolled in the HBT Medical Plan. If you are enrolled in a high deductible health plan (HDHP), as that term is defined under Section 223 of the Internal Revenue Code, you are not an Eligible Employee for purposes of the Plan until you have satisfied the out-of-pocket deductible requirement as set forth annually by the Internal Revenue Service (IRS) during the Plan Year.

B. Who is an Eligible Spouse?

If you are an Eligible Employee, your spouse may become an "Eligible Spouse" for purposes of the Plan if he or she is legally married to you on the date on which you become an Eligible Employee (or while you remain an Eligible Employee).

C. Who is an Eligible Domestic Partner?

If you are an Eligible Employee, your domestic partner may become an "Eligible Domestic Partner" for purposes of the Plan if he or she is an eligible domestic partner under the Employer's medical plan.

D. When can I participate in the Plan?

You can participate in the Plan if you are enrolled in the Employer's medical plan. Your Eligible Spouse or Eligible Domestic Partner is not required to be enrolled in the Employer's medical plan for their expenses to be reimbursed under the Plan.

You and your Eligible Spouse or Eligible Domestic Partner will participate in the Plan on the date you meet the above eligibility requirement(s), provided you are an Eligible Employee on such date.

III. BENEFITS

A. What expenses are eligible for reimbursement?

You will be entitled to receive reimbursement for the eligible expenses listed on the Eligible Expense Appendix to this Summary Plan Description.

Eligible expenses must be incurred during the Period of Coverage (generally, the Plan Year). Eligible expenses are "incurred" when the care or service is provided, not when you or your Eligible Spouse or Eligible Domestic Partner are billed or charged or pay for the expense. Thus, an eligible expense that has been paid but not incurred (e.g., pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

Eligible expenses include those for services for you (or your Eligible Spouse or Eligible Domestic Partner) that are not covered by your (or their) group health plan. Any expense that is reimbursed by any other source (including any reimbursement accounts held by your Eligible Spouse or Eligible Domestic Partner) is ineligible for reimbursement.

If you are enrolled in a High Deductible Health Plan (HDHP), eligible expenses may only be incurred *after* you have met the minimum statutory deductible applicable to your coverage (single or family). The minimum statutory deductible for 2025 is $1,650 for an HDHP with single coverage and $3,300 for an HDHP with family coverage. The minimum statutory deduction is adjusted for inflation annually.

If you and your Eligible Spouse or Eligible Domestic Partner or Dependent Children have family coverage, then the minimum statutory deductible applicable to HDHP family coverage must be met.

B. For whom can I receive reimbursement of eligible expenses?

You will be entitled to receive reimbursement for Eligible Expenses incurred by the following Covered Persons:

- You
- Your Eligible Spouse or Eligible Domestic Partner, whether or not they are enrolled

C. How will the Plan be administered?

The Employer will credit up to $10,000 to your account for use. The $10,000 credit is a lifetime household maximum. The $10,000 maximum benefit amount for any given Period of Coverage will be reduced by the amount of any benefits you obtain from a Member School's Adoption and Surrogacy Assistance Plan, if the member school offers such a plan. Please refer to the Maven Wallet for The PAISBOA Health Benefit Trust Program Overview for more information.

The first Period of Coverage / Plan Year ends October 31, 2024, and each subsequent Period of Coverage / Plan Year ends each 10/31.

D. Will I be able to carry over any unused benefits?

Yes, you can carry over any unused benefits at the end of the Period of Coverage to the subsequent Period of Coverage while you and/or your Eligible Spouse or Eligible Domestic Partner participate in the Plan. However, you can only be reimbursed up to $10,000 in your lifetime career with a PAISBOA Health Benefit Trust member school.

IV. REIMBURSEMENT

A. When must I submit claims for reimbursement?

You must submit claims for reimbursement of expenses by the following: 90 days from when the expense was incurred.

If you terminate participation in the Plan during the Period of Coverage, you must submit claims for reimbursement of expenses no later than 90 days after termination of participation. Any claim that is not submitted within 90 days of the date the eligible expense was incurred will be denied.

You may submit claims to any health care flexible spending account under which you or your Eligible Spouse or Eligible Domestic Partner or Dependent Children have coverage before or after you may receive reimbursement under this Plan. However, at no time can you submit for reimbursement from this plan and your flexible spending account for the same reimbursable items.

B. Where do I submit claims?

All claims should be submitted through the Maven Clinic mobile application. If you do not wish to submit your claim through the Maven Clinic mobile application, please email support@mavenclinic.com or write Maven Clinic Co., at 160 Varick, 6th Floor, New York, NY 10013, Attn: Wallet Operations.

C. How are claims paid?

To the extent that a claim is approved, Maven will reimburse you.

Certain reimbursements for eligible expenses you receive under the Plan may be excluded from income under Internal Revenue Code Section 213(d), such as eligible expenses incurred for diagnostic purposes or to overcome an inability to have a child as supported by documentation of a medical diagnosis of infertility. These reimbursements will not be reported on your W-2 as wages and should not be subject to standard payroll tax withholding.

Reimbursements for step child adoption and surrogacy expenses are taxable income. These reimbursements will be reported and mailed to you on a 1099 form annually, and are subject to standard personal income tax when your annual tax return is prepared.

The HBT does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan.

You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan. You are solely responsible for complying with your personal income tax filing and payment obligations. Neither the HBT nor the Claim Administrator will provide any legal or tax advice or guarantee any particular tax treatment. You must immediately repay any excess payments/reimbursements. You must reimburse the HBT for any liability the HBT may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

D. What information should I include with the claim?

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator or Claim Administrator may request any additional information necessary to evaluate the claim.

E. When does my coverage end?

Your participation in the Plan ends upon the earliest of the following:

- The date you or your Eligible Spouse or Eligible Domestic Partner or Dependent Child submits a falsified, altered, or fraudulent claim; or
- The date you cease to be an Eligible Employee.
- Your Eligible Spouse or Eligible Domestic Partner's participation in the Plan ends upon the earliest of the following:
- The date he or she ceases to be an Eligible Spouse or Eligible Domestic Partner or Dependent Child; or
- The date your participation ends.

Coverage will also end if the PAISBOA Health Benefit Trust discontinues this Plan or amends this Plan so that you are no longer eligible.

If an individual ceases to be a Covered Person under the Plan, the Plan shall reimburse Eligible Expenses incurred through the date the person ceases to be a Covered Person.

F. Can my beneficiaries make claims after my death?

If you die, your beneficiaries may submit claims for Eligible Expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose provided that such beneficiary is your spouse or one or more of your dependents. If no beneficiary is specified, the Plan Administrator may pay any amount due to your spouse or, if there is no spouse, to your dependents in equal shares.

V. MISCELLANEOUS

A. Administrative Information

1. The PAISBOA Health Benefit Trust (HBT) is the Plan Sponsor and Plan Administrator of the HBT Integrated Fertility Health Reimbursement Arrangement.

   Address: 301 Iven Ave, Suite 315, Wayne PA 19087
   Phone number: 484-580-8844
   Email: executive.director@phbtrust.org
   Employer Identification Number: 46-7526272

2. The Employer's fiscal year and the plan year end on 10/31.

3. The Plan part of the PAISBOA Health Benefit Plan which is a welfare benefit plan that has been assigned plan number 501. The Plan is intended to qualify as an employer-provided medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code and the regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45.

4. The Plan's designated agent for service of legal process is the Executive Director of the PAISBOA Health Benefit Trust. Any legal papers should be delivered to him or her at the address above. However, service may also be made upon the Plan Administrator at the same address.

5. The Plan is paid for by the Plan Sponsor from the Health Benefit Trust. No Eligible Employee or other person shall have any claim against, right to, or security or other interest in any asset of the HBT from which any payment under this Plan may be made.

B. Administrator Discretion

The Plan Administrator administers the Plan and has the discretionary authority to interpret all Plan provisions and to determine all issues arising under the Plan, including issues of eligibility, coverage, and benefits, and to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides, in its sole discretion, that a Claimant is entitled to them. The Plan Administrator's failure to enforce any provision of the Plan shall not affect its right to later enforce that provision or any other provision of the Plan. The Plan Administrator may delegate some of its administrative duties to agents. Any construction, interpretation, or application of the Plan by the Plan Administrator is final, conclusive, and binding. The Claim Administrator has no authority to exercise discretion.

C. Amendment and Termination

The Employer may amend, terminate or merge the Plan at any time.

D. HIPAA Privacy Rights

Group health plans, including the Plan, are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. You may receive a separate notice from the Plan Administrator that outlines its health privacy policies, including with regard to electronic PHI.

E. Loss or Assignment of Benefit

You may lose all or part of your account if the Plan Administrator or Claim Administrator cannot locate you when your benefit becomes payable to you. You are responsible for keeping the Plan Administrator and the Claim Administrator informed of any changes in your address and phone number. You should also keep a copy, for your records, of any notices you send. You may not alienate, sell, transfer, anticipate, commute, pledge, attach, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary. Any attempt to assign your benefits will not be recognized, except as required by law.

F. Coordination with Other Plans

All claims for benefits that are covered by an insurance policy must be made to the insurance company issuing such insurance policy.

G. Effect of the Plan on Your Employment Rights

The Plan is not to be construed as giving you any rights against the Plan except those expressly described in this document. The Plan is not a contract of employment between you and your HBT member school.

VI. CONTINUATION RIGHTS

A. Military Service

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

B. COBRA

Under Federal law, you, your Eligible Spouse or Eligible Domestic Partner may be entitled to COBRA continuation coverage in certain circumstances. Please see the "COBRA Notice" provided by the Plan Administrator for important information about your right to COBRA continuation coverage, if applicable. The COBRA Notice generally explains COBRA continuation coverage and when it may become available to you. The Plan Administrator will inform you of these rights, if any, when you terminate employment.

COBRA is a federal law that gives certain employees, spouses, and dependent children of employees the right to temporary continuation of their health care coverage under the Plan Administrator's major medical or other health insurance plan at group rates. If you incur an event known as a "Qualifying Event," and if you are covered under the Plan when the Qualifying Event occurs, then you will be entitled under COBRA to elect to continue your coverage under the Plan if you pay the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events:

- Your termination from employment (for reasons other than gross misconduct) or reduction of hours;
- Your divorce or legal separation from your spouse;
- Your Dependent Child ceases to be a dependent child under the terms of the HBT medical plan; and
- Your becoming eligible to receive Medicare benefits.

If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. You are responsible for informing the Plan Administrator of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual who becomes disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. In all other cases to which COBRA applies, COBRA continuation coverage will be for a period of 36 months.

C. FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving benefits.

VII. LEGAL PROVISIONS

A. Code and ERISA Compliance

It is intended that this Plan will meet all applicable requirements of the Internal Revenue Code, ERISA, and all regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA, the provisions of the Code and/or ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

B. Privacy

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices.

C. Claim Procedures for Health Benefits

The Plan Administrator may direct the Claim Administrator to perform, solely in a ministerial capacity, any of the administrative procedures described herein on its behalf.

Application for Benefits. You or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Claim Administrator. Any such claim must be in writing and must include all information and evidence that the Claim Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Claim Administrator may request any additional information necessary to evaluate the claim.

Timing of Notice of Denied Claim. The Claim Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Claim Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Claim Administrator shall provide the Claimant with a notice identifying (1) information about the claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available, (2) any denial code (and its corresponding meaning) that was used in denying the claim, (3) the reason or reasons for such denial, (4) the pertinent Plan provisions on which the denial is based, (5) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (6) an explanation of the steps that the Claimant must take if he wishes to appeal the denial and the time limits applicable to such steps, including a statement that the Claimant may bring a civil action under Section 502(a) of ERISA following a denial on review, and (7): (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request; or (B) 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 for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Claim Administrator on or before the 180th day after he receives the Claim Administrator's notice that the claim has been wholly or partially denied. If a Claimant does not file an internal appeal within this 180-day period, he loses his right to appeal. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, reasonable access to and copies of all documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. An appeal must be in writing, must be provided to the Claim Administrator, and must include the following information:

(1) Claimant's name and address,
(2) The fact that Claimant is disputing a denial of a claim or the Claim Administrator's act or omission,
(3) The date of the notice that the Administrator informed the Claimant of the denied claim, and
(4) The reason(s), in clear and concise terms, for disputing the denial of the claim or the Claim Administrator's act or omission.

An appeal should also include any relevant documentation not already provided to the Claim Administrator.

If the Claim Administrator receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that Claimant has provided to it, Claimant will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for the Claim Administrator's notice of final internal adverse benefit determination. Similarly, if the Claim Administrator identifies a new or additional reason for denying your claim, that new or additional reason will be disclosed to Claimant and Claimant will be given a reasonable opportunity to respond to that new rationale before the due date for the Claim Administrator's notice of final internal adverse benefit determination.

Claimant will be provided, upon request and free of charge, documents and other information relevant to his claim. Any time before the appeal deadline, Claimant may submit copies of all relevant documents, records, written comments, testimony, and other information to the Claim Administrator. The Plan is required to provide Claimant with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing an appeal, the Claim Administrator shall take into account all relevant documents and other information that the Claimant provides with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination. The Claim Administrator shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Claim Administrator may deem relevant. In considering the appeal, the Claim Administrator shall:

(1) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is not the individual who made the adverse benefit determination that is the subject of the appeal, the subordinate of such individual, or an individual whose terms and conditions of employment are affected by the results of his decision;

(2) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(3) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(4) Provide that the health care professional engaged for purposes of a consultation under Subsection (2) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Claim Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination. The Claimant shall lose the right to appeal if the appeal is not timely made. If an appeal is timely made, the Claimant has the right to an internal appeal and, if applicable, an external review to an independent review organization.

The Claimant will not be allowed to take legal action against the Plan, the Claim Administrator, the Claim Administrator, or any other entity to whom administrative or claims processing functions have been delegated unless he exhausts his internal appeal rights. But the Claimant is not required to pursue external review in order to preserve his right to file a lawsuit. (In fact, as explained later in this summary, the Claimant may be unable to take further legal action if he pursues an external appeal because the external appeal process results in a binding determination.)

Denial of Appeal. If an appeal is wholly or partially denied, the Claim Administrator shall provide the Claimant with a notice identifying (1) information about the claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available, (2) the reason or reasons for such denial with a discussion of the decision, (3) the pertinent Plan provisions on which the denial is based, (4) any denial code (and its corresponding meaning) that was used in denying the claim, (5) a statement that the Claimant 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 Claimant's claim for benefits, (6) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the review determination, either the rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or other similar criterion will be provided to the Claimant free of charge upon request, and (7) a statement describing the Claimant's right to bring an action under Section 502(a) of ERISA and to the external appeals process.

Exhaustion of Remedies; Limitations Period for Filing Suit. Before a suit can be filed in federal court, claims must exhaust internal remedies. This exhaustion requirement applies to all types of claims under the Plan, including: (i) recovery of benefits under the Plan, (ii) enforcement of your rights under the terms of the Plan, and (iii) clarification as to your rights to future benefits under the terms of the Plan. Any claim or lawsuit related to benefits under the Plan must be brought in the correct court or forum no later than 24 months after the earliest of:

- the date your first benefit payment was made or due,
- the date your request for a Plan benefit was first denied or
- the earliest date you knew or should have known the material facts on which your lawsuit is based (the "24-month Claims Period").

However, if you start the claims and appeals procedure described in this document or individual benefit booklet by submitting your claim to the Claims Administrator within the 24-month Claims Period, the deadline for you to file your lawsuit will not expire until the later of the last day of the 24-month Claims Period and three months after the final notice of denial of your appealed claim is sent to you by the Claims Administrator. Any claim or action filed under the administrative claims and appeals procedures described in this document or individual benefit booklet or any lawsuit that is filed in a court or any other forum after the end of this 24-month period (or, if applicable, after the end of the three-month period following exhaustion the administrative claims and appeals procedures described in this document or individual benefit booklet) will be time-barred.

VIII. YOUR RIGHTS UNDER ERISA

As a participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This federal law provides that you have the right to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration if a 5500 is required to be filed by the plan.

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

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

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

In addition, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the 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. The Claim Administrator is not a fiduciary of the Plan and processes eligibility verification, enrollments and claims solely at the direction of the Plan Administrator. 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 your benefits or exercising your rights under ERISA.

If your claim for a benefit 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 Plan 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 Plan 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. 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.

If you have questions about eligibility, enrollment, or a claim, you should contact the Claim Administrator. If you have any other questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest 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.

IX. MEDICAL EXPENSES APPENDIX

Procedures related to egg freezing, IVF, and/or IUI
- Embryo/egg/sperm extraction, freezing, storage, and thawing
- Intracytoplasmic sperm injection (ICSI) and assisted hatching
- Fertilization
- Gamete intrafallopian tube transfer (GIFT)
- Zygote intrafallopian transfer (ZIFT)
- Other treatments (including over-the-counter medications) recommended by your doctor related to IUI/IVF

Diagnostic and screening tests to improve likelihood of pregnancy success
- Preimplantation genetic screening (PGS)
- Preimplantation genetic testing (PGT-A, PGT-M)
- Diagnostic hormone kits

Reversal of Sterilization

Ovulation tracking or monitoring devices, kits and services (e.g. The AVA Bracelet)

At-home fertility hormone tests

Medications related to any of the above

- Any maternity-related out of pocket costs for medical services (copays, deductibles, coinsurance) not covered under the plan or any other source
- Any maternity-related Rx not covered under the plan
- Reasonable and necessary cost of travel to obtain [maternity or reproductive] medical care for participants living in a jurisdiction where the medical care or procedure is restricted or otherwise unavailable:
    - Car and rental car expenses; parking fees and tolls; bus, taxi, rideshare, train, plane, and ferry fares; and ambulance services. Note that rental car expenses are limited to the portion attributable to the medical appointment or other care. Instead of actual car expenses, a standard mileage rate (22 cents per mile) for use of a car to obtain medical care is permitted. Taxi or rideshare expenses are only reimbursable when accompanied by a hotel stay or air travel. Air travel is limited to economy seats.
    - Meal expenses while away from home undergoing treatment if they are provided at a hospital or similar licensed institution at which the individual is receiving medical care
    - Lodging expenses are reimbursable up to $50 per day