University of California

Residents and Fellows

INFERTILITY HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN

SUMMARY PLAN DESCRIPTION

EFFECTIVE March 1, 2023

I. INTRODUCTION

The University of California ("University of California") has established the University of California Infertility Health Reimbursement Arrangement (HRA) Plan ("Plan"), a group health plan, for the benefit of its eligible employees. This Summary Plan Description ("SPD") briefly describes the basic features of the Plan, the eligibility rules, the expenses that qualify for reimbursement, and other important information concerning the Plan. This is followed by the Claims and Appeals Procedures, a general notice of COBRA Continuation Coverage Rights, and the Plan's Notice of Privacy Practices.

There is also a written Plan document that serves as the formal Plan rules, a copy of which you may obtain upon request. In the event there is a conflict between this SPD and the Plan document, the Plan document will control. You should direct any questions you have to UC Residents.

II. DEFINITIONS

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

Claims Administrator. The entity designated by the Employer to administer claims. Carrot Fertility, Inc. is the Plan's Claims Administrator.

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

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

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 C to the Plan.

Effective Date. March 1, 2023.

Eligible Employee. An Employee of the Employer who is enrolled in an employer-sponsored medical plan, whether sponsored by Employer or their spouse's employer.

Employer. The University of California.

Participant. An individual who is an Eligible Employee who commences participation in the Plan.

Period of Coverage. March 1, 2023 - December 31, 2023. Any subsequent Period of Coverage is each 12-month period beginning on Jan 1.

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

Plan Administrator. The President of the University, notwithstanding that certain administrative functions for the Plan may be delegated to another entity or individual.

Plan Sponsor. The Employer.

Qualified Beneficiary. A Participant in the Plan, or a Participant's spouse or domestic partner who was covered under the 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 a group health plan sponsored by the Employer that meets the requirements of Treasury Regulation §54.9815-2711(d)(2)(ii) and timely pays the applicable COBRA premium for such coverage.

III. PLAN INFORMATION

A. Plan Sponsor and Plan Administrator

The Plan is sponsored by the University of California, which also serves as the Plan Administrator. The Plan Administrator administers the Plan and has full and sole discretionary authority to administer the Plan, to interpret all Plan provisions and to determine all issues arising under the Plan, including issues of eligibility, coverage and benefits. The decision of the Plan Administrator on any construction, interpretation, or administration shall be final, conclusive, and binding on all persons having an interest in or under the Plan.

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, and such delegation includes discretionary authority unless that authority is specifically limited in the delegation. The Plan Administrator has delegated to the Claims Administrator responsibility for the adjudication and processing of Participant claims and appeals.

You may contact the Plan Administrator for any further information about the Plan at:

The Regents of the University of California
1111 Franklin Street, Oakland, CA 94607, US
Phone: +1 (510) 987-0784
Federal ID: 94-3067788

The Plan Administrator is the Plan's agent for service of legal process.

B. Eligibility and Participation

Only Eligible Employees and Qualified Beneficiaries may participate in the Plan. 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. 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.

If you are a Participant, you and your spouse or domestic partner must provide the Plan Administrator, or the Claims Administrator, if applicable, with any information reasonably requested for the administration

of the Plan. You and your spouse or domestic partner must notify the Plan Administrator if you divorce or terminate your partnership.

C. Cost of Coverage

Except with respect to COBRA, the Plan Sponsor pays the cost of coverage under the Plan. All reasonable expenses incurred in administering the Plan are paid by the Employer.

D. Termination of Participation

Except for continuation coverage as may be provided under COBRA, participation in the Plan terminates upon the earlier of:

a. The effective date of termination of the Plan;
b. The date on which a Participant is no longer an Eligible Employee; 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.

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.

E. Funding

All benefits under the Plan will be paid by UC Residents from its general assets. Participant contributions to the Plan are not permitted, except with respect to COBRA coverage.

F. Plan Benefits

A Participant who is not concurrently enrolled in a high-deductible health plan ("HDHP") within the meaning of Code section 223(c)(2) with a health savings account ("HSA") within the meaning of Code section 223(d) is eligible to receive reimbursement of Covered Infertility Care Expenses incurred on and after the Effective Date of the Plan until the Participant's participation in the Plan terminates, subject to a maximum lifetime limit of $30,000.00.

A Participant who is concurrently enrolled in a HDHP with an HSA is 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, subject to a maximum lifetime limit of $30,000.00.

A Qualified Beneficiary is eligible to receive reimbursement of Covered Infertility Care Expenses as provided under COBRA.
The maximum benefit payable for Covered Infertility Expenses in any Period of Coverage shall be reduced by all amounts previously reimbursed under the Plan and any other Carrot benefit reimbursements.

NOTE: If you terminate your employment and then are rehired and again become a Participant in the Plan, the lifetime maximum benefit for you will be reduced by all amounts previously reimbursed under the Plan and any other Carrot benefit reimbursements.

The limits on benefits under the Plan may be changed by UC Residents and any changes will be communicated to Eligible Employees.

Additional details about the benefits provided under the Plan are available at get-carrot.com.

G. Circumstances that May Limit, Terminate, or Reduce Benefits

The Claims Administrators and the Plan Administrator have the right to repayment if they overpay a claim for any reason or pay a claim in error and may offset other Plan benefits to recover the overpayment amount as permitted under applicable law. Benefits may be limited, reduced or terminated in the case of an Eligible Employee's fraud or intentional misrepresentation, or as required to comply with legal requirements applicable to the Plan.

H. Corrections

If you are overpaid benefits from the Plan, you are obligated to immediately notify the Plan Administrator of the overpayment and return the overpaid amount to the Plan. The Plan Administrator has the right to increase or decrease any benefits or collect previously paid benefits if, after payment was made, an error in pertinent information or a mistake in payment is discovered. 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, and has the authority to take whatever action is necessary to enforce the Plan's lien on the overpayment.

I. Indemnification

If you receive one or more payments or reimbursements in connection with the Plan that appeared to be, but are not, reimbursable under the Plan, you must indemnify and reimburse the Employer for any liability the Employer incurs for failure to withhold income or Social Security tax from those payments or reimbursements. However, any such indemnification and reimbursement will not be greater than the following: the additional income tax that you would have owed if the payments or reimbursements had been made to you as regular cash compensation, plus your share of any Social Security tax that would have been paid on that compensation, less any such additional income and Social Security tax actually paid by you.

J. Amendment and Termination; Reservation of Rights

UC Residents, in its sole discretion, may amend or terminate all or any part of the Plan. Any Covered Infertility Care Expenses incurred after the effective date of the Plan's termination will not be reimbursed under the Plan.

IV. CLAIMS

A. Claims Processing

The Claims Administrator is the Plan's named fiduciary for claims and appeals. The Claims Administrator has full and sole discretionary authority to determine all claims and appeals and decisions of the Claims Administrator are conclusive and binding. Carrot is the Plan's Claims Administrator and is responsible for the adjudication and processing of Participant reimbursement claims.

Only Covered Infertility Care Expenses will be reimbursed under the Plan. To receive a reimbursement under the Plan for a Covered Infertility Care Expense, you must upload a paid statement or superbill from a qualifying provider approved by Carrot via the Carrot online platform. Claims must be filed by 90 days following the end of each Period of Coverage to receive reimbursement of eligible Covered Infertility Care Expenses incurred in the previous Period of Coverage, unless the Participant terminates employment prior to the end of a Period of Coverage (and he or she only has until 30 days following their termination date to submit eligible claims for reimbursement). 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.

No reimbursements will be made for Covered Infertility Care Expenses incurred after participation in the Plan terminates. A Participant may submit a claim for reimbursement of any Covered Infertility Care Expense incurred during the Period of Coverage immediately prior to termination of participation in the Plan, within 30 days after the Participant's termination.

Claims for reimbursement must include:

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 you will not request reimbursement from any other source.

You are entitled to notification of the decision on your claim within 30 days after the Claims Administrator’s receipt of the claim. This 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Claims Administrator, including in cases where a claim is incomplete. The Claims Administrator will notify you of the need for the extension and the time by which you will receive a determination on your claim. If your claim does not include the required information or does not follow the Plan's procedures for filing claims, the Claims Administrator will notify you within 30 days of the informational or procedural deficiency and how it may be cured. You will be given 45 days after such notice to submit the additional information. If you do not submit the additional information, the Claims Administrator will make the decision based on the information that it has.

If your claim is approved, you will be paid by automated clearing house ("ACH") payment pursuant to the claims processing schedule agreed to by UC Residents and Carrot.

B. Denied Claims

If your claim is denied, the notice that you receive from the Claims Administrator will include the following information:

(a) The specific reason for the denial;
(b) A reference to the specific Plan provision(s) on which the denial is based;
(c) A description of any additional material or information necessary for you to perfect your 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 similar criteria was relied upon in denying the claim, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge 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 your circumstances, or a statement that such explanation will be provided free of charge upon request.

C. Appeal Procedures

You have the right to appeal the Claims Administrator's denial of your claim. Your appeal must be in writing, must be provided to the Claims Administrator, and must include the following information:

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

You should also include any documentation that you have not already provided to the Claims Administrator. Your appeal must be delivered to the Claims Administrator within 180 days after receiving the denial notice or the Claims Administrator's act or omission. If you do not file your appeal within this 180-day period, you lose your right to appeal.

At any time before the appeal deadline, you may submit copies of all relevant documents, records, written comments, and other information to the Claims Administrator. The Plan is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your appeal, the Claims Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

The appeal determination will not afford deference to the initial claim denial and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor a subordinate of that individual. If deciding an appeal that is based in whole or in part on a medical judgment, the Claims Administrator will consult with an independent health care professional that is qualified in the areas of dispute and was not involved in the initial claim denial. Upon

request, the Claims Administrator will provide the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, even if the advice was not relied upon in making the benefit determination.

You will receive notification of the decision on your appeal within 60 days after receipt of your request for review.

If your appeal is denied, the notice that you receive will include the following information:

(1) The specific reason for the denial upon review;
(2) A reference to the specific Plan provision(s) on which the denial is based;
(3) A statement providing that you are required to receive, upon request and free of 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 similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, or 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 to you free of charge 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 your circumstances, or a statement that this will be provided to you free of charge upon request; and
(6) A statement describing your right to bring a civil action under applicable law, including notice of the Plan's limitations period for bringing a civil action.

PLEASE NOTE: 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 your appeal has been denied, regardless of any state or federal statutes establishing provisions relating to limitations of actions. Any claim for benefits that you may have relating to or arising under the Plan may only be brought in the U.S. District Court for the Northern District of California. No other court is a proper venue or forum for your claim. The U.S. District Court for the Northern District of California will have personal jurisdiction over you and any other participant or beneficiary named in the action.

V. MISCELLANEOUS

A. Non-Discrimination Requirements

The Plan must comply with applicable non-discrimination requirements under Code section 105(h). If you are deemed to be a "highly compensated employee," reimbursements to you may be limited or treated as taxable compensation by UC Residents so that the Plan as a whole does not unfairly favor those who are highly paid. You will be notified of these limitations if you are affected.

B. Governing Law

The Plan is intended to comply with applicable provisions of the Code. This SPD shall be construed and reformed as necessary to meet these laws as applicable. Except as described in this document, no one may rely on any statement or representation that alters, modifies, amends, or is inconsistent with the written terms of the official governing plan document. This is true regardless of whether the statement or representation is oral, written, electronic, or otherwise.

The laws of the State of California shall apply to the Plan unless preempted by federal law.

C. COBRA

An Eligible Employee who participates in the Plan, and any spouse or domestic partner of an Eligible Employee who participates in the 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, will be given the opportunity to continue the Plan coverage that they had on the day before the qualifying event for the periods prescribed by COBRA, if the Qualified Beneficiary (i) elects COBRA coverage under this Plan and under a group health plan sponsored by the Employer that meets the requirements of Treasury Regulation §54.9815-2711(d)(2)(ii) and (ii) timely pays the applicable COBRA premium for such coverage. The Plan Administrator will determine the COBRA premium each year. See Appendix A for more information about COBRA.

D. No Employment Rights Conferred

Participation in the Plan does not give you the right to employment with UC Residents.

E. No Guarantee of Tax Consequences

Neither UC Residents 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 is the obligation of the 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.

VI. EXECUTION

This Plan has been established by: [counterpartySignerSignature_wtkcCSr] ,
dated [counterpartySignerDateField_9VKm03t] .

APPENDIX A – GENERAL NOTICE OF COBRA COVERAGE CONTINUATION RIGHTS THROUGH CARROT

Introduction
You're getting this notice because, by submitting a qualified medical expense through Carrot, you recently gained coverage under an infertility group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your partner, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This notice is based on the model COBRA general notice published by the U.S. Department of Labor and includes general information about COBRA for group health plans that typically provide a wider range of benefits than your Carrot group health plan.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and your partner when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact Carrot.

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

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You and your partner could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse or domestic partner of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse or domestic partner dies;
- Your spouse's or domestic partner's hours of employment are reduced;

- Your spouse's or domestic partner's employment ends for any reason other than his or her gross misconduct;
- Your spouse or domestic partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse or dissolve your domestic partnership.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse, or dissolution of the domestic partnership), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: cobra@get-carrot.com. This notice must include your full name, the name of your partner, and the type and date of the qualifying event.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their partners.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your eligible family members may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Notice of such disability must be provided to cobra@get-carrot.com and must include your full name, the name of the disabled individual, and the date of disability.

Second qualifying event extension of 18-month period of continuation coverage
If your partner experiences another qualifying event during the 18 months of COBRA continuation coverage, your partner can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension

may be available to your partner getting COBRA continuation coverage if you die or become entitled to Medicare benefits (under Part A, Part B, or both); or if you and your partner get divorced or legally separated. This extension is only available if the second qualifying event would have caused your partner to lose coverage under the Plan had the first qualifying event not occurred. Notice of a second qualifying event must be provided to cobra@get-carrot.com and must include your full name, the name of your partner, and the type and date of the second qualifying event.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your partner through the Health Insurance Marketplace, Medicare, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. Other coverage options that may be available through the Health Insurance Marketplace, Medicare, Medicaid, or other group health plan coverage options (such as a spouse's plan) may not provide the same types of benefits as COBRA coverage under Carrot. You can learn more about many of these options at **www.healthcare.gov**.[1]

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to cobra@get-carrot.com. For more information about your rights under COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes
To protect you and your partner's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
All inquiries regarding this Notice should be sent to cobra@get-carrot.com.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

APPENDIX B – NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.** This notice is effective as of March 1, 2023.

Summary

Your Rights
You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Plan Contact Information:
For any inquiries related to this Appendix B, please contact legal@get-carrot.com.

Details

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page B-1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.
- The complaint should generally be filed within 180 days of when the act or omission complained of occurred.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, and on our web site, or we will mail a copy to you.

APPENDIX C – 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