The University of California

Residents and Fellows

INFERTILITY HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN

EFFECTIVE March 1, 2023

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ARTICLE I ESTABLISHMENT AND PURPOSE OF THE PLAN

I.01 Establishment of Plan.

Effective March 1, 2023, the University of California hereby establishes this Infertility Health Reimbursement Arrangement ("HRA") Plan (hereinafter "Plan") for the purpose of providing certain benefits to Eligible Employees who become Participants in the Plan.

I.02 Purpose.

a. Tax Treatment

This Plan is intended to qualify as an employer-provided medical reimbursement plan under Internal Revenue Code ("Code") Sections 105 and 106 and regulations issued thereunder, and as a "health reimbursement arrangement" or "HRA" as defined under Internal Revenue Service (IRS) Notice 2002-45. The Plan will be interpreted at all times to accomplish that objective. Amounts reimbursed under the Plan are intended to be eligible for exclusion from Plan participants' gross income under Code Section 105(b).

ARTICLE II DEFINITIONS

When used in this Plan, the following words and phrases shall have the following meanings:

II.01 Carrot

Carrot Fertility, Inc., (or its successor) and its affiliates and subsidiaries.

II.02 Claims Administrator.

The entity designated by the Employer to administer claims under Section V.03 of this Plan.

II.03 Claimant.

An individual who makes a claim for reimbursement in accordance with Section V.03 of this Plan.

II.04 COBRA.

The Consolidated Omnibus Budget Reconciliation Act of 1985, and Treasury Regulations and guidance issued thereunder, as amended.

II.05 Code.

The Internal Revenue Code of 1986 as amended, and Treasury Regulations and guidance issued thereunder, as amended.

II.06 Covered Infertility Care Expense.

A medical expense that is incurred by a Participant or Qualified Beneficiary, or their eligible spouse or domestic partner, for infertility-related care for the purpose of overcoming an inability to have children that is listed in Appendix A to the Plan.

II.07 Effective Date of Plan.

March 1, 2023.

II.08 Eligible Employee.

An Eligible Employee is an employee of the Employer who is a UC Resident or Clinical Fellow and who is enrolled in a UC Resident and Clinical Fellow medical plan. A UC Medical Resident or Clinical Fellow here means an individual who is enrolled in a University Graduate Medical Education (GME) training program and works at least 20 hours a week.

Eligible Employees may submit expenses for reimbursement on behalf of their eligible dependents. Eligible dependents are limited to legal spouses and domestic partners.

II.09 Employer.

The University of California.

II.10 HIPAA.

The Health Insurance Portability and Accountability Act of 1996, as amended.

II.11 HRA.

A health reimbursement arrangement as defined in IRS Notice 2002-45, and related IRS guidance.

II.12 Participant.

An Eligible Employee who has met the eligibility requirements under Section III.01 and commenced participation in the Plan under Section III.02. A Qualified Beneficiary shall also be treated as a Participant for purposes of payment of benefits under Article V, but only to the extent required under COBRA.

II.13 Period of Coverage.

March 1, 2023 – December 31, 2023. Any period subsequent to 2023 is a Period of Coverage and shall constitute a 12-month period beginning on Jan 1.

II.14 Plan.

The University of California Residents and Fellows Infertility Health Reimbursement Arrangement (HRA) Plan, as set forth herein, and any modification, amendment, extension or renewal thereof.

II.15 Plan Administrator.

The President of the University shall serve as the Plan Administrator of the Plan, except to the extent the duties of the Plan Administrator are delegated to the UC Medical Residents and Fellows Benefits Program,

and notwithstanding that certain administrative functions for the Plan may be delegated to another entity or individual.

II.16 Plan Sponsor.

The Employer.

II.17 Qualified Beneficiary.

Qualified Beneficiary means a Participant in the Plan, or a Participant's spouse or domestic partner who was covered under this Plan on the day before a qualifying event that provides such individual an opportunity to continue Plan coverage under COBRA, provided such individual (a) elects COBRA coverage under the Plan and timely pays the applicable COBRA premium, and (b) elects COBRA coverage under an employer-sponsored group health plan that meets the requirements of Treasury Regulation §54.9815-2711(d)(2)(ii) and timely pays the applicable COBRA premium for such coverage.

II.18 Regents.

Regents and The Regents of the University of California, a public corporation and agency of the State of California and the constitutional trustee of the public trust known as the University of California.]

II.19 University

University means the University of California, a public trust and public corporation of the State of California.

ARTICLE III ELIGIBILITY AND PARTICIPATION

III.01 Eligibility for Participation.

Only an Eligible Employee or a Qualified Beneficiary, as defined in Article II, may participate in the Plan. Any person who does not meet the definition of an Eligible Employee or a Qualified Beneficiary will not be entitled to any benefits under the Plan.

III.02 Commencement of Participation.

For Periods of Coverage beginning on and after the Effective Date, an Eligible Employee will become a Participant in the Plan as of the first date on which the Eligible Employee submits a request for reimbursement for Covered Infertility Care Expenses during the applicable Period of Coverage.

III.03 Termination of Participation.

Except for continuation coverage as may be provided under section V.08 of the Plan, coverage under the Plan will terminate upon the earlier of:

a. The effective date of termination of the Plan;

b. The date on which a Participant ceases to be an Eligible Employee or the individual ceases to be a Qualified Beneficiary; or

c. The date on which a Participant has received reimbursements for Covered Infertility Care Expenses for themselves and their eligible spouse or partner that, together with amounts reimbursed to the Participant for adoption, surrogacy, or other benefits, if any, meets the lifetime maximum.

In addition to the above listed events, an eligible spouse or partner will cease to be covered under the Plan when (1) they fail to be covered under the Employer's major medical plan, (2) for a spouse, the date of divorce, legal separation, or marriage annulment or (3) for a partner, when the partnership ends.

III.04 Participation Following Termination of Employment.

If an Eligible Employee who is an employee of the Employer permanently terminates his or her employment and then is rehired by the Employer and again becomes a Participant in the Plan, the Lifetime Maximum Benefit for such Participant will be reduced by all amounts previously reimbursed under the Plan and any family forming benefits offered by the Employer.

ARTICLE IV FUNDING

IV.01 Participant Contributions.

Participant contributions to the Plan are not permitted except as provided in section V.08 in relation to COBRA coverage.

IV.02 Employer Funding.

All benefits under the Plan will be paid by Employer.

IV.03 No Funding under Cafeteria Plan.

Under no circumstances will benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits) or otherwise under a cafeteria plan.

IV.04 Funding of the Plan.

All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no requirement for a trust to be established under the Plan.

ARTICLE V BENEFITS

V.01 Benefits Eligibility.

a. Except as provided in Section V.01(b), a Participant shall be eligible to receive reimbursement of Covered Infertility Care Expenses for themselves or on behalf of their eligible spouse or domestic partner incurred on and after the Effective Date until the Participant's participation in the Plan terminates under Section III.03. An expense is incurred at the time the care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the service.

b. For each Period of Coverage, a Participant who is enrolled a high-deductible health plan within the meaning of Code section 223(c)(2) with a health savings account within the meaning of Code section 223(d) shall be eligible to receive reimbursement of Covered Infertility Care Expenses incurred on and after the date the Participant has incurred medical expenses within the definition of Code section 213(d) in excess of the applicable IRS minimum deductible under Code section 223(c)(2), as adjusted annually.

c. A Qualified Beneficiary shall be eligible to receive reimbursement of Covered Infertility Care Expenses as provided under COBRA.

V.02 Benefits Limit.

The Plan will reimburse Covered Infertility Care Expenses up to the Maximum Benefit(s) amount described below. No other benefit is provided under the Plan.

a. Maximum Benefit.

The lifetime benefit maximum is $30,000.00 (this is the total benefit amount available to reimburse eligible expenses incurred by the Eligible Employee and/or their eligible spouse or domestic partner, as applicable). The maximum benefit payable for Covered Infertility Care Expenses in any Period of Coverage shall be reduced by the amount reimbursed to the Participant for adoption, surrogacy, or other benefits, if any, in the same Period of Coverage, subject to the lifetime maximum.

b. Period of Coverage.

Only expenses incurred by a Participant (for themselves or for their eligible spouse or domestic partner) during a Period of Coverage will be eligible for reimbursement.

c. Changes.

The Maximum Benefit for future Periods of Coverage may be changed by the Employer and shall be communicated to employees.

d. Nondiscrimination.

Reimbursements to highly compensated individuals may be limited or treated as taxable compensation by the Employer to comply with Code §105(h).

V.03 Claims for Reimbursement.

As of the Effective Date, the Plan Administrator has designated Carrot as the Claims Administrator and delegated to the Claims Administrator responsibility for the adjudication and processing of Participant reimbursement claims.

a. Eligible Expenses.

To receive a reimbursement under the Plan, a Participant or Qualified Beneficiary or their eligible spouse or partner must incur an expense that qualifies for reimbursement, i.e. a Covered Infertility Care Expense.

b. Manner of Claim.

A claim for reimbursement shall be made by the Participant or Qualified Beneficiary, or his or her authorized representative ("Claimant"), by uploading a paid statement or superbill from a qualifying provider approved by Carrot via the platform established, or by such other method determined, from time to time, by the Claims Administrator.

c. Time Period for Filing Claims.

Participants shall have until 90 days following the end of each Period of Coverage to submit requests for reimbursement of eligible Covered Infertility Care Expenses incurred in the previous Period of Coverage.

d. Claims Substantiation.

In addition to any other requirements, a claim must set forth:

1. the name of the individual(s) for whom a Covered Infertility Care Expense was incurred;
2. the nature and date of the Covered Infertility Care Expense incurred;
3. the amount of the requested reimbursement; and
4. a statement that such Covered Infertility Care Expense has not otherwise been reimbursed and is not reimbursable through any other source and that Claimant will not request reimbursement from any other source.

e. Denied Claims.

Sections V.04, V.05 and V.06, below, apply to denied claims.

f. Reimbursements After Termination.

No Covered Infertility Care Expense incurred after participation in the Plan terminates shall be reimbursed. A Participant (or the Participant's estate) may submit a claim for reimbursement of any Covered Infertility Care Expense incurred during the Period of Coverage immediately prior to termination of participation, by 30 days after the Participant's termination.

V.04 Claims Review and Payment of Benefits.

a. Timing of Claims Review.

1. Within thirty (30) days after receipt by the Claims Administrator of a claim for reimbursement of any Covered Infertility Care Expense, the Claims Administrator will notify the Claimant of its determination of the claim. The 30-day time period may be extended for an additional fifteen (15) days for matters beyond the control of the Claims Administrator, including in cases where a claim is incomplete. The Claims Administrator will provide written notice of any extension, including the reasons for the extension.

2. If the claim does not include substantially all of the information required, or otherwise fails to follow the Plan's procedures for filing claims, the Claims Administrator shall notify the Claimant (or the Claimant's authorized representative) within thirty (30) days of the informational or procedural deficiency and how it may be cured. The Claimant shall be given forty-five (45) days to provide the necessary information.

b. Payment of Benefits.

Reimbursement of approved claims will be paid by automated clearing house ("ACH") payment pursuant to the claims processing schedule agreed to by the Employer and the Claims Administrator.

V.05 Notice of Denied Claims.

Any denial of a claim shall be provided in writing and shall include:

a. The specific reason(s) for the denial;

b. References to the Plan provisions on which the denial was based;

c. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

d. The Plan's appeal procedures and the time limits applicable to such procedures;

e. If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, 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 denying the claim and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; and

f. If the denial is based on 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 circumstances, or a statement that such explanation will be provided free of charge upon request.

V.06 Appeal Procedures.

Claims Administrator's Determinations. The Claims Administrator has discretionary authority to determine all claims and appeals. The Claims Administrator's determinations shall be final and binding on all persons.

a. Timing of Filing an Appeal.

A Claimant whose claim is denied, in whole or in part, must file a written request for review (appeal) with the Claims Administrator within one hundred eighty (180) days after the receipt of written notice of such denial from the Claims Administrator. If a request for review is not made within the above-referenced timeframe, all rights to an appeal and to file suit in court will be permanently forfeited.

b. Review by Claims Administrator.

The following procedures shall apply to the review of the appeal:

1. The Claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the claim;
2. The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits (other than privileged documents);
3. The review shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such comments, documents, records, and other information were submitted or considered in the initial benefit determination;
4. The review shall not afford deference to the initial claim denial and shall be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual;
5. In deciding an appeal that is based in whole or in part on a medical judgment, the Claims Administrator shall consult with an independent health care professional that is qualified in the areas of dispute and was not involved in the initial claim denial; and
6. The Claims Administrator shall, upon request, provide for the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

c. Timing of Notice of Decision on Appeal.

If a Claimant appeals, the Claims Administrator shall transmit its written decision of the appeal to the Claimant within sixty (60) days of its receipt of the request for review.

d. Notice of Denial of Appeal.

A notice of an adverse determination on review (denied appeal) shall set forth, in a manner calculated to be understood by the Claimant (or the Claimant's authorized representative):

1. The specific reason(s) for the adverse determination;
2. Reference to the Plan provisions on which the adverse determination is based;
3. A statement that the Claimant (or the Claimant's authorized representative) is entitled to receive without charge reasonable access to any document (a) relied on in making the determination, (b) submitted, considered or generated in the course of making the benefit determination, (c) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied appeal without regard to whether the statement was relied on;

4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit 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 criterion will be provided free of charge to the Claimant upon request;

5. If the adverse determination is based on experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's circumstances, or a statement that this will be provided without charge on request; and

6. A statement describing the Claimant's right to bring a civil action, including notice of the Plan's limitations period for bringing a civil action.

e. Limitations Period.

Notwithstanding any other provision of the Plan, a civil action related to a claim for benefits must be filed within one year from the date on which the Claims Administrator provides notice that the Claimant's appeal has been denied, regardless of any state or federal statutes establishing provisions relating to limitations of actions.

V.07 COBRA.

An Eligible Employee who participates in this Plan, and any spouse or domestic partner of an Eligible Employee who participates in this Plan, who is a "qualified beneficiary" within the meaning of COBRA, and whose coverage terminates under the Plan because of a "qualifying event" within the meaning of COBRA, shall be given the opportunity to continue the Plan coverage that he or she had on the day before the qualifying event for the periods prescribed by COBRA, only if the Qualified Beneficiary elects COBRA, subject to all conditions and limitations under COBRA. However, in the event that such coverage is modified for all similarly-situated non-COBRA Participants prior to the date continuation coverage is elected, such a Qualified Beneficiary shall be eligible to continue the same coverage that is provided to similarly-situated non-COBRA Participants. A premium for continuation coverage shall be charged to the Qualified Beneficiary in such amounts and shall be payable at such times as are established by the Plan Administrator and permitted by COBRA. The Plan Administrator shall determine the COBRA premium annually. The twelve-month determination period begins each January 1 (the calendar year).

ARTICLE VI PLAN ADMINISTRATION

VI.01 Plan Administration.

The President of the Employer is the Plan Administrator and may delegate any duty or power to another entity or individual. The Plan shall be administered for the exclusive benefit of persons entitled to participate in the Plan.

VI.02 Duties of Plan Administrator.

Unless delegated to another person or entity, the Plan Administrator has the duty and full power to administer this Plan.

a. General Powers and Duties.

Except as delegated to the Claims Administrator, the Plan Administrator shall have full and sole discretionary authority to determine all questions concerning the administration, interpretation, and application of the Plan, including full and sole discretionary authority to determine eligibility for benefits and to construe the terms of the Plan. Any such determination by the Plan Administrator made in exercise of its discretionary authority shall be conclusive and binding upon all persons. The discretionary power of the Plan Administrator shall be exercised in a non-discriminatory manner with regard to all similarly situated Eligible Employees or Participants. The Plan Administrator shall be deemed to have properly exercised its authority unless it has abused its discretion hereunder by acting arbitrarily or capriciously.

b. Specific Duties.

The powers and duties of the Plan Administrator include, but are not limited to, the following:

1. To adopt such procedures and regulations as are necessary for the proper and efficient administration of the Plan and consistent with the terms and purposes of the Plan;
2. To request and receive from all Eligible Employees such information as the Plan Administrator will from time to time determine to be necessary for the proper administration of the Plan;
3. To maintain all necessary records for the administration of the Plan; and
4. To comply with any applicable statutory or regulatory requirement under local, state or federal law to disclose or report information about the Plan, Participants, Eligible Employees, or the Employer, and to disclose such information subject to any legal enforcement activity or subpoena.

c. Claims Administration.

As of the Effective Date, the Plan Administrator has delegated to the Claims Administrator responsibility for the adjudication and processing of Participant claims and appeals, limited to the power and duty to:

1. make any determination as to what constitutes a Covered Infertility Care Expense;
2. authorize the payments of benefits;
3. prescribe procedures to be followed and the forms to be used to claim reimbursements pursuant to this Plan; and
4. review claims or claim denials under the Plan.

d. Payment of Expenses of Administering the Plan.

All reasonable expenses incurred in administering the Plan are paid by the Employer.

VI.03 Corrections.

a. General Rule.

Amounts paid in error belong to the Plan. The Plan Administrator may require an increase or decrease in any benefits or may collect previously paid benefits if, after payment has commenced, any error in any pertinent information or any mistake in payment is discovered.

b. Lien.

The Plan possesses a lien on any amounts paid but not owed under the terms of the Plan in the amount of the overpayment plus interest. The lien is enforceable regardless of the reason for the mistake in payment or the fault or knowledge of the person in possession of the mistakenly paid amount. Any person in receipt of an amount paid but not owed under the Plan has an obligation to immediately notify the Plan Administrator of the overpayment and to promptly return the overpaid amount to the Plan. The lien shall remain in effect until the Plan is repaid in full.

c. Corrective Action.

The Plan Administrator may, on behalf of the Plan, take whatever action is necessary to enforce the Plan's lien on any overpayments. The Plan Administrator has sole discretion to choose the methods for enforcing the Plan's lien. These methods include, without limitation, the Plan's recoupment of the overpayment from future benefit payments and a court action seeking imposition of a constructive trust and disgorgement of the overpaid amount plus interest, or any other claim under applicable law.

d. Mistake of Fact.

Any mistake of fact or misstatement of fact, other than benefits paid in error, shall be corrected when it becomes known and proper adjustment shall be made. The Employer and Claims Administrator shall not be liable in any manner for any determination of fact made in good faith.

VI.04 Inability to Locate Payee.

If the Plan Administrator is unable to make payment to any person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such person will be forfeited following a reasonable time after the date any such payment first became due.

VI.05 Appointment of Advisors.

The Plan Administrator may engage the service of advisers, professionals and other persons to help it carry out its responsibilities.

VI.06 Allocation of Responsibility.

Except to the extent required by law, no party acting (or declining to act) shall have any liability for a breach of duty of another party with respect to the Plan.

ARTICLE VII PROTECTED HEALTH INFORMATION

VII.01 Definitions.

Whenever used in this Article, the following terms shall have the respective meanings set forth below. All capitalized terms used but not otherwise defined in this Article VII shall have the same meaning as those terms have under HIPAA and the HITECH Act, including the regulations implementing the privacy and security rules of HIPAA and the HITECH Act.

a. "Health Information" means information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined in 45 CFR § 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined in 45 CFR § 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

b. "Protected Health Information" ("PHI") means Health Information, including demographic information, that is (1) transmitted or maintained in any form or medium, (2) collected from an individual and created or received by a health care provider, health plan, employer, or health care clearinghouse, and (3) identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved. PHI includes electronic PHI ("ePHI") described in 45 CFR §160.103.

c. "Summary Health Information" means Health Information that summarizes the claims history, expenses, or types of claims by individuals for whom the Plan provides benefits, and from which the following information has been removed:

1. names;
2. geographic information more specific than state;
3. all elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);
4. other identifying numbers, characteristics, or code, including, not limited to, Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, Internet Protocol address, or serial numbers;
5. facial photographs or biometric identifiers (e.g., fingerprints); and
6. any information of which the Plan Sponsor has actual knowledge that could be used alone or in combination with other information to identify an individual.

VII.02 Disclosure of Summary Health Information.

Except as prohibited by 45 CFR §164.502(a)(5)(i), the Plan may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan. Plan sponsor shall only use the Summary Health Information for the purposes specified in this Section VII.02.

VII.03 Disclosure of Enrollment Information and PHI.

The Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan. The Plan will disclose PHI to the Plan Sponsor only in accordance with 45 CFR § 164.504(f) and the provisions of this Article.

VII.04 Certification.

This Article shall constitute certification by the Plan Sponsor that this Plan includes the provisions required under 45 CFR § 164.504(f).

VII.05 Plan Sponsor Obligations

With respect to PHI, the Plan Sponsor agrees to:

a. Not use or disclose PHI other than as permitted or required by the Plan document or as required by law;

b. Ensure that any agents to whom the Plan Sponsor provides PHI received from the Plan Administrator agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

c. Not to use or disclose PHI for employment-related actions and decisions unless authorized by the Participant;

d. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the Participant;

e. Report to the Plan any PHI use or disclosure of information that is inconsistent with the uses or disclosures in this Article of which it becomes aware;

f. Make PHI available to the Participant in accordance with 45 CFR § 164.524;

g. Make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;

h. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

i. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining the Plan's compliance with 45 CFR Part 164;

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

k. Ensure that adequate separation between the Plan and the Plan Sponsor, as required by this Article and by 45 CFR § 164.504(f)(2)(iii), is established and maintained.

VII.06 Plan Sponsor's Access to PHI.

Adequate separation will be maintained between the Plan and the Plan Sponsor. Therefore, in accordance with HIPAA, only the Plan Administrator may be given access to PHI, and such person or entity may use and disclose PHI only for Plan administration functions that the Plan Sponsor performs.

VII.07 Noncompliance.

If the persons described herein or any other employees do not comply with the Plan document, the Plan Sponsor shall provide an effective mechanism for resolving issues of noncompliance, including disciplinary sanctions, in accordance with Plan Administrator policies. The Plan Sponsor shall cooperate with the Plan Administrator to correct and mitigate any such noncompliance.

VII.08 Security of Electronic PHI.

The Plan Sponsor will reasonably and appropriately safeguard electronic PHI ("ePHI") created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the Plan. Specifically, the Plan Sponsor will:

a. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

b. Ensure that the adequate separation between the Plan and Plan Sponsor, as required by this Article and by 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

c. Ensure that any agent to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the ePHI; and

d. Report to the Plan any security incident concerning ePHI of which it becomes aware.

ARTICLE VIII AMENDMENT AND TERMINATION

VIII.01 Amendment.

The Employer may amend all or any part of this Plan at any time for any reason.

VIII.02 Termination.

The Employer reserves the right to terminate or partially terminate the Plan, or discontinue Employer contributions to the Plan at any time. Nothing in the Plan is intended to or will be construed to entitle any Eligible Employee or other person to vested or non-terminable benefits.

VIII.03 Effective Date of Amendment or Termination.

Any such amendment, discontinuance or termination will be effective as of the date the Employer determines.

VIII.04 Limitation of Obligations.

The Employer shall provide all benefits accrued by Eligible Employees under the Plan through its termination. No reimbursements shall be made for Covered Infertility Care Expenses incurred after the effective date of the Plan's termination.

ARTICLE IX MISCELLANEOUS

IX.01 Limitation of Rights.

Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits under the Plan, shall be construed as giving to any Participant or other person any legal or equitable right against the Plan Sponsor, the Employer, the Plan Administrator, the Claims Administrator or the Plan, except as specifically provided in the documents setting forth the Plan.

IX.02 Restriction on Alienation.

The interests of persons entitled to benefits under the Plan are not subject to their debts or other obligations and, except as may be required by the tax withholding provisions of the Code or any state's income tax act, may not be voluntarily or involuntarily sold, transferred, alienated, assigned, or encumbered.

IX.03 Facility of Payment.

When any person entitled to benefits under the Plan is disabled or is in any way incapacitated so as to be unable to manage his/her affairs, the Plan Administrator may cause such person's benefits to be paid to such person's legal representative for his/her benefit, or to be applied for the benefit of such person in any other manner that the Plan Administrator determines appropriate.

IX.04 Termination of Coverage.

Coverage under the Plan may be terminated due to fraud or an intentional misrepresentation of material fact, or because the Participant knowingly provided the Plan Administrator or Claims Administrator with false information. Upon 30 days written notice, the Employer has the right to terminate coverage in such circumstances and to seek reimbursement of all expenses paid by the Plan.

IX.05 No Employment Contract.

This Plan is not an employment contract. Any employment rights of an Eligible Employee are neither enlarged nor diminished by the establishment of the Plan.

IX.06 Severability.

If any provision of the Plan is declared invalid or unenforceable by a court or agency of competent jurisdiction, such stricken provision shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

IX.07 Plan Provisions Control.

If any term or provision of any summary or description of this Plan is, in any construction, interpreted as being in conflict with a provision of this Plan, as set forth in this document, the provision of this Plan shall control.

IX.08 Notice.

Any notice to be delivered to a Participant or Qualified Beneficiary under this Plan shall be given in writing and delivered, personally or by first-class mail, postage prepaid, addressed to the Participant at his or her last known address. Any communication addressed to such Participant at the last known address shall be binding upon the Participant for all purposes of the Plan. Notwithstanding the foregoing, a Participant may be provided any notice required under this Plan via electronic delivery.

IX.09 No Guarantee of Tax Consequences.

Neither the Employer nor the Claims Administrator make any commitment or guarantee that any amounts paid to or for the benefit of a Participant or Qualified Beneficiary under this Plan will be excludable from their gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant or Qualified Beneficiary to determine whether each payment under this Plan is excludable from their gross income for federal, state, and local income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Qualified Beneficiary is includable in their gross income for federal, state or local income tax purposes, then under no circumstances will the recipient have any recourse against the Employer, the Plan Administrator or the Claims Administrator with respect to any increased taxes or other losses or damages suffered by the Participant or Qualified Beneficiary as a result thereof.

IX.10 Gender/Number.

Whenever any words are used in this Plan in the masculine gender, they should be construed as though they were also used in the feminine gender in all situations where they would so apply; wherever any words are used in this Plan in the singular form, they should be construed as though they were also used in the plural form in all situations where they would so apply, and vice versa.

IX.11 Applicable Laws.

Except to the extent superseded by the laws of the United States, this Plan and all rights and duties thereunder shall be governed, construed, and administered in accordance with the laws of the State of California.

IX.12 Forum Selection.

Any court action must be brought in the U.S. District Court of the Northern District of California.

IX.13 Headings.

The headings and subheadings of this Plan have been inserted for convenience of reference only and are to be ignored in any construction of the provisions hereof.

IX.14 No Waiver of Terms.

No term, condition or provision of the Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of the Plan except by written agreement of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

CERTIFICATE OF EXECUTION

To record the establishment of the Plan the Employer's authorized representative hereby executes this document on this date: _____.

By: _____

Title: _____

Date: _____

APPENDIX A. COVERED INFERTILITY CARE EXPENSES

- Covered Infertility Care Expenses include procedures and services to overcome an inability to have children as indicated by a medical diagnosis of infertility, or to address other medical necessity
- Covered Infertility Care Expenses must be recommended and supervised by an eligible provider, subject to the mandatory provisions used by Carrot (such provisions, as applied to fertility clinics included within Carrot's standard offering as of the Effective Date, are as set forth below):
    - Reports to Center for Disease Control and Prevention (CDC) and/or Society for Assisted Reproductive Technology (SART)
    - Have a Medical Director, or practicing staff physician, with Subspecialty Board Certification in Reproductive Endocrinology and Infertility by The American Board of Obstetrics and Gynecology (ABOG) or a physician who meets grandfathered REI criteria set by American Society for Reproductive Medicine (ASRM)
    - Laboratory is appropriately accredited through either the College of American Pathologists (CAP) or The Joint Commission (TJC)
    - Laboratory director must be an Embryology Laboratory Director (ELD), or a High-complexity Clinical Laboratory Director (HCLD)); for ELDs or HCLD's being credentialed today, both of which require either an MD or a PhD
- Examples of covered treatments include but are not limited to:
    - Fertility consultations
    - Semen analysis
    - Fertility preservation for males and females
    - Genetic testing related to fertility (e.g., PGT-A, PGT-M)
    - Intrauterine insemination
    - In vitro fertilization
    - Transportation of reproductive material with an approved vendor
    - Storage costs for eggs, sperm, and/or embryos
    - Fertility medications
    - Acupuncture (only when recommended by an eligible provider)
- The following treatments are examples of care that is not covered:
    - Fertility-related treatments under the care of primary care providers or OB/GYNs
    - Herbal treatments
    - Nutrition counseling
    - General genetic tests
    - Physical therapy or fitness-related expenses