AILERON MANAGEMENT LLC WRAP PLAN

SUMMARY PLAN DESCRIPTION

January 1, 2026

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INTRODUCTION

Aileron Management, LLC (the "Company") established the **Aileron Management LLC Wrap Plan** (the "Plan") effective **January 1, 2023**. This summary describes the Plan and together with the incorporated documents, describes the benefits offered under the Plan (the "Included Benefits").

This Summary Plan Description ("SPD") supersedes any and all previous SPDs. Although the purpose of this document is to summarize the significant provisions of the Plan, the Plan document and Included Benefit documents will prevail in the event of any inconsistency.

ADMINISTRATIVE INFORMATION

General Plan Information

The Plan's name is **Aileron Management LLC Wrap Plan**
The Plan's number is **501**
The Plan Year is the 12 month period ending on **December 31**.

The Plan is an "employee welfare benefit plan" for purposes of ERISA that includes the benefits listed in the Included Benefits Appendix of this SPD to the extent those benefits are covered by ERISA.

Plan Sponsor

Aileron Management, LLC
100 W Washington St
Ste 300
Greenville, SC 29601
Phone: (864) 999-2300
Employer Identification Number: 83-1169497

Plan Administrator

Aileron Management, LLC
100 W Washington St
Ste 300
Greenville, SC 29601
Phone: (864) 999-2300

Claims administration for any Included Benefit may be facilitated by a third party. Contact information for the claims administrator of any benefit is available in the applicable Included Benefits document.

Agent for Service of Legal Process

Chief Executive Officer, Aileron Management, LLC
100 W Washington St
Ste 300
Greenville, SC, 29601
Phone: (864) 999-2300

Service of legal process may also be made upon the Plan Administrator.

Plan Funding

The Plan is not funded by a trust.

The cost of benefits offered under the Plan is either covered by contributions from the Company, contributions by you, or will be shared by you and the Company. Where you and the Company share the cost of coverage, the Company will contribute the difference between your premium and the amount required to pay benefits under the Plan.

Any dividends, retroactive rate adjustments, rebates, or other refunds of any type that may become payable under any Included Benefit or in connection with an Included Benefit do not become assets of the Plan but are the property of, and will be retained by, the Company.

ELIGIBILITY

Your eligibility for participation and for benefits under the Plan is described in the documents summarizing the Included Benefits. These documents are available from the Plan Administrator. See the Appendix to this Plan document for a list of the Included Benefits and their eligibility requirements.

The Company offers medical benefits (meaning any group health benefit that provides minimum essential coverage – usually a major medical plan) to Full-time Employees, their dependent children and/or spouses. Dependent children and spouses are defined in the separate subsidiary Contracts for medical benefits.

The Company uses the Look-Back Measurement Method to determine whether an employee is a Full-time Employee for purposes of medical benefits coverage under the Plan.

Look-Back Measurement Method

If as a new employee, the Company reasonably expects that you will work on average at least 30 hours per week or 130 hours per month, you will be offered medical benefits coverage under the Plan according to the standard eligibility and enrollment waiting periods set by the Plan, as detailed in the Included Benefit information.

If as a new employee, the Company either does not reasonably expect that you will work on average at least 30 hours per week or 130 hours per month, or if the Company cannot determine how many hours you will work at the time you are hired, you must first complete an Initial Measurement Period during which you are not eligible to enroll in medical benefits under the Plan. At the end of your Initial Measurement Period, if you are a Full-time Employee, you will be eligible for medical benefits under the Plan for the Stability Period according to the standard eligibility and enrollment waiting periods set by the Plan (as detailed in the Included Benefit information) once you have completed both the Measurement and Administrative Periods.

As an ongoing employee, the Company will determine whether you are a Full-time Employee by looking at your hours of service during the Standard Measurement Period. If you are a Full-time Employee during the Standard Measurement Period, you will be eligible for medical benefits under the Plan during the entire Stability Period, regardless of the your actual number of hours of service during the Stability Period, as long as you remain an employee of the Company during that time. Similarly, if you are not calculated to be a Full-time Employee during the Standard Measurement Period, you will not be eligible for medical benefits during the entire Stability Period.

The Company uses an Administrative Period to calculate whether an ongoing employee is a Full-time Employee and to offer coverage to those Full-time Employees during an open enrollment period.

The periods listed below apply to all Employees measured using a Look-Back Period:

Standard Measurement Period begins **November 1 and is 12 months** long
Administrative Period begins **November 1 and is 2 months** long
Stability Period begins **January 1 and is 12 months** long

If you had been enrolled in medical benefits coverage under the Plan at the time of termination of employment and you are subsequently rehired, you may re-enroll in the medical benefits under the Plan effective on your rehire date as long as you have not had a Break in Service and the Stability period (if one applies to you) that would apply on the date of your reemployment is the same Stability Period that was in effect when you left employment. If your reemployment date is during a new Stability Period, you can only re-enroll in the medical benefits on that date if, based on your Measurement Period, you are a Full-time Employee on your rehire date. If you had not satisfied any applicable waiting period prior to leaving employment, if you are rehired, your waiting period will be reduced by your prior period of employment.

A Break in Service is a period of 13 or more consecutive weeks in which you did no work for the Company. If you hadn't completed 13 weeks of work for the Company prior to leaving employment, a Break in Service is a period of four or more consecutive weeks during in which you did no work for the Company, as long as that period is longer than the period you did work

for the Company. If you are rehired after a Break in Service, you will become eligible to enroll in the medical benefits under the Plan as if you were a new employee.

PAYMENTS FROM THIRD PARTIES

The Plan has a specific and first right of reimbursement from any payment, amount, or recovery you receive from a third party relating to expenses covered by the Plan. By accepting the benefits of the Plan, you agree to these rights of the Plan, which are described in the Plan document. Below is a summary of these rights. If the reimbursement provisions in this "Payments from Third Parties" provisions conflict with subrogation, right of recovery, or reimbursement provisions in an insurance contract or other document governing the Included Benefit at issue, the provisions in the other document will govern.

The Plan's share of the recovery will not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to the reduction. Further, the Plan's right to reimbursement will not be affected or reduced by any equitable defenses that may affect the Plan's right to reimbursement.

The Plan may enforce its rights by requiring you to assert a claim to any of the benefits to which you may be entitled. The Plan will not pay your attorneys' fees or costs associated with the claim or lawsuit without express written authorization from the Company.

If the Plan should become aware that a Participant has received a third party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to the Participant and any covered dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of the Participant.

By participating in the Plan, you consent and agree:

- that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party.
- to cooperate with the Plan in reimbursing the Plan for costs and expenses.
- to notify the Plan if you have any reason to believe that the Plan may be entitled to recovery from any third party and to sign an agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle you payment, amount or recovery from a third party.
- to not assign your rights to settlement or recovery against a third person or party to any other party, including your attorney(s), without the Plan's consent.

If you fail or refuse to execute the required agreement, the Plan may deny payment of any benefits until the agreement is signed. Alternatively, if you fail or refuse to execute the required agreement and the Plan nevertheless pays benefits to you, your acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

The Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

These rights apply even after you are no longer a Participant in the Plan. The Plan Administrator has the authority and discretion to resolve all disputes regarding the Plan's subrogation and reimbursement rights and to make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

CONTINUATION RIGHTS

Continuation Rights Generally

In certain instances, you or your dependents may be entitled, under state or federal law, to continue some or all of your benefits under this Plan after termination of employment or during a qualified leave of absence. Contact the Company for more information.

Military Service

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

FMLA

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

COBRA

If you are participating in an Included Benefit subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) and the Company is not a small employer, then COBRA applies. A small employer is generally an employer that employs fewer than 20 employees, but you should contact the Plan Administrator who can inform you if the Company is a small employer not subject to COBRA and is not required to comply with these rules. Except as set forth in an Included Benefit document, the following shall apply only to the Included Benefits subject to COBRA:

A. Qualifying Events.

You have the right to continue your coverage under the Plan if any of the following events results in your loss of coverage under the Plan:

- termination of employment for any reason other than gross misconduct
- reduction in your hours of employment

Your spouse and dependent children (including children born to you or placed for adoption with you) have the right to continue coverage under the Plan if any of the

following events results in their loss of coverage under the Plan:

- termination of your employment for any reason other than gross misconduct
- reduction in your hours of employment
- you become enrolled in Medicare
- you and your spouse divorce or are legally separated
- your death
- your dependent ceases to be a dependent child for purposes of COBRA

Persons entitled to continue coverage under COBRA are called Qualified Beneficiaries. You will be provided notice of your right to elect COBRA continuation coverage. For certain health FSAs, if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available under the Plan for the remainder of the Plan Year, you, your spouse, and/or your dependent child(ren) generally do not have the right to elect COBRA continuation coverage.

B. Continuing Coverage.

You may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

C. Notice.

You, your spouse, or your dependent child(ren) must notify the Plan Administrator or its delegate in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days after the later of (1) the date of the Qualifying Event or (2) the date on which coverage is lost under the Plan because of the event. After receiving notice of a Qualifying Event, the Plan Administrator will provide Qualifying Beneficiaries with an election notice, which describes the right to COBRA continuation coverage and how to make an election. Notice to your spouse is deemed notice to your covered dependents that reside with the spouse.

You or your dependent(s) are responsible for notifying the Plan Administrator or its delegate if you or your dependent(s) become covered under another group health plan or entitled to Medicare.

D. Election Procedures and Deadlines.

A Qualified Beneficiary may make an election for COBRA continuation coverage if they are not covered under the Plan as a result of another Qualified Beneficiary's COBRA continuation election. To elect COBRA continuation coverage, you must complete the applicable election form within 60 days from the later of (1) the date the election notice was provided to you or (2) the date that the Qualified Beneficiary would otherwise lose coverage under the Plan due to the Qualifying Event and submit it to the Plan Administrator or its delegate. If the Qualified Beneficiary does not return the

election form within the 60-day period, it will be considered a waiver of his or her COBRA continuation coverage rights.

E. Cost of COBRA Continuation Coverage.
The cost of COBRA continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. For Qualified Beneficiaries receiving the 11-month disability extension of continuation coverage, the premium for those additional months may be increased to 150% of the applicable premium.

F. When Continuation Coverage Ends.
You may be able to continue coverage for up to 18, 29, or 36 months, depending on the circumstances of your qualifying event(s). If the coverage you elect is for a health FSA that meets certain requirements, you may only be able to continue coverage until the end of the Plan Year in which the Qualifying Event occurs. However, COBRA continuation coverage may end earlier for any of the following reasons:

- You fail to make a required COBRA continuation coverage contribution;
- The date that you first become covered under another Plan;
- The date that you first become entitled to Medicare; or
- The date the Employer no longer provides a Plan to any of its employees.

AMENDMENT AND TERMINATION

The Company intends to continue the Plan indefinitely, but reserves the right to amend or terminate the Plan or an Included Benefit, in whole or in part, at any time and for any reason. No participant or beneficiary has a vested right in or to any future Plan benefits.

INCLUDED BENEFIT DOCUMENTS INCORPORATED BY REFERENCE

This Plan incorporates the terms of all welfare benefit plans listed in the Appendix that are subject to ERISA and sponsored by Company and any affiliate who has adopted the Plan ("Included Benefits"). See the Appendix to this Summary Plan Description for a list of these Included Benefits. Certain documents describing these Included Benefits include information about eligibility, benefits, and employee/employer contributions for each of the separate Included Benefits, which are incorporated by reference into this summary plan description. These documents may include summary plan descriptions for the Included Benefits, as well as summary benefit booklets, certificates of coverage, enrollment materials, etc. These documents, together with this document, constitute the entire summary plan description for the Plan.

CLAIMS PROCEDURES

In General

Unless the applicable Included Benefit specifies claims procedures, the following procedures will apply. In all cases, the Plan Administrator or Claims Administrator will administer claims in accordance with Section 503 of ERISA and the associated regulations.

You must submit your claim for benefits in accordance with the Plan Administrator's guidelines. Claims may also be submitted to the Plan Administrator at the address specified at the beginning of this document.

Before you can file a lawsuit for benefits under the Plan, you must exhaust the Plan's internal remedies. A lawsuit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

A request for benefits is a "claim" subject to these procedures only if you (or your authorized representative) file the claim in accordance with these procedures. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under this section. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" for purposes of this section, unless the Plan Administrator determines that the inquiry is an attempt to file a claim. If the Plan Administrator or its delegate receives a claim, but there is not enough information to process the claim, you will be given an opportunity to provide the missing information.

You may designate an authorized representative by providing to the Plan Administrator with written notice of the designation. In the case of a claim for medical benefits involving urgent care, your health care professional with knowledge of your medical condition may act as your authorized representative.

Timing of Notice of Claim

The Plan Administrator will notify you of a claim denial within a reasonable period of time, but not later than the time frames below. The time frames will vary depending on the type of Included Benefit and may be extended for any period of time necessary for you to respond to a request for additional information.

Group Health Plan Claims

The following procedures apply to the Included Benefits that are "group health plans." These include any plan providing medical care, such as medical, dental, or health FSA plans, and some wellness or employee assistance programs.

A. Urgent Care Claims.

An "urgent care" claim is any claim for medical care or treatment where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If you fail to follow the Plan's procedures for filing an urgent care claim, the Plan Administrator will notify you of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than 24 hours following the failure. Notification may be oral, unless you request written notification. This paragraph applies only to a communication from you that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific individual, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the claim by the Plan. If you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify you of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified information, or (2) the end of the period given to you to provide the specified additional information.

B. Pre-Service Claims.

A "pre-service" claim is any claim where the Plan conditions receipt of the benefit on approval in advance of obtaining medical care. If you fail to follow the Plan's procedures for filing a pre-service claim, the Plan Administrator will notify you of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than 5 days following the failure. Notification may be oral, unless you request written notification. This paragraph applies only to a communication by you that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific individual, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Plan Administrator will notify you if its determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but no

later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan Administrator for up to an additional 15 days. The Plan Administrator may only extend the deadline if they determine both that such an extension is necessary due to matters beyond the control of the Plan and they notify you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

C. Post-Service Claims.

A post-service claim is any claim for a benefit under the plan that is not a pre-service claim. In the case of a post-service claim, the Plan Administrator will notify you of the Plan's adverse benefit determination within a reasonable period of time, but no later than 30 days after receipt of the claim. This period may be extended one time by the Plan Administrator for up to an additional 15 days. The Plan Administrator may only extend the deadline if they determine both that such an extension is necessary due to matters beyond the control of the Plan and they notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

D. Concurrent Care Claims.

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute claim denial. The Plan Administrator will notify you of the denial at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a review of that denial before the benefit is reduced or terminated.

Any request by you to extend the course of treatment beyond the period of time or number of treatments that is an urgent care claim will be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator will notify you of the denial, whether adverse or not, within 24 hours after the Plan receives the claim, provided that the claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

<u>Disability Benefit Claims</u>

The Plan Administrator will provide you with notice of an adverse benefits determination within 45 days after receipt of the claim. This period may be extended for up to 30 days, provided that

the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The period for making the determination may be extended for up to an additional 30 days if Plan Administrator notifies you prior to the expiration of the first 30-day extension period of the circumstances of the extension and the date by which the Plan expects to render a decision. Any notice extension under this section will explain the standards on which the entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded at least 45 days within which to provide the specified information.

Non-Group Health Plan and Non-Disability Benefit Claims

For all other claims not described above, the Plan Administrator will provide you with a notice of claim denial within 90 days after receipt of the claim. This period may be extended one time by the Plan Administrator for up to an additional 90 days. The Plan Administrator may only extend the deadline if they determine both that such an extension is necessary due to matters beyond the control of the Plan and they notify you of the extension prior to the expiration of the initial 90-day period.

Content of Notice of Adverse Benefit Determination

If your claim is denied, the Plan Administrator will provide you with a written notice identifying:

1. the reason(s) for the denial;
2. the Plan provisions on which the denial is based;
3. any material or information needed to grant the claim and an explanation of why the additional information is necessary; and
4. an explanation of the steps that you must take if you wish to appeal the denial.

In addition, if the denied claim is for a group health plan or disability benefit under the Plan, the following information will also be included in the written notice:

1. the specific rule, guideline, protocol, or other similar criterion, if any, that was relied upon in the denial; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or
2. 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 your medical circumstances, or a statement that the explanation will be provided free of charge to you upon request.

If the denied claim is for a disability benefit under the Plan, the following information will also be included in the written notice:

1. A discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination made by the Social Security Administration that was presented to the Plan.
2. 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 medical circumstances, or a statement that such explanation will be provided free of charge upon request.
3. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.
4. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for disability benefits.

In the case of a denied urgent care claim where the Included Benefit is a group health plan, the notice will include a description of the expedited review process applicable to such claims.

This information may be provided orally provided that a written or electronic notification is furnished to you not later than 3 days after the oral notification.

Appeal of Adverse Benefit Determination

You may appeal the denial of a claim by filing a written appeal with the Plan Administrator on or before the 60th day after you receive the Plan Administrator's written notice that the claim has been denied. If the denial involves a claim under an Included Benefit that is a group health plan or disability plan, you may file a written appeal on or before the 180th day after you receive written notice of the denial.

If the denial involves a claim for disability benefits, a denial includes a cancellation or discontinuance of coverage that has retroactive effect (unless it is due to your failure to pay required premiums).

Your written appeal must identify both the grounds and specific Plan provisions upon which the appeal is based. You will lose the right to appeal if your appeal is not timely made.

The Plan will provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefit. You may submit written comments, documents, records, and other information relating to the claim for benefits. The Plan will take into account all comments, documents, records, and other information you submit relating to the claim, without regard to whether such information was submitted or considered in the initial claim. The Plan Administrator will consider the merits of your written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant.

If the claim is for group health plan or disability plan benefits the following will apply:

1. The review will not afford deference to the initial claim denial. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the denial that is the subject of the appeal, nor the subordinate of that individual.
2. In deciding an appeal of any denial that is based on a medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the claim denial that is the subject of the appeal, nor the subordinate of any such individual.
3. The Plan will identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether the advice was relied upon in the denial.
4. In the case of an urgent care claim, the Plan will expedite review of the claim and you may submit a request for an expedited appeal of a denial orally or in writing. All necessary information, including the Plan's benefit determination on review, will be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious method.

If the claim is for disability benefits under the Plan, the following will apply:

1. Before the Plan issues any adverse benefit determination, the Plan Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan) in connection with the claim, and any new or additional rationale must be provided to you as soon as possible and sufficiently in advance of the date on which the Plan must provide you with the notice of final adverse benefit determination so that you have a reasonable opportunity to respond prior to that date.

2. If the determination is based on a new or additional rationale, you will 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 adverse benefit

determination is required to be provided to give you a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it in time for you to have a reasonable opportunity to respond, the Plan's deadline for providing a notice of final adverse benefit determination will be delayed until you have had reasonable opportunity to respond. After you respond, or had a reasonable opportunity to respond but failed to do so, the Plan Administrator will notify you of the Plan's benefit determination as soon as a Plan acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.

The Plan Administrator will ordinarily rule on an appeal of a claim denial for any non-group health plan or disability benefit within 60 days following receipt of the claimant's request for review by the Plan. The time frame will begin at the time your appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. However, if special circumstances require an extension and the Plan Administrator furnishes you with a written extension notice during the initial period, the Plan Administrator may extend this period of time by 60 days if written notice of the extension is furnished to you prior to the termination of the initial 60-day period. In the event that the extension is due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review will start on the date that you respond to the request for additional information. If the claim is for disability benefits, the 60-day initial period and extension period referred to in this paragraph shall be shortened to 45 days.

If the claim is for group health plan or disability benefits, the Plan Administrator will notify you of the Plan's benefit determination on review as follows:

1. *Urgent Care Claims*: The Plan Administrator will notify you of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination by the Plan.
2. *Pre-Service Claims:* The Plan Administrator will notify you of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt by the Plan of your request for review of an adverse benefit determination.
3. *Post-Service Claims:* The Plan Administrator will notify you of the Plan's benefit determination on review within a reasonable period of time, but no later than 60 days after receipt by the Plan of your request for review of an adverse benefit determination.

All claims and appeals involving disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with

respect to any individual (such as a claims adjudicator or medical expert) will be made based upon the likelihood that the individual will support the denial of benefits.

Denial of Appeal

If an appeal is wholly or partially denied, the Plan Administrator will provide you with a notice that includes all of the information contained in the earlier Section, *Content of Notice of Adverse Benefit Determination*, as well as a statement describing your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. You will also be notified of your right to bring an action under section 502(a) of ERISA.

In the case of a group health plan or a plan providing disability benefits, the notice will also include a statement that you and your Plan may have other voluntary alternative dispute resolution options, such as mediation, and information about contacting your local U.S. Department of Labor Office and your State insurance regulatory agency. For disability benefit claims, you will be notified of any applicable contractual limitations period that applies to your right to bring an action under section 502(a) of ERISA, including the calendar date that the contractual limitations period expires for the claim.

The determination rendered by the Plan Administrator will be binding upon all parties. You must exhaust all internal remedies before you may file a claim or lawsuit in court.

REFUNDS/INDEMNIFICATION

You must immediately repay any excess payments/reimbursements. You must reimburse the Company for any liability the Company may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may to the extent permitted by applicable law, offset your salary or wages, and/or offset other benefits payable under this Plan.

YOUR RIGHTS UNDER ERISA

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

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements (if applicable), updated summary plan descriptions, and, for a Plan covering 100 or more participants, copies of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.

For Plans covering 100 or more employee participants, receive a summary of the Plan's annual financial report. The Plan Administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.

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

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of 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.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and

responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

SPECIAL ENROLLMENT RIGHTS

To the extent required by the portability provisions of the Health Insurance Portability and Accountability Act (HIPAA), if you are declining enrollment for yourself or your dependents (including your spouse) in a group health plan benefit under this Plan because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. If you or your dependents become ineligible for Medicaid or a state child health program (CHIP) or become eligible for premium assistance under Medicaid or a state child health program (CHIP), you must request enrollment within 60 days. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within the time period specified by the Company. Such enrollment, in the case of a birth, adoption, or placement for adoption, may be made retroactive to the date of the event if such request is made within 30 days after the birth, adoption, or placement for adoption.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

To the extent required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this Plan provides coverage for all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the Plan or coverage. Written notice of the availability of such coverage shall be delivered to Participants upon enrollment and annually thereafter. Contact the Plan Administrator for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

LOSS OF BENEFIT

You may lose all or part of any payment due to you if we cannot locate you when your benefit becomes payable to you.

NON-ALIENATION

You may not alienate, anticipate, commute, pledge, encumber, or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

PLAN ADMINISTRATOR DISCRETION

The Plan Administrator has the discretionary authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation, or application of the Plan by the Plan Administrator is final, conclusive, and binding on all parties.

INCLUDED BENEFITS APPENDIX

Your Standard Eligibility Requirements apply to all Included Benefits unless otherwise indicated in the chart below, and are as follows: To be eligible for insurance benefits, employees need to work at least 30 hours per week. The waiting period for insurance benefits is the first of the month following 30 days of employment.

Eligibility information relating to medical coverage offered under this Plan is further specified in the section of this SPD titled, “Eligibility.”

Provider	Type of Benefit	Employer Contributions	Eligibility
Hooray Health	Major Medical	See Human Resources for Cost Information	See 'Standard Eligibility Requirements' set forth above
Gravie	Major Medical	See Human Resources for Cost Information	See 'Standard Eligibility Requirements' set forth above
Guardian	Dental	See Human Resources for Cost Information	See 'Standard Eligibility Requirements' set forth above
Guardian	Vision	None, Employee pays 100%	See 'Standard Eligibility Requirements' set forth above
Guardian	Short-Term Disability	None, Employee pays 100%	See 'Standard Eligibility Requirements' set forth above
Guardian	Long-Term Disability	Employer pays 100%	See 'Standard Eligibility Requirements' set forth above
Guardian	Life/AD&D	Employer pays 100%	See 'Standard Eligibility Requirements' set forth above
Guardian	Life Insurance	None, Employee pays 100%	See 'Standard Eligibility Requirements' set forth above
WEX	Health Flexible Spending Account (FSA)	None, Employee pays 100%	See 'Standard Eligibility Requirements' set forth above

Risk Solutions Insurance Company	Stop-Loss	Employer pays 100%	See 'Standard Eligibility Requirements' set forth above
Guardian	Accident / Critical Illness	None, Employee pays 100%	See 'Standard Eligibility Requirements' set forth above
Guardian	Hospital Indemnity	See Human Resources for Cost Information	Automatically available to employees enrolled in Hooray Health Major Medical plan; to those not enrolled in Hooray Health Major Medical plan, this is a voluntary benefit. To be eligible for insurance benefits, employees need to work at least 30 hours per week. The waiting period for insurance benefits is the first of the month following 30 days of employment.