Rivian and Volkswagen Group Technologies, LLC

Progyny Fertility
Health Reimbursement Arrangement Plan
Summary Plan Description

This booklet, together with the separate benefit booklets provided to you by your employer that contain the specific details about your benefit coverages, constitute the Summary Plan Description for the Progyny Fertility Health Reimbursement Arrangement Plan. Please read this booklet carefully and keep it along with your separate benefit booklets for future reference. If you require further information or have any questions, we encourage you to contact the ***Benefits Office at https://rivianprod.service-now.com/guidepost***

Effective
01/01/2025

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Introduction

This booklet presents basic information about the health reimbursement arrangement ("HRA") benefit provided by your employer's Fertility Health Reimbursement Arrangement Plan (the "Plan"), as of 01/01/2025, and your rights to benefits as a plan participant. The Plan is maintained for the benefit of eligible employees and their eligible dependents, and the purpose of the Plan is to provide reimbursement for expenses for certain fertility services incurred by those individuals covered under the Plan.

This booklet and any separate benefit booklet(s) provided to you by your employer together constitute the Summary Plan Description for your HRA benefit under the Plan, which is intended to comply with the disclosure requirements set forth in regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA) of 1974. Please refer to the applicable separate benefit booklets for complete details on specific items such as benefit coverage, definitions, coordination of benefits, waiting periods, exclusions and limitations.

On page 6 of this booklet the official Plan disclosures are provided for the Plan along with the identity of the applicable Plan Sponsor, Plan Administrator, insurers and claims administrators (if any) and other important information specific to each of these benefits.

The Summary Plan Description is based on a number of legal documents that may include policies, contracts, collective bargaining agreements, plan documents and trust agreements. Although the Summary Plan Description is intended to be accurate, any differences between it and the legal documents will be governed by the legal documents.

Eligibility and Benefits

Requirements regarding eligibility for participation and the conditions pertaining to eligibility to receive benefits are generally described on the Member Guide. Information about the HRA benefit are generally described on the Member guide. Further requirements and conditions of eligibility and further information about your HRA benefit can be found in the separate benefits booklet(s) for the HRA.

Benefit Claims

A claim for benefits is a request for a Plan benefit or benefits, made by a covered employee/dependent or their representative that complies with the Plan's reasonable procedure for making benefit claims. A claim for benefits includes a request for a coverage determination, for pre-authorization or approval of a Plan benefit, or for a utilization review determination in accordance with the terms of the Plan. A claim for benefits should be filed with the applicable insurance carrier or third party administrator in accordance with the procedures set forth in the applicable benefits booklet issued by that insurance carrier or third party administrator and the Member Guide.

Appealing a Denied Claim

If you have any questions about a claim payment, contact the third party administrator. If you do not agree with the reason why your claim was denied, in whole or in part, you should write to the third party administrator that denied your claim. Please refer to Schedule A for a summary of applicable claim procedures and appeal processes.

Note that the Plan Administrator has full discretionary authority to control and manage the operation and administration of the Plan. For this purpose, the Plan Administrator's discretionary powers will include, but will not be limited to, interpretation of the Plan with respect to eligibility to participate, coverage and benefits under the Plan. The Plan Administrator may delegate this discretionary authority to a third-party administrator.

Any determination by the Plan Administrator, or any authorized delegate, shall be binding and final in the absence of clear and convincing evidence that the Plan Administrator or delegate acted arbitrarily and capriciously.

Loss of Benefits

Your employer is the Plan Sponsor and in its sole discretion, may at any time modify, amend or terminate the provisions, terms and conditions of the Plan without the consent of any participant or any beneficiary under the Plan. Any modification, amendment or termination of the Plan will be by a written instrument signed by an officer of the Plan Sponsor, or his or her authorized delegate, and delivered to the Plan Administrator. No vested rights of any nature are provided by the Plan.

Circumstances, if any, which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits are described in the Member Guide and in the separate benefit booklets.

NOTE: If you lose coverage under the Plan, contact the benefits office at the contact set forth front page to determine what arrangements, if any, may be made to continue your group coverage or to convert to any available individual coverage. Certain rights to continue health care coverage are outlined on page 7.

Sources of Plan Contributions

Contributions for certain coverages under the Plan shall be made solely by the participating employers.

Your Rights Under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA)

Receive Information About Your Plan and Benefits

ERISA provides that all plan participants shall be entitled 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.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operations 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 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.

Continue Group Health Plan Coverage

In certain instances, you will be entitled to continue health care coverage for yourself, spouse, domestic partner, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event (as described in further detail below, under "Continuation of Health Care Benefits – COBRA"). You or your dependents may have to pay for such coverage.

You should review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare 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 Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan

fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your 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 on the U.S. Department of Labor's website, or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

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Additional Documentation

The following documentation will be furnished without charge as a separate document by the Plan Administrator:

- upon request, a description of the Plan's procedures for Qualified Medical Child Support Orders;
- automatically, provider lists/directories for the applicable health provider networks utilized by the Plan; and
- automatically, claims procedures for HRA benefits to the extent such procedures change prior to the next revision of this Summary Plan Description.

Agent for Service of Legal Process

Legal process may be served on the Plan Administrator.

Important Information About Your Plan

Plan Name and Number	*Plan Sponsor & Identification Number*	*Plan Administrator & Agent for Legal Services*	*Plan Type, Administration & Plan Year End*	*Coverage Period End*	*TPA*
Health Reimbursement Arrangement Plan (PN **501**)	Rivian and Volkswagen Group Technologies, LLC 14600 Myford Rd. Irvine, CA 92606 EIN: 84-4942307	Rivian and Volkswagen Group Technologies, LLC 14600 Myford Rd. Irvine, CA 92606 888-748-4261	HRA **[Self-Insured]** December 31	Dec. 31	**Progyny, Inc.** **1359 Broadway, 2nd Fl** **New York, NY 10018** **833-205-3996**

Continuation of Health Care Benefits - COBRA

A Federal law known as "COBRA" requires that most employers sponsoring group health plans offer employees and their families ("qualified beneficiaries") the opportunity to elect and pay for a temporary extension of health coverage called "continuation coverage" at group rates in certain instances ("qualifying events") where coverage under the employer's Plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of that law. (Both you and your spouse should take time to read this notice carefully.)

If you are an employee covered by the Plan, you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). Your COBRA benefits under an HRA plan may operate differently from COBRA benefits under a group health plan offering health, dental and vision benefits. The Plan will administer COBRA in accordance with IRS Notice 2002-45. Please contact [the Plan Administrator/COBRA Administrator listed below] for further information.

If you are the spouse of an employee covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for any of the following four reasons:

(1) The death of your spouse;

(2) Your spouse's separation from employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the Employer;

(3) Divorce or legal separation from your spouse; or

(4) Your spouse becomes entitled to Medicare.

Rights similar to those described above may, in certain instances, apply to retirees, spouses and dependents if your employer is involved in a proceeding under Title 11, United States Code, and those individuals lose health coverage as a result of that proceeding.

Under the law, the employee or a family member has the responsibility to inform your employer of a divorce, legal separation or a child losing dependent status under the Health Plan within 60 days of the later of the date of such event or the date on which coverage would be lost because of such event. Failure to do so within the time limits will result in loss of eligibility for COBRA continuation. Your employer has the responsibility to notify the Plan Administrator of the employee's death, separation from employment, reduction in hours or Medicare entitlement.

If you lose coverage because of a qualifying event, you have at least 60 days from the date you lost coverage to inform your employer that you want to elect continuation coverage. If you do not elect continuation coverage on a timely basis, your Plan coverage will end. If you elect continuation coverage, your employer is required to permit you to elect and purchase coverage, which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members.

However, the law also provides that your continuation coverage may be cut short for any of the following five reasons:

(1) Your employer no longer provides Plan coverage to any of its employees; or

(2) The premium for continuation coverage is not paid on a timely basis.

You do not have to show that you are insurable to choose continuation coverage. However, as discussed above, you will have to pay all the required premiums for your continuation coverage.

Failure to pay any required premium on a timely basis will result in the permanent termination of continuation coverage.

Continuation coverage under COBRA is provided subject to the qualified beneficiary's eligibility for coverage. The Plan Administrator reserves the right to terminate your COBRA continuation coverage retroactively if you are determined to be ineligible.

If You Have Questions About COBRA
If you have questions about COBRA continuation coverage, you should contact the Benefits Office, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of any Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send the Plan Administrator.

Administration of COBRA/Contact Information
The Plan Administrator is responsible for administering COBRA. Notices that you are required to send to the Plan Administrator should be sent to isolved Benefit Services, at QBmail@isolvedhcm.com or 800-594-6957

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Continuation of Health Care Benefits -- USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA) provides for continuation of health care coverage for employees called for active duty military service. Except to the extent greater benefits are provided by your employer, the maximum length of extended coverage under USERRA is the lesser of:

• 24 months beginning on the date that the military leave begins; or
• A period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional 2% administration fee. If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the Veterans Administration) incurred as a result of the military service.

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Genetic Information Nondiscrimination Act of 2008 (GINA)

In addition, under the Genetic Information Nondiscrimination Act of 2008 (GINA), neither an insurance provider nor your employer may not discriminate against you on the basis of genetic information, including by adjusting premiums and contribution amounts.

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Summary of HIPAA Privacy Rights

A federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will require group health plans to protect the confidentiality of your private health information. The privacy and security provisions of HIPAA will apply to your employer's Health Reimbursement Arrangement Plan (Plan #5**01**).

The Plan and your employer, as plan sponsor of the Plan, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as otherwise permitted or required by applicable law. By law, the Plan will require all of their business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of your employer.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the applicable Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

To the extent required by applicable law, the Plan will maintain a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact the Benefits Office. If you have questions about the privacy of your health information, please contact the Benefits Office or your employer's designated privacy official.

SCHEDULE A
ERISA CLAIMS AND APPEAL PROCEDURES

ERISA Claims Procedures For Health Claims

Claims for Benefits

A claim for benefits is a request for a plan benefit or benefits, made by a covered employee/dependent or their representative, that complies with the plan's reasonable procedure for making benefit claims. A claim for benefits includes a request for a coverage determination, for pre-authorization or approval of a plan benefit, or for a utilization review determination in accordance with the terms of the plan.

Post-Service Claims

"Post-Service Claims" are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Plan Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Plan Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Plan Administrator will notify you of the denial within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

Pre-Service Claims

"Pre-Service Claims" are those claims that require notification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision (whether or not adverse) from the Plan Administrator within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 15 days of receipt of the pre-service claim. You will be given at least 45 days from the receipt of this notice to correct your claim.

The Plan Administrator will notify you of its determination within 15 days after the claim is received, unless the Plan administrator determines, in its discretion, that special circumstances require an extension of time for processing the claim. If an extension of time is required, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision shall be furnished to you prior to the end of the initial 15-day period. If the extension is necessary because of your failure to provide missing information and you are notified of that fact, the extension shall not exceed a period of 15 days beginning as of the earlier of (i) the date the missing information is received by the Plan Administrator or (ii) the end of the period afforded to you to provide the missing information. Otherwise, the extension shall not exceed 15 days from the end of the initial 15 day period.

If all of the needed information is received within the 45-day time frame, the Plan Administrator will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45 day period, your claim will be denied.

Urgent Claims That Require Immediate Action

"Urgent Care Claims" are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination (whether or not adverse) in writing or electronically as soon as possible, but not later than 72-hours after the Plan Administrator receives all necessary information, taking into account the seriousness of your condition.

If you filed an Urgent Care Claim improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Plan Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Plan Administrator's receipt of the requested information; or
- The end of the 48 hour period within which you were to provide the additional information, if the information is not received within that time.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided by the Plan Administrator within 24 hours of the receipt of your request, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the Plan Administrator reduces or terminates such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, the Plan Administrator shall notify you (sufficiently in advance of the termination or reduction to appeal the decision and obtain a determination upon review of the decision) before the course of treatment is reduced or terminated.

Notice of Adverse Benefit Determination

If a claim is wholly or partially denied, or if a rescission of coverage occurs (each, an "Adverse Benefit Determination") the Plan Administrator will furnish the Plan Participant with a written notice of the Adverse Benefit Determination. The written notice will contain the following information:

(a) the specific reason or reasons for the Adverse Benefit Determination;

(b) specific reference to those Plan provisions on which the Adverse Benefit Determination is based;

(c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary;

(d) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review;

(e) In the case of an Adverse Benefit Determination by the Plan:

- 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 Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request;

- 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 Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(f) In the case of an Adverse Benefit Determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims;

(g) In the case of an Adverse Benefit Determination, the Plan must:

- Ensure that any notice of Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and provide notice of the opportunity to request (i) the diagnosis code and its corresponding meaning, and (ii) the treatment code and its corresponding meaning);

- Ensure that the reason or reasons for the Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the group health plan's standard, if any, that was used in denying the claim;

- Provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

- Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

Appeals of Claim Denials

If you disagree with a claim determination after following the above steps, you can contact the Plan Administrator in writing to formally request an appeal. In your appeal, you may submit written comments, documents, records, and other information relating to your claim for benefits. You shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review of your claims shall take into account all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered in the initial benefit determination. With respect to a claim for benefits under a group health plan, the Plan will identify, upon request to the Plan Administrator, any medical experts whose advice was obtained on behalf of the Plan in connection with a your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of health care service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

You may appeal any denial of a claim within 180 days of receipt of such a denial by submitting a written request for review to the Plan Administrator.

The review of your appeal shall not afford deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. In deciding an appeal 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 and 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.

In the case of a claim involving urgent care, you are entitled to an expedited review process pursuant to which--

- You may submit a request for an expedited appeal of an adverse benefit determination orally or in writing; and
- All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Participant by telephone, facsimile, or other available similarly expeditious method.

The Plan must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give the claimant a reasonable opportunity to respond prior to that date.

Before the Plan can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give the claimant a reasonable opportunity to respond prior to that date.

Timing of Notification of Benefit Determination on Review

For purposes of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted below due to a Participant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the Participant until the date on which the Participant responds to the request for additional information.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You hereby consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Claims, see "Urgent Claim Appeals That Require Immediate Action" below.

If you are not satisfied with the first level appeal decision of the Plan Administrator, you have the right to request a second level appeal from the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days of the receipt of the first level appeal decision.

Please note that the Plan Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

Urgent Claim Appeals That Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Plan Administrator as soon as possible. The Plan Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

The Plan Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Plan Administrator's decisions are conclusive and binding. The Plan Administrator has final claims adjudication authority under the Plan.

Manner of Notification of Final Internal Adverse Benefit Determination

The Plan Administrator shall provide a Participant with written or electronic notification of a Plan's benefit determination on review. In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Participant:

(a) The specific reason or reasons for the Adverse Benefit Determination;

(b) Reference to the specific Plan provisions on which the Adverse Benefit Determination is based;

(c) A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;

(d) A statement describing any voluntary appeal procedures offered by the Plan and the Participant's right to obtain the information about such procedures;

(e) A statement of the Participant's right to bring an action under section 502(a) of the Act; and

(f) The following information --

- 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 rule, guideline, protocol, or other

similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Participant upon request;

- 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 Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(g) In the case of an Adverse Benefit Determination the Plan must:

- Ensure that any notice of Final Internal Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

- Ensure that the reason or reasons for the Final Internal Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the group health plan's standard, if any, that was used in denying the claim. This description must also include a discussion of the decision.

- Provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

- Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

External Review

In the case of an Adverse Benefit Determination, you may be entitled to request an independent, external review of our decision. If your situation is urgent, you may be entitled to an expedited external review.

More information about your external review rights, including the timeframe and procedure for requesting an external review, will be provided to you in the Notice of Final Internal Adverse Benefit Determination.