This SPD is approved by employer for use as the final form of the SPD.

By: _____ **Date:** _____

AJE Holdings, LLC
MEC Medical Option

GRAVIE
ADMINISTRATIVE SERVICES

January 2023

Questions?	**Gravie Administrative Services Customer Service staff is available to answer questions about *your* coverage Monday through Friday from 8AM to 5PM Central Time.** **Customer Service: 866.863.6232** **When contacting Customer Service, please have *your* identification card available. If *your* questions involve a bill, we will need to know the date of service, type of service, the name of the *provider* and the charges involved.**
Telephone Numbers for Utilization Management Vendor for Pre-certification and Pre-Service/Concurrent Care ***Claims***	**Monday through Friday 7 AM to 7 PM Central Time** **Customer Service 855.451.8365** **Magellan 800.424.0472**
Website	**Gravie member website:** https://member.gravie.com **Aetna provider network directory:** www.Aetna.com/asa **Magellan formulary list:** https://magellan.adaptiverx.com/webSearch/index?key=cnhmbGV4LnBsYW4uUGxhblBkZlR5cGUtNjU
Mailing Address	***Claims*, appeal requests, pre-certification, and written inquiries should be mailed to:** **Customer Service Department** **Gravie Administrative Services** **P.O. Box 211543** **Eagan, MN 55121**
Prescription Drugs **Magellan Rx**	**Telephone: 800.424.0472** **Website: www.Magellanrx.com**

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I. Rights of *Covered Persons*

The *Plan*, as defined in Section II. *Your* Employer *(Plan Administrator)*, includes one or more health *benefit* options, which may have different eligibility requirements and/or *benefits*. If a different *Summary Plan Description (SPD), SPD* option, provision or amendment applies to certain *benefit* options or classifications of individuals eligible under the *Plan*, *you* will be furnished a copy of the *SPD, SPD* option, provision or amendment that is applicable to *you*. This *SPD* applies only to the MEC Medical Option and the eligible employees enrolled for participation in this option of the *Plan*.

As a participant in the *Plan*, *you* have certain rights and protections under the Employee Retirement Income Security Act of 1974 (*ERISA*), as amended.

ERISA provides that all *Plan* participants shall be entitled to:

Receive Information about this *Plan* and Its *Benefits*

- Examine, without charge, at the *Plan Administrator's* office and at other specified locations, such as work sites, all documents governing the *Plan*, including insurance contracts, 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 (EBSA).
- Obtain, upon written request to the *Plan Administrator*, copies of documents governing the operation of the *Plan*, including insurance contract and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The *Plan Administrator* may make a reasonable charge for the copies.
- Receive a summary of the *Plan* annual financial report. The *Plan Administrator* is required by law to furnish *you* with a copy of the summary.

Continue Group Health Plan Coverage

- Continue health care coverage for *yourself* and/or *covered dependents* if there is a loss of coverage under the *Plan* as a result of a qualifying event. *You* may have to pay for such coverage. Review this *Summary Plan Description* and the documents governing the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce *Your* Rights

If *your claim* for *benefits* under the *Plan* is denied or ignored, in whole or in part, within certain time schedules *you* have a right to:

- Know why this was done;
- Obtain copies of documents relating to this decision without charge; and
- Appeal any denial.

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 calendar days, *you* may file suit in a Federal court within two years of *your* request.

In such 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* under the *Plan* that is denied or ignored, in whole or in part, *you* may file suit in a state or Federal court, within two years of the *claim* denial, (if any), or if there is no *claim* denial within two years of the date of service. In addition, if *you* disagree with the *Plan Administrator'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, within two years of the date of such order. 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 Federal court, within two years of the date of such event. 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 costs and fees. If *you* lose, the court may order *you* to pay these costs and fees, for example, if it finds *your* claim 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 (EBSA), U.S. Department of Labor, listed in *your* telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), 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 (EBSA).

Your Rights and Responsibilities

You have the following rights and responsibilities:

1. A right to receive information about Gravie Administrative Services, its services, its *participating providers* and *your member* rights and responsibilities.
2. A right to be treated with respect and recognition of *your* dignity and right to privacy.
3. A right to available and accessible services.
4. A right to be informed of *your* health problems and to receive information regarding treatment alternatives and risks that are sufficient to assure informed choice.
5. A right to participate with *providers* in making decisions about *your* health care.
6. A right to a candid discussion of appropriate or *medically necessary preventive health care services,* regardless of cost or benefit coverage.
7. A right to refuse treatment.
8. A right to privacy of medical, dental, and financial records maintained by *your plan administrator* and its *participating providers* in accordance with existing law.
9. A right to voice complaints and/or appeals about *your plan administrator's* policies and procedures or care provided by *participating providers*.
10. A right to file a complaint with Gravie Administrative Services and the United States Department of Labor's Employee Benefits Security Administration and to initiate a legal proceeding when experiencing a problem with Gravie Administrative Services or its *participating providers*.

    For information, contact the United States Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) /www.dol.gov/ebsa/healthreform.
11. A right to make recommendations regarding member rights and responsibilities policies.
12. A responsibility to supply information (to the extent possible) that *participating providers* need in order to provide care.
13. A responsibility to supply information (to the extent possible) that *your plan administrator* requires for health plan processes such as enrollment, claims payment and benefit management, and providing access to care.
14. A responsibility to understand *your* health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
15. A responsibility to follow plans and instructions for care that *you* have agreed on with *your providers*.
16. A responsibility to advise *your plan administrator* of any discounts or financial arrangements between *you* and a *provider* or manufacturer for *health care services* that alter the charges *you* pay.

II. *Your* Employer (*Plan Administrator*)

Your Employer, which also serves as the *Plan Sponsor* and the *Plan Administrator*, has established an employee welfare benefit plan (the *Plan*) to provide health care *benefits*. This *Plan* is "self-insured" which means that the *Plan Sponsor* pays the claims from its own assets for *covered services*. The MEC Medical Option of this *Plan* is described in this *Summary Plan Description (SPD)*, which is part of the official document of the *Plan*. *Your* Employer has contracted with *Gravie* to provide claim processing, pre-certification and other administrative services. However, *your* Employer is solely responsible for payment of *your* eligible claims.

The *Plan Administrator* in its sole discretion shall, to the fullest extent permitted by law, determine appropriate courses of action in light of the reason and purpose for which this *Plan* is established and maintained. The *Plan Administrator* has, to the fullest extent permitted by law, the exclusive and final discretionary authority to revise the method of accounting for the *Plan*, establish rules, and prescribe any forms required for administration of the *Plan*. All determinations and decisions made by or on behalf of the *Plan Administrator* will be final and binding on the *Plan*, all persons covered by the *Plan*, all persons or entities requesting payment or a *claim* for *benefits* under the *Plan* and all interested parties, to the fullest extent permitted by law. The *Plan Administrator* retains all fiduciary responsibilities with respect to the *Plan*, has the exclusive and final binding discretionary authority to interpret and administer the *Plan*, resolve any ambiguities that exist and make all factual determinations, to the fullest extent permitted by law, except to the extent the *Plan Administrator* has expressly delegated to other individuals or entities one or more fiduciary responsibilities with respect to the *Plan*.

The *Plan Sponsor*, by action of its governing body or an authorized officer or committee, reserves the right to change or terminate the *Plan*. The decision to change the *Plan* may be due to changes in federal laws governing welfare benefits, or for any other reason. The *Plan* may be changed to transfer the *Plan's* liabilities to another plan or split this *Plan* into two or more parts.

The *Plan Administrator* has the power to delegate specific duties and responsibilities. Any reference in the *SPD* to the *Plan Administrator* is also a reference to its delegated designee. Any delegation by the *Plan Administrator* may allow further delegations by such individuals or entities to whom the delegation has been made. The *Plan Administrator* may rescind any delegation at any time. Each person or entity to whom a duty or responsibility has been delegated, shall be responsible for only those duties or responsibilities and shall not be responsible for any act or failure to act of any other individual or entity.

III. Gravie Administrative Services (*Gravie, TPA*)

Gravie, as an external administrator referred to as a *third party administrator (TPA)*, provides certain administrative services, including claim processing services, subrogation, utilization management, and complaint resolution assistance.

IV. Introduction to *Your* Coverage

A. *Summary Plan Description (SPD)*

This *Summary Plan Description (SPD)* is *your* description of the MEC Medical Option of the *Plan Sponsor's Plan*. **Please read this entire *SPD* carefully. Many of its provisions are interrelated; so reading just one or two provisions may give *you* incomplete information regarding *your* rights and responsibilities under the *Plan***. The *SPD* describes the *Plan's benefits* and limitations for *your* health care coverage. Included in this *SPD* is a *Benefit* Schedule that states the amount payable for the *covered services*. *Benefits* are not covered for excluded services and exclusions include, but are not limited to, *health care services* that are not *medically necessary* as determined by the *Plan Administrator*. Be sure to review the list of exclusions as well as the *Benefit* Schedule. A *provider* recommendation or performance of a service, even if it is the only service available for *your* particular condition, does not mean it is a *covered service*. *Benefits* are not available for *medically necessary* services, unless such services are also *covered services*. ***Benefits* are limited to the most cost effective and *medically necessary* alternative**. The *Plan Administrator* has, to the fullest extent permitted by law, the sole, final, and exclusive discretion to determine *benefits* available under the *Plan*.

Italicized words used in this *SPD* have special meanings and are defined at the back of this *SPD*. *You* should keep *your SPD* in a safe place for *your* future reference. Amendments that are included with this *SPD* or adopted by the *Plan Sponsor* are fully made a part of this *SPD.*

This *SPD* is intended to comply with the Employee Retirement Income Security Act of 1974 (*ERISA*), as amended. This *Plan* is maintained exclusively for *you*. *Your* rights under the *Plan* are legally enforceable.

B. Administrative Services Agreement

The signed Administrative Service Agreement between *your* Employer and the *TPA* constitutes the entire agreement between *your* Employer and the *TPA*. A version of the Administrative Service Agreement is available for inspection from *your* Employer.

C. Identification Cards

The *TPA* issues an identification (ID) card containing important coverage information. Please verify the information on the ID card and notify Customer Service if there are errors. If any ID card information is incorrect, *claims* for *benefits* under the *Plan* or bills and/or invoices for *your* health care may be delayed or temporarily denied. *You* will be asked to present *your* ID card whenever *you* receive services.

D. Designated Website or *Provider* Directory

You may find *participating providers* on the designated website listed on the inside cover of this *SPD*. Coverage may vary according to *your provider* selection.

The list of *participating providers* frequently changes and the *TPA* does not guarantee that a listed *provider* is a *participating provider*. *You* may want to verify that the *provider you* choose is a *participating provider* by calling Customer Service at the telephone number listed on the inside cover of this *SPD*. If you call Customer Service, the *TPA* will respond to *you* as soon as practicable but in no case later than 1 business day after *your* call is received, through a written electronic communication or, at *your* request, a hard copy communication. *Provider* directories are available to *you* upon request.

If *You* called Customer Service, or used an Internet-based provider directory made available by the *TPA* to confirm that a *provider* was a *participating provider* before you received certain *health care services* from the *provider, but* the *provider* which furnished the *health care services* after *you* received such information was a *non-participating provider*:

Then the *Plan*:

(A) Shall not impose on *you* a cost-sharing amount (e.g. a *deductible* or *copaymen*t) for such *health care services* furnished by the *non-participating provider* that is greater than the cost-sharing amount that would apply had such *health care services* been furnished by a *participating provider*; and

(B) Shall apply the out-of-pocket maximum that would apply if such *health care services* were furnished by a *participating provider*.

E. Conflict with Existing Law

If any provision of this *SPD* conflicts with any applicable law, only that provision is hereby amended to conform to the minimum requirements of the law.

F. Privacy

This *Plan* is subject to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule. In accordance with the HIPAA Privacy Rules, the *Plan* and the *TPA* acting on the *Plan's* behalf, maintains, uses, or discloses *your* Protected Health Information for purposes such as claims processing, utilization review, quality

assessment, case management and otherwise as necessary to administer the *Plan*. *You* can obtain a copy of the *Plan's* Notice of Privacy Practices (which summarizes the *Plan's* HIPAA Privacy Rule obligations, *your* HIPAA Privacy Rule rights and how the *Plan* may use or disclose health information protected by the HIPAA Privacy Rule) from the *Plan Administrator*.

G. Processing Delays, Fraud, Misrepresentation, Rescission and Right to Audit

If routine processing delays occur, those delays will not deprive *you* of coverage for which *you* are otherwise eligible, nor will they give *you* coverage under the *Plan* for which *you* are not eligible under the *Plan*. *You* will not be eligible for coverage beyond the scheduled termination of *your* coverage because of a failure to record or communicate the termination except where required by law. It is *your* responsibility to confirm the accuracy of statements made by the *Plan Administrator* or the *TPA*, in accordance with the terms of this *SPD* and other plan documents. *Your* coverage may not be retroactively terminated unless *you* request it or *you* (or someone acting on *your* behalf) falsifies information, submits fraudulent, altered or duplicate billings, allows another person not covered under the *Plan* to use *your* coverage, or performs an act or practice that constitutes fraud or intentional misrepresentation (including an omission) of material fact under the terms of the *Plan*. Notwithstanding, *you* may be terminated, including being retroactively terminated, due to *your* failure to timely pay *your* required *contributions,* if any.

For the purpose of managing *your* overall health status, health conditions and diseases; for care coordination and quality improvement purposes; for disease management purposes; for claim processing purposes; and for payment purposes, by enrolling in coverage *you* authorize: (1) the *Plan* to disclose *your* health information with health care *providers* and subcontractors of health care *providers* or of the *Plan* that provide services; and (2) such health care *providers* and subcontractors to disclose *your* health information to each other and to the *Plan*.

Determination of *your* coverage will be made at the time a *claim* is reviewed. In addition, the *Plan Administrator* may require *you* to furnish proof of *your* eligibility status and may, at reasonable times and upon reasonable notice, audit or have audited *your* records regarding eligibility, enrollment, termination, *contributions* and the coverage provided under the *Plan*. If the *Plan Administrator* determines that, after reasonable requests, *you* have failed to provide adequate records or sufficient proof of *your* eligibility status, the *Plan Administrator* may, in its sole discretion, rescind or terminate *your* coverage to the extent permitted by law.

H. Summary of Benefits and Coverage (SBC)

The SBC is an informational summary of *your benefits* and coverage under this *SPD,* including coverage examples, that is prepared in a uniform style. If there is a conflict between this *SPD* and the SBC, this *SPD* governs and the *TPA* will administer your coverage in accordance with this *SPD*.

I. Medical Equipment, Supplies and *Prescription Drugs*

Your coverage under this *SPD* does not guarantee that medical equipment, supplies or *prescription drugs* will continue to be covered, even if the equipment, supply or drug was covered previously in a *calendar year*.

J. *Essential Health Benefits* Benchmark

Employer acknowledges and agrees that, to the extent required by the *Affordable Care Act*, the *essential health benefits* of the Utah benchmark apply to the *Plan*.

K. Balance Billing

1) If you receive *emergency services* (for which benefits are provided under this *SPD*) because of an *emergency medical condition* with respect to a visit at an *emergency department of a hospital* or an *independent freestanding emergency department*, which is a *non-participating provider,* then such *non-participating provider* may not bill *you*, and may not hold *you* liable, for any amount for such *emergency services* which is more than the *copayment* requirement for such services by *participating provider*s under this *SPD*.

2) If a *non-participating provider* furnishes *health care services* other than *emergency services* (for which benefits are provided under this *SPD*) to *you* at a *hospital* or ambulatory surgical center, which is a *participating provider*, then:

    a) The *non-participating provider* may not bill *you*, and may not hold *you* liable, for any amount for such *health care services* furnished by such *non-participating provider* with respect to a visit at the *hospital* or ambulatory surgical center which is more than the *deductible* requirements for such services under this *SPD*; unless;

    b) The *health care services* are not *ancillary services* and the *non-participating provider* satisfies the notice and consent criteria in paragraph (c).

c) The *non-participating provider* provides to the *covered person*:

i. A written notice in paper or electronic form, as selected by *you*, that contains the following information:

- A statement that the *provider* is a *non-participating provider*;
- The good faith estimated amount that such *non-participating provider* may charge *you* for the *health care services* involved (and any other related *health care services* reasonably expected to be furnished by the *non-participating provider*), including notification that the provision of the estimate or consent does not constitute a contract with respect to the estimated charges or a contract that binds the *covered person* to be treated by the *hospital*, ambulatory surgical center, or *non-participating provider*;
- A statement that prior notification or other care management limitations may be required in advance of receiving such *health care services* at the *hospital* or ambulatory surgical center;
- A statement that consent to receive such *health care services* from such *non-participating provider* is optional and that the *covered person* may instead seek care from an available *participating provider* and in that event the cost-sharing responsibility of the *covered person* would not exceed the responsibility that would apply with respect to such *health care services* furnished by a *participating provider*.

ii. A consent form that must be signed by the *covered persons* before such *health care services* are furnished and that:

- Acknowledges that the *covered person* has been:
  - Provided with the written notice described in paragraph (i) of this subsection, in the form selected by the *covered person*; and
  - Informed that the payment of such charge by the *covered person* might not accrue toward meeting any limitation that *your* coverage places on cost sharing, including an explanation that such payment might not apply to an in-network *deductible* or *out-of-pocket maximum* applied under *your* coverage;
- States that by signing the consent form, the *covered person* agrees to be treated by the *non-participating provider* and understands the *covered person* may be balance billed and subject to cost sharing requirements that apply to *health care services* furnished by the *non-participating provider*; and
- Documents the time and date on which the *covered person* received the written notice described in paragraph (i) of this subsection and the time and date on which the *covered person* signed the consent form to be furnished such *health care services* by such *non-participating provider*.

The No Surprises Act prohibits balance billing in most circumstances. If you have questions regarding what constitutes a "Balance" bill, please contact Customer Service at the number listed on the inside cover of this *SPD*.

L. Continuity of Care

1) If you are a *continuing care patient* and:

   a) The *Plan Administrator's* contract with the *participating provider* that is providing *your* continuing care terminates for any reason other than the *participating provider*'s failure to meet applicable quality standards or fraud;

   b) *Your* benefits under this *SPD* for the *health care services* provided by the *participating provider* that is providing *your* continuing care terminate because of a change in the terms of the *Plan Administrator* contract with such *participating provider*.

2) Then:

   a) The *Plan Administrator* will notify *you* of the applicable event described in (1) and *your* right to elect continued transitional care from such *non-participating provider* (in the event of notice under (1)(A)) or such *participating provider* (in the event of notice under (1)(B));

   b) The *Plan Administrator* will provide *you* with an opportunity to notify the *Plan* of *your* need for transitional care; and

c) The *Plan Administrator* will allow *you* to elect to continue to have benefits for transitional care provided under this *SPD*, under the same terms and conditions as would have applied under this *SPD* had the applicable termination not occurred, as long as such benefits are for the course of treatment provided by such *non-participating provider* (in the event of notice under (1)(A)) or such *participating provider* (in the event of notice under (1)(B)) relating to *your* status as a *continuing care patient* during the period beginning on the date on which the notice in (2)(A) is provided and ending on the earlier of:

i. The 90-day period beginning on such date; or

ii. The date on which *you* are no longer a *continuing care patient* of such *non-participating provider* (in the event of notice under (1)(A)) or such *participating provider* (in the event of notice under (1)(B)).

M. Transition of Care

If a *covered person* is under the care of a *non-participating provider* at the time of joining the Plan, there are a limited number of medical conditions that may qualify for transition of care. If transitional care is appropriate, specific treatment by a *non-participating provider* may be covered at the *participating provider* level of benefits for a limited period of time. The *TPA* will review and approve or deny such requests.

N. Binding Arbitration

NOTE: The Employee is enrolled in a plan provided by the Employer that is subject to ERISA. Any dispute involving an Adverse Benefit Determination must be resolved under ERISA's claims procedure rules, and is not subject to mandatory binding arbitration. The individual may pursue voluntary binding arbitration after he or she has completed an appeal under ERISA. If the individual has any other dispute which does not involve an Adverse Benefit Determination, this Binding Arbitration provision applies.

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Participant and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Participant and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Participant.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Participant and the Plan Administrator, or by order of the court, if the Participant and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

O. Clerical Error/Delay

Any clerical error by the *Plan Administrator* or an agent of the *Plan Administrator* in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by *covered persons* due to such clerical error will be returned to the *covered person*; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to so remedy amounts owed may result in termination of coverage. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the *Plan*, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered. If, an overpayment occurs in a *Plan* reimbursement amount, the *Plan* retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a *covered person*, the amount of overpayment may be deducted from future benefits payable.

T. Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the *TPA* for this self-insured *Plan* is not cashed within one year of the date of issue, the check will be voided and the funds will be retained by this *Plan* and applied to the payment of current benefits and administrative fees under this *Plan*. In the event a *covered person* subsequently requests payment with respect to the voided check, the *Plan Sponsor* for the self-insured *Plan* shall make such payment under the terms and provisions of the *Plan* as in effect when the claim was originally processed.

V. Eligibility, Enrollment, and *Effective Date*

A. Eligibility

You are eligible to enroll for coverage if *you* are:

1. Classified by the *Plan Sponsor* as a full-time employee whose standard hours are a minimum of 32 hours per week.

2. An eligible dependent of the employee. An employee must enroll for coverage in order to enroll eligible dependents. If both parents are covered as employees, a child may be covered as a dependent of either parent, but not both.

Eligible dependents include a *covered employee's*:

1. Children, from birth through end of the month in which the child reaches age 26, including:
   a. Natural child;
   b. Child who is legally adopted by or placed with *covered employee* for legal adoption from the earlier of the adoption date or the date of placement for adoption. Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support;
   c. Stepchild;
   d. Child for whom *covered employee* is designated a foster parent by an authorized social services agency or by a court of law;
   e. Grandchild, if such child resided in the *covered employee's* home since the date of initial discharge from the *hospital* after birth and are dependent on *covered employee* for a majority of their financial support and the parent of the grandchild is also a *covered dependent*;
   f. Child for whom covered employee is the legal guardian appointed by a court of law;
   g. Child covered under a valid Qualified Medical Child Support Order (QMCSO), as defined under section 609 of the Employee Retirement Income Security Act (ERISA) and its implementing regulations, which is enforceable against an eligible employee or a covered employee. An eligible employee or a covered employee may contact the Plan Administrator for free assistance in obtaining information regarding the procedures governing QMCSO determinations. The Plan Administrator is responsible for determining whether or not a medical child support order is a valid QMCSO.

2. Dependent children who are disabled. Application for extended coverage and proof of incapacity must be furnished to the *Plan Administrator* within 31 calendar days after the dependent child reaches age 26. The *Plan Administrator* may ask for an independent medical exam to determine the functional capacity of the dependent child. After this initial proof, the *Plan Administrator* may request proof again as needed. A dependent child may be eligible for coverage if coverage has not otherwise terminated under this *Plan* and if the dependent child meets all of the following criteria:
   a. Became disabled before age 26;
   b. Was a *covered dependent* under the *Plan* prior to reaching age 26;
   c. Is incapable of self-sustaining employment, because of a *physical disability*, developmental mental disability, mental illness, or mental health disorder that is expected to be ongoing for a continuous period of at least two years from the date initial proof is supplied to the *Plan*;
   d. Is dependent on *covered employee* for a majority of financial support and maintenance; and
   e. Is unmarried.

   If the dependent child is disabled and 26 years of age or older at the time of the *covered employee's* enrollment in this *Plan*, the *covered employee* may enroll the dependent child if within 31 calendar days after the *covered employee's* initial enrollment in this *Plan* the *covered employee* provides the *Plan* with proof that such dependent child meets all of the following requirements:
   a. Became disabled before age 26;
   b. Received health coverage through the *covered employee* within the 60-day period immediately preceding the *covered employee's* enrollment for coverage under this *Plan*;
   c. Is incapable of self-sustaining employment, because of a *physical disability*, developmental mental disability, mental illness, or mental health disorder that is expected to be ongoing for a continuous period of at least two years from the date initial proof is supplied to the *Plan*;

d. Is dependent on *covered employee* for a majority of financial support and maintenance; and
e. Is unmarried

The *Plan Administrator* may also request an independent medical examination to determine the functional capacity of the dependent child. The disabled dependent child shall be eligible for coverage provided that the *covered employee* provides the *Plan Administrator* with ongoing proof, as requested by the *Plan Administrator,* that such dependent child is and continues to be disabled and dependent on the *covered employee*, as described above, unless coverage otherwise terminates under this *SPD*.

B. Enrollment and *Effective Date*

New Enrollment. The eligible employee must apply to enroll, including any eligible dependents that the eligible employee wishes to enroll, and pay any required *contribution*, within 31 calendar days of the date the employee first becomes eligible. Coverage will be effective on the first day of the month after 60 days.

Annual Enrollment. Subject to all eligibility and enrollment provisions, the employee may enroll, and may include eligible dependents; or a *covered employee* may add eligible dependents during the Employer's annual enrollment period. Coverage will be effective on the date indicated during the annual enrollment.

Special Enrollment Period for Employees and Dependents. If *you* are an eligible employee or an eligible dependent of an eligible employee but not enrolled for coverage under this *Plan*, *you* may enroll for coverage under the terms of this *Plan* if all the following conditions are met:

1. *You* were covered under a group health plan, covered under stsplx22 or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

2. The eligible employee stated in writing at the time of initial eligibility that coverage under a group health plan, stsplx22, or health insurance coverage was the reason for declining enrollment, but only if the Employer required a statement at such time and provided the employee with notice of the requirement and the consequences of such requirement at the time;

3. *Your* coverage described in paragraph 1 above was:
   a. Terminated under a COBRA or state continuation provision and the coverage under such provision was exhausted; or
   b. Terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer *contributions* toward such coverage were terminated; or
   c. Terminated as a result of loss of eligibility for stsplx22; or
   d. Coverage under a group health plan with a plan year that differs from the plan year applicable to coverage under this *SPD* and such coverage ended either at the close of such other group health plan's plan year in relation to an open enrollment period or upon the occurrence of one or more of the following qualifying change in status events experienced by the eligible employee or dependent, but only to the extent such event is recognized under this Employer's Section 125 cafeteria plan, if applicable:

      i. A significant reduction in benefits available under the other group health plan; or
      ii. A significant increase in the cost charged to the eligible employee or dependent for coverage under the other group health plan; or
      iii. A reduction in working hours that caused a significant increase in the cost charged to the eligible employee or dependent for coverage under the other group health plan; or
      iv. A covered dependent is eligible to enroll in an individual health insurance plan through the Marketplace. An employee is allowed to drop group health plan coverage and reduce their pre-tax election amount for group medical premiums mid-year from family to self-only coverage if the following conditions are met:

         1. One or more of the employee's dependents are eligible for a special or open enrollment period in the Marketplace, and

         2. The change to the employee's election is related to their dependent(s) intended enrollment in individual health insurance coverage through the Marketplace. The Marketplace health insurance coverage must be effective beginning no later than the day immediately following the last day they are covered under the employee's employer plan; and

4. The eligible employee requested such enrollment not later than 31 calendar days after the date of the event described in paragraphs 3.a, 3.b or 3.d above, or not later than 60 calendar days after the date of loss of eligibility for stsplx22 described in paragraph 3.c above.

Coverage will be effective on the date of the event described in paragraphs 3.a - c above or on the date action is taken under the other group health plan's contract for the events described in paragraph 3.d above, provided the *Plan* receives the application for coverage as required.

Special Enrollment Period for *Covered Persons* due to the Acquisition of New Dependents. New dependents may enroll if all the following conditions are met:

1. A group health plan makes coverage available to a dependent of an employee; and

2. The employee is eligible for coverage under this *Plan*; and

3. They become dependents of the employee through marriage, birth, adoption, placement for adoption, or legal guardianship. This *Plan* shall provide a dependent special enrollment period during which the person may be enrolled under this *Plan* as a dependent of the employee, and in the case of the birth, adoption, children placed for adoption, or the legal guardianship of a child, the employee may enroll and the spouse of the employee may be enrolled as a dependent of the employee if such spouse is otherwise eligible for coverage. The eligible employee, if not previously enrolled, is required to enroll when a dependent enrolls for coverage under this *Plan*. In the case of marriage, the employee, the spouse, and any new dependents resulting from the marriage may be enrolled, if otherwise eligible for coverage; and

4. Application must be received within 31 calendar days of the date the employee first acquires the dependent and coverage will be effective on the date of the marriage, birth, adoption, placement for adoption, or legal guardianship as described in paragraph 3 above.

Notwithstanding paragraph 4 above, if a *covered employee* has a spouse and/or dependent child/children covered under this *Plan* and subsequently acquires an eligible dependent child through birth or adoption, the newly acquired dependent child will be considered covered under the *Plan* effective on the date of the birth or adoption, provided that the employee enrolls the newly acquired dependent child within 60 days of the birth or adoption.

Note: Other dependents (such as siblings of a newborn child) are entitled to special enrollment rights upon the birth or adoption of a child.

Special Enrollment Period for Medicaid and Children's Health Insurance Program (CHIP) Participants. If an eligible employee and/or the eligible employee's eligible dependents are covered under a state Medicaid Plan or a state CHIP (if applicable) and that coverage is terminated as a result of loss of eligibility, then such employee may request enrollment in the *Plan* on behalf of the eligible employee and/or eligible dependents. Such request shall be submitted to the *Plan* not later than 60 calendar days after the eligible employee's and/or the eligible employee's dependent's coverage ends under such state plans.

If an eligible employee and/or the eligible employee's eligible dependents become eligible for coverage under a state Medicaid Plan or a state CHIP (if applicable), and the Employer has not opted out of the premium assistance subsidy offered by the state, then such employee may request enrollment in the *Plan* on behalf of the eligible employee and/or such eligible dependents. The eligible employee shall request such enrollment in the *Plan* no later than 60 calendar days after the date the employee and/or the eligible employee's eligible dependents are determined to be eligible for coverage under such state plans.

VI. Benefit Schedule

Benefits listed in this Schedule are according to what the *Plan* pays.

This *Plan* only pays *benefits* if *you* choose a *participating provider*. If *you* use a *non-participating provider*, *you* pay all charges.

Benefits	***Participating Provider Plan* Payment**	***Non-Participating Provider Plan* Payment**
A. Preventive Contraceptive Methods and Counseling for Women	The *Plan* covers preventive contraceptive methods and counseling services by female *covered persons* as described in the Preventive Health Care Services Schedule ("Schedule"). The Schedule, which includes preventive contraceptive methods and counseling services for women provided by the *Affordable Care Act*, is available on the *TPA's* member website or by calling Customer Service. This coverage includes the full range of Food and Drug Administration approved contraceptive methods for women with reproductive capacity, including women's contraceptive drugs, devices, and delivery methods obtained from a retail pharmacy, mail order pharmacy, or received at a *provider's* office.	
Women's prescription contraceptives received at a retail pharmacy mail order pharmacy, or retail/maintenance drug pharmacy:		
• Generic oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law up to a 30-calendar day supply from a retail pharmacy, up to a 90-calendar day supply from a mail order pharmacy, and up to a 90-calendar day supply from a retail/maintenance drug pharmacy; and • Brand name oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which no generic alternative exists up to a 30-calendar day supply from a retail pharmacy, and up to a 90-calendar day supply from a mail order pharmacy, and up to a 90-calendar day supply from a retail/maintenance drug pharmacy.	100% of *eligible charges*.	Not covered.

a. Brand name oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which a generic alternative exists up to a 30-calendar day supply from a retail pharmacy, and up to a 90-calendar day supply from a mail order pharmacy, and up to a 90-calendar day supply from a retail/maintenance drug pharmacy.	Not covered	Not covered.

Women's prescription contraceptives, sterilization procedures, and *covered person* education received at a *provider's* office:

• Generic injectable, implantable, and insertable contraceptives that require a prescription under applicable law; and • Brand name injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which no generic alternative exists.	100% of *eligible charges.*	Not covered.
• Brand name injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which a generic alternative exists.	Not covered.	Not covered.
• Sterilization procedures, excluding the reversal of sterilization procedures.	100% of *eligible charges.*	Not covered.
• *Covered person* education and counseling about contraceptive methods.	100% of *eligible charges.*	Not covered.

The *Plan Administrator* uses a drug *formulary* to determine which *prescription drugs* are covered. The *formulary* for Magellan is Magellan Rx Standard Formulary. The *formulary* is subject to periodic review and modification. For information, *you* may call Magellan Rx at the phone number listed on the inside front cover of this *SPD*.

Exclusions:

- Please see the section entitled "Exclusions."
- Abortions.

- Non-prescribed over-the-counter contraceptives, including condoms, spermicides, and emergency contraceptives.
- Hysterectomies.

- Anesthesia and facility services related to sterilization procedures performed during other surgical procedures such as Cesarean section birth, gall bladder removal, and abdominal hernia repair.
- Reversal of sterilization procedures.
- Male sterilizations.

Benefits	Participating Provider Plan Payment	Non-Participating Provider Plan Payment
B. *Preventive Health Care Services*	The *Plan* covers preventive services required by the *Affordable Care Act.* These services and their frequency and time frames are stated in the Preventive Health Care Services Schedule ("Schedule"). The Schedule may be amended, from time to time, on a prospective basis, and is available by contacting Customer Service.	
The Schedule includes certain routine services such as: • Counseling for certain conditions. • Routine immunizations. • Routine laboratory tests, pathology and radiology. • Routine physical examinations. • Routine screenings for certain cancers and certain other conditions. **Note**: If any of the services listed above are prenatal or child health supervision services, see below for further benefit information.	100% of *eligible charges*.	Not covered.
• Certain prescribed preventive medications required under the *Affordable Care Act*. **NOTE:** For a list of prescribed preventive medications that are required under the *Affordable Care Act*, please refer to Magellan Rx Standard Formulary at the website located on the inside cover of this *SPD* or by calling Customer Service.	100% of *eligible charges*.	Not covered.

***Preventive Health care services* that are in Addition to Those Required by the *Affordable Care Act*:**

• Routine eye examination limited to one exam per *covered person* per *calendar year*.	100% of *eligible charges.*	Not covered.
• Routine hearing examination, limited to one exam per *covered person* per *calendar year*.	100% of *eligible charges*.	Not covered.
• Routine prenatal care services.	100% of *eligible charges*.	Not covered.
• One routine postnatal care exam that includes a health exam, assessment, education and counseling provided during the period immediately after childbirth.	100% of *eligible charges*.	Not covered.
• Child health supervision services (as defined below).	100% of *eligible charges*.	Not covered.

Female *covered persons* may obtain annual preventive health examinations and prenatal screenings from obstetricians and gynecologists in the *participating provider* network, without a referral from another *physician* or prior approval from the *Plan*.

Child health supervision services includes pediatric preventive services, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations, up to age 18. Coverage includes at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, and once a year from 24 months to 72 months.

Prescription Drugs* covered as *Preventive Health Care Services. The *Plan* covers certain *prescription drugs* which are required to be covered without cost-sharing as *preventive health care services* under the *Affordable Care Act.* The *Plan's formulary* identifies these *prescription drugs* as being included in the "$0 Cost Share" tier and may be obtained by accessing the Magellan Rx member website or by calling Magellan Rx. More information regarding *benefits* for *prescription drugs* that are *preventive health care services* can be found under the "Preventive Contraceptive Methods and Counseling for Women" section and this section of this *SPD*.

Notes:
- Non-*preventive health care services* are not covered under this section of the *SPD*.
- Non-routine *health care services*, including but not limited to non-routine prenatal services.

Exclusions:

- Please see the section entitled "Exclusions."
- Any *health care service* performed during or in conjunction with an annual or periodic wellness exam that exceeds the services described in this section of the *SPD*.
- Electronic cigarettes, e-cigarettes, personal vaporizers, and similar forms of nicotine delivery systems.
- Non-*preventive health care services* are not covered under this section of the *SPD*.
- Non-routine *health care services*, including but not limited to non-routine prenatal services.
- Tobacco cessation intervention programs and *health care services*, except as covered under the *SPD*.
- *Prescription drugs* and prescribed OTC drugs for tobacco cessation, except as covered under the *SPD.*
- Brand name *prescription drugs* for which a generic equivalent exists.

VII. Exclusions

Many exclusions are interrelated so please read this entire section. The *Plan* will not cover charges *incurred* for any of the following services:

1. *Health care services* that are not *preventive health care services* or preventive contraceptive methods and counseling for women as identified in the Benefit Schedule of this *SPD*.

2. *Health care services* for *sickness* or *injury*.

3. *Health care services* that the *Plan Administrator* determines are not *medically necessary*, unless the specific terms of a *participating provider's* written agreement with the national network vendor applicable to the *Plan* precludes application of the exclusion.

4. *Health care services* received before coverage under this *Plan* begins or after *your* coverage under this *Plan* ends.

5. *Health care services* that the *Plan Administrator* determines are *investigative* and associated expenses, unless the specific terms of a *participating provider's* written agreement with the national network vendor applicable to the *Plan* precludes application of the exclusion.

6. *Health care services* not directly related to *your* care.

7. *Health care services* ordered or rendered by *providers* or para-professionals unlicensed by the appropriate state regulatory agency.

8. *Health care services* not rendered in the most cost-efficient setting or manner appropriate for the condition based on medical standards and accepted practice parameters of the community, or provided at a frequency other than that accepted by the medical community as medically appropriate.

9. Charges for *health care services* determined to be duplicate services by the *Plan Administrator*.

   Charges for *health care services* received from *non-participating providers,* including *non-participating provider* Pharmacies.

10. *Health care services* prohibited by law or regulation, or illegal under applicable laws.

11. *Health care services* received outside the United States.

12. Vision lenses, eyeglasses, frames and their related fittings.

13. Routine eye examinations, except as covered under this *SPD*.

14. Routine hearing examinations, except as covered under this *SPD*.

15. Contact lenses and their related fittings.

16. *Health care services* or items for personal comfort or convenience.

17. Any *health care services* provided by a relative (i.e., a spouse, or a parent, brother, sister, or child of the *covered employee* or of the *covered employee's* spouse) or anyone who customarily lives in the *covered employee's* household.

18. *Health care services* provided by massage therapists, doulas and personal trainers.

19. *Health care services* provided by providers who have not completed professional level education and licensure as determined by the *Plan Administrator*.

20. *Health care services* for the treatment of sexual dysfunction.

21. *Orthognathic surgery*.

22. Massage therapy.

23. Alternative therapies such as aromatherapy and reflexology.

24. *Vocational rehabilitation*.

25. Homeopathic or naturopathic medicine, including dietary supplements.

26. Holistic medicine and services, including dietary supplements.

27. Abortion.

28. Acupuncture.

29. Charges billed by *providers* that are not in compliance with generally accepted guidelines established by the Centers for Medicare & Medicaid Services (CMS) and/or the *TPA's* policies.

30. *Health care services* and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for driving under the influence/driving while intoxicated, competency evaluations, and adoption studies.

31. Services provided to *you* if *you* also have other primary insurance coverage for those services and *you* do not provide the *Plan* with the necessary information to pursue coordination of benefits, as required under this *SPD*.

32. Halfway houses, extended care facilities or comparable facilities, foster care, adult foster care, and family child care.

33. Sterilization reversals.

34. Cochlear implants.

35. Nutritional and food supplements, except as covered under this *SPD*.

36. Health club memberships.

37. Recreational, *educational*, or self-help therapy or items primarily *educational* in nature or for vocation, comfort, convenience or recreation.

38. Weight loss drugs, including off-label use of drugs for weight loss.

39. Any weight loss programs and related *health care services* that are not otherwise covered as *preventive health care services*.

40. Costs, charges, fees and other losses for non-*health care services*.

41. *Bariatric surgeries*, including preoperative procedures, initial procedures, surgical revisions and subsequent procedures.

42. Services provided during a telehealth and/or virtual visit for the sole purpose of: scheduling appointments; filling or renewing existing prescriptions; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; services that would similarly not be charged for in an onsite medical office visit; telephone conversations, e-mails, or facsimile transmissions between licensed health care *providers*; or e-mails, or facsimile transmissions between a licensed health care *provider* and a patient.

43. *Health care services* and supplies not ordered by a *provider,* such as but not limited to, cholesterol testing, glucose testing and mammograms unless specifically listed in the *Plan's* schedule of *Preventive Health Care Services* or provided by a *participating provider.*

VIII. Ending *Your* Coverage

Your coverage will terminate on the earliest of the following dates:

a. The date the *Plan* is terminated;
b. The end of the month in which the *covered employee* retires;
c. The end of the month in which *your* eligibility under the *Plan* ends;
d. The end of the month in which *your* written request is received to terminate coverage due to *your* enrollment in Medicare or another group health plan;
e. For a dependent, the end of the month in which *your* written request is received to terminate *your* dependent's coverage due to *your* dependent's enrollment in Medicare or another group health plan;
f. When *you* do not make *your* required *contribution* for coverage under the *Plan*. Termination will be retroactive to the last day for which *your* required *contribution* has been timely received; or
g. The date *you*, or someone acting on *your* behalf, have performed an act or practice that constitutes fraud or made an intentional misrepresentation (including an omission) of material fact under the terms of the *Plan*.
h. The end of the month following the date *you* enter active military duty for more than 31 days. Upon completion of active military duty, contact the Employer for reinstatement of coverage.
i. The date of the death of the *covered person*. In the event of the *covered employee's* death, coverage for the *covered employee's* dependents will terminate the end of the month in which the *covered employee's* death occurred.
j. When the maximum period for coverage under COBRA Continuation Coverage expires for a *covered person*.
k. For a child who is entitled to coverage through a QMCSO, the end of the month in which the earliest of the following occurs:
    i. The QMCSO ceases to be effective; or
    ii. The child is no longer a child as that term is used in *ERISA*; or
    iii. The child has immediate and comparable coverage under another plan; or
    iv. The *covered employee* who is ordered by the QMCSO to provide coverage is no longer eligible as determined by the Employer; or
    v. The Employer terminates family or dependent coverage; or
    vi. The relevant premium or *contribution* toward the premium is last paid.

For a covered dependent child, coverage will terminate the end of the month in which the child is no longer eligible as a *covered dependent*. If *your* covered dependent child is disabled, coverage will end the end of the month in which the covered dependent child marries or is no longer disabled.

IX. Leaves of Absence

A. Family and Medical Leave Act (FMLA)

If *you* are absent from work due to an approved family or medical leave under the Family and Medical Leave Act of 1993 (FMLA), coverage may be continued for the duration of the approved leave of absence as if there was no interruption in employment. Such coverage will continue until the earlier of the expiration of such leave or the date *you* notify the Employer that *you* do not intend to return to work. *You* are responsible for all required *contributions*.

If *you* do not return after an approved leave of absence, coverage may be continued under the "COBRA Continuation Coverage" section, provided that *you* elect to continue under that provision. If *you* return to work immediately following *your* approved FMLA leave, no new *waiting periods* will apply.

FMLA applies to employees of a covered employer that work at a worksite within 75 miles of where that employer employs at least 50 employees.

B. The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Continuation of *Benefits*. *Covered employee*s who are absent due to service in the uniformed services and/or their *covered dependent*s may continue coverage pursuant to USERRA for up to 24 months after the date the *covered employee* is first absent due to uniformed service duty.

Eligibility. A *covered employee* is eligible for continuation under USERRA if the *covered employee* is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard or the commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

*Covered dependent*s who have coverage under the *Plan* immediately prior to the date of the *covered employee's* covered absence are eligible to elect continuation under USERRA.

Upon the *covered employee's* return to work immediately following the *covered employee's* leave under USERRA, no new *waiting periods* will apply.

Premium Payment. If continuation of *Plan* coverage is elected under USERRA, the *covered employee* or *covered dependent* is responsible for payment of the applicable cost of coverage. If the *covered employee* is absent for not longer than 31 calendar days, the cost will be the amount the *covered employee* would otherwise pay for coverage. For absences exceeding 31 calendar days, the cost may be up to 102% of the cost of coverage under the *Plan*. This includes the *covered employee's* share and any portion previously paid by the Employer.

Duration of Coverage. Elected continuation coverage under USERRA will continue until the earlier of:

1. Twenty-four months, beginning the first day of absence from employment due to service in the uniformed services;

2. The day after the *covered employee* fails to apply for or return to employment as required by USERRA, after completion of a period of service;

3. The early termination of USERRA continuation coverage due to the *covered employee's* court-martial or dishonorable discharge from the uniformed services; or

4. The date on which this *Plan* is terminated.

The continuation available under USERRA does not affect continuation available under "COBRA Continuation Coverage." *Covered employee*s should contact their Employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the Employer of any changes in marital status or a change of address.

Return to Work Requirements. Under USERRA a *covered employee* is entitled to return to work following an honorable discharge as follows:

1. Less than 31 days service: By the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight-hour rest period.

2. Thirty-one to 180 days: The *covered employee* must apply for reemployment no later than 14 days after completion of military service.

3. One hundred and eighty-one days or more: The *covered employee* must apply for reemployment no later than 90 days after completion of military service.

4. Service-connected *injury* or illness: Reporting or application deadlines are extended for up to two years for persons who are hospitalized or convalescing.

C. Michelle's Law

Under *Michelle's Law*, group health *plans* and health insurers are prohibited from terminating the coverage of a student dependent whose enrollment in a *plan* requires student status at a postsecondary educational institution, if the student status is lost because of a qualifying *Medically Necessary Leave of Absence*.

Michelle's Law applies to a group health plan or related insurance coverage only if the *plan* or insurer receives written certification by the student dependent's treating physician stating that (1) the child is suffering from a serious illness or injury and (2) the Leave of Absence (or other change in enrollment) is *Medically Necessary*.

A student dependent is one who, regarding group health *plan* or health insurance coverage is both:

1. A dependent child, under the *plan*'s or coverage's terms, of a participant or beneficiary in the *plan* or coverage.
2. Was enrolled in the *plan* or coverage, on the basis of being a student at a postsecondary educational institution, immediately before the first day of the *Medically Necessary Leave of Absence* involved.

X. COBRA Continuation Coverage

The *covered employee*, the covered spouse and covered dependent children may continue coverage under the *Plan* when a qualifying event occurs. *You* may elect COBRA for *yourself* regardless of whether the *covered employee* or other eligible dependents in *your* family elect COBRA. A *covered employee* and a covered spouse may elect COBRA on behalf of each other and/or their covered dependent children. If a loss of coverage qualifying event occurs:

1. In certain cases, the covered employee may continue his or her coverage and may also continue coverage for his or her covered spouse, covered dependent children, domestic partners and covered dependent children of the domestic partner when coverage would normally end

2. In certain cases, the covered spouse and covered dependent children may continue coverage when coverage would normally end. A domestic partner and the covered dependent children of the domestic partner may not continue coverage except as a *dependent* of a *covered employee* at the option of the *covered employee*;

3. Coverage will be the same as that for other similar *covered persons*; and

4. Continuation coverage under this *Plan* ends when this *Plan* terminates or as explained in detail on the following Continuation Chart. The *covered employee*, the covered spouse and covered dependent children may, however, be entitled to continuation coverage under another group health plan offered by the Employer. *You* should contact the Employer for details about other continuation coverage.

For additional information about *your* rights and obligations under the *Plan* and/or federal COBRA law, *you* should contact the Employer, which is the official *Plan Administrator*.

Qualifying Events

1. Loss of coverage under this *Plan* by the *covered employee* due to one of these events:
   a. Voluntary or involuntary termination of employment of the *covered employee* for reasons other than "gross misconduct."
   b. Reduction in the hours of employment of the *covered employee*.
   c. Layoff of the *covered employee*.
   d. Leave of absence of the *covered employee*.
   e. Early retirement of the *covered employee*.

2. Loss of coverage under this *Plan* by the covered spouse and/or covered dependent children due to one of these events:
   a. Voluntary or involuntary termination of employment of the *covered employee* for reasons other than "gross misconduct."
   b. Reduction in the hours of employment of the *covered employee*.
   c. Layoff of the *covered employee*.
   d. Leave of absence of the *covered employee*.
   e. Early retirement of the *covered employee*.
   f. *Covered employee* becoming entitled to Medicare.
   g. Divorce or legal separation of the *covered employee*.
   h. Death of the *covered employee*.

3. Loss of coverage under this *Plan* by the covered dependent child due to loss of "dependent child" status under this *Plan*.

4. Loss of coverage under this *Plan* due to the bankruptcy of the Employer under Title XI of the United States Code. For purposes of this qualifying event (bankruptcy), a loss of coverage includes a substantial elimination of coverage that occurs within one year before or after commencement of the bankruptcy proceeding. Applies to the covered retiree, the covered spouse and covered dependent children.

Required Procedures

When the initial qualifying event is death, termination of employment or reduction in hours (including leave of absence, layoff, or retirement), or Medicare entitlement of the *covered employee*, or the bankruptcy of the Employer, the *Plan Administrator* will offer continuation coverage to qualified *covered persons*. *You* do not need to notify the *Plan Administrator* of these qualifying events. However, for other qualifying events including divorce or legal separation of the *covered employee* and loss of dependent child status, COBRA continuation is not available to *you* if *you* do not provide timely, written notice to the *Plan Administrator* as required below by the *Plan*. *You* must also provide timely, written notice to the *Plan Administrator* of other events, such as a Social Security disability determination or second qualifying events, in order to be eligible for an extension of COBRA continuation as required by the *Plan* as stated in this section. To elect COBRA, *you* must make a timely, written election as required by the *Plan* as stated in this section.

What the *Plan Administrator* must do:

1. Provide initial general COBRA notices as required by law;

2. Determine if the *covered person* is eligible to continue coverage according to applicable laws;

3. Notify persons of the unavailability of COBRA continuation;

4. Notify the *covered person* of the *covered person's* rights to continue coverage provided that all required notice and notification procedures have been followed by the *covered employee*, covered spouse and/or covered dependent children;

5. Inform the *covered person* of the premium *contribution* required to continue coverage and how to pay the premium *contribution*; and

6. Notify the *covered person* when the *covered person* is no longer entitled to COBRA or when the *covered person's* COBRA continuation is ending before expiration of the maximum (18, 29, 36 month) continuation period.

What *You* must do:

1. *You* must notify the *Plan Administrator* in writing of a divorce or legal separation within 60 calendar days after either the date of the qualifying event, or the earliest date coverage would end due to the qualifying event, whichever is later;

2. *You* must notify the *Plan Administrator* in writing of a covered dependent child ceasing to be eligible within 60 calendar days after either the date of the qualifying event, or the earliest date coverage would end due to the qualifying event, whichever is later;

3. *You* must submit *your* written notice of a qualifying event within the 60-day timeframe, as explained previously in paragraphs 1 and 2, using the *Plan's* approved notice form. (*You* may obtain a copy of the approved form from the *Plan Administrator*.) This notice must be submitted to the *Plan Administrator* in writing and must include the following:

- The name of the *Plan*;
- The name and address of the *covered employee* or former *covered employee*;
- The names and addresses of all applicable dependents;
- The description and date of the qualifying event;
- Requested documentation pertaining to the qualifying event such as: decree of divorce or legal separation; and
- The name, address and telephone number of the individual submitting the notice. This individual can be a *covered employee*, former *covered employee*, dependent, or a representative acting on behalf of the employee or dependent.

All written notices as described previously in paragraphs 1, 2, and 3, under "What *You* must do" must be timely sent to the *Plan Administrator* at the address indicated in the section of this *SPD* entitled "Specific Information About *Your Plan*."

You must follow the *Plan's* procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this *SPD*, unless a different procedure is expressly required by the Employer or its COBRA administrator.

4. To elect continuation, *you* must notify the *Plan Administrator* of *your* election in writing within 60 calendar days after the date the *covered person's* coverage ends, or the date the *covered person* is notified of continuation rights, whichever is later. To elect continuation, *you* must complete and submit *your* written election within the 60-day timeframe using the *Plan's* approved election form. (*You* may obtain a copy of the approved form from the *Plan Administrator* .) This election must be submitted to the *Plan Administrator* in writing at the address as described in this section; and

5. *You* must pay continuation premium *contributions*:
   a. The premium *contribution* to continue coverage is the combined Employer plus *covered employee* rate charged under the *Plan*, plus the Employer may charge an additional two percent of that rate. For a *covered person* receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium *contribution* for those additional months may be increased to 150% of the *Plan's* total cost of coverage. The continuation election form will set forth *your* continuation premium *contribution* rate(s).
   b. The first premium *contribution* must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the *covered person's* monthly payments are due and payable by check at the beginning of each month for which coverage is continued.
   c. The *covered person* must pay subsequent premium *contributions* by check on or before the required due date, plus the 30 calendar day grace period required by law or such longer period allowed by the *Plan*.

What *You* must do to apply for COBRA extension:

A. Social Security Disability:

1. If *you* are currently enrolled in COBRA continuation under this *Plan*, and it is determined that *you* are totally disabled by the Social Security Administration within the first 60 calendar days of *your* current COBRA coverage, then *you* may request an extension of coverage provided that *your* current COBRA coverage resulted from the *covered employee's* leave of absence, retirement, reduction in hours, layoff, or the *covered employee's* termination of employment for reasons other than gross misconduct. To request an extension of COBRA, *you* must notify the *Plan Administrator* in writing of the Social Security Administration's determination within 60 calendar days after the latest of:
   - The date of the Social Security Administration's disability determination;
   - The date of the *covered employee's* termination of employment, reduction of hours, leave of absence, retirement, or layoff; or
   - The date on which *you* would lose coverage under the *Plan* as a result of the *covered employee's* termination, reduction of hours, leave of absence, retirement, or layoff.

2. *You* must submit *your* written notice of total disability within the 60-day timeframe, as described previously in paragraph 1, and before the end of the 18th month of *your* initial COBRA coverage using the *Plan's* approved disability notice form. (*You* may obtain a copy of the approved form from the *Plan Administrator* .) This notice must be submitted, in writing, to the *Plan Administrator* and must include the following:
   - The name of the *Plan*;
   - The name and address of the *covered employee* or former *covered employee*;
   - The names and addresses of all applicable dependents currently on COBRA;
   - The description and date of the initial qualifying event that started *your* COBRA coverage;
   - The name of the disabled *covered person*;
   - The date the *covered person* became disabled;
   - The date the Social Security Administration made its determination of disability;
   - Requested copy of the Social Security Administration's determination of disability; and
   - The name, address and telephone number of the individual submitting the notice. This individual can be a *covered employee*, former *covered employee*, dependent, or a representative acting on behalf of the employee or dependent.

   You must follow the *Plan's* procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this *SPD*, unless a different procedure is expressly required by the Employer or its COBRA administrator.

3. To elect an extension of COBRA, *you* must notify the *Plan Administrator* of the Social Security Administration's determination, in writing, within the 60 calendar day and the initial 18-month continuation period timeframes, by following the notification procedure as previously explained in paragraphs 1 and 2, and submitting the *Plan's* approved form; and

4. *You* must pay continuation premium *contributions*:
   a. The premium *contribution* to continue coverage is the combined Employer plus *covered employee* rate charged under the *Plan*, plus the Employer may charge an additional two percent of that rate. For a *covered person* receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium *contribution* for those additional months may be increased to 150% of the *Plan's* total cost of coverage. The disability notice form will set forth *your* continuation premium *contribution* rate(s).
   b. The first premium *contribution* must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the *covered person's* monthly payments are due and payable by check at the beginning of each month for which coverage is continued.
   c. The *covered person* must pay subsequent premium *contributions* by check on or before the required due date, plus the 30 calendar day grace period required by law or such longer period allowed by the *Plan*.

B. Second Qualifying Events for *Covered Dependent*s Only:

1. If *you* are currently enrolled in COBRA continuation under this *Plan* and the *covered employee* dies, or in the case of divorce or a legal separation of the *covered employee*, or a covered dependent child loses eligibility, then *you* may request an extension of coverage provided that *your* current COBRA coverage resulted from the *covered employee's* leave of absence, retirement, reduction in hours, layoff, or the *covered employee's* termination of employment for reasons other than gross misconduct or resulted from a Social Security Administration disability determination. To request an extension of COBRA, *you* must notify the *Plan Administrator* in writing within 60 calendar days after the later of:
   - The date of the second qualifying event (death, divorce, legal separation, loss of dependent child status); or
   - The date on which the *covered dependent*(s) would lose coverage as a result of the second qualifying event.

   Note: This extension is only available to a covered spouse and covered dependent children. This extension is not available when a *covered employee* becomes entitled to Medicare.

2. *You* must submit *your* written notice of a second qualifying event within the 60-day timeframe, as previously described in paragraph 1, using the *Plan's* approved second event notice form. (*You* may obtain a copy of the approved form from the *Plan Administrator* .) This notice must be submitted to the *Plan Administrator* in writing and must include the following:
   - The name of the *Plan*;
   - The name and address of the *covered employee* or former *covered employee*;

- The names and addresses of all applicable dependents currently on COBRA;
- The description and date of the initial qualifying event that started *your* COBRA coverage;
- The description and date of the second qualifying event;
- Requested documentation pertaining to the second qualifying event such as: a decree of divorce or legal separation or death certificate; and
- The name, address and telephone number of the individual submitting the notice. This individual can be a *covered employee*, former *covered employee*, dependent, or a representative acting on behalf of the employee or dependent.

You must follow the *Plan's* procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this *SPD*, unless a different procedure is expressly required by the Employer or its COBRA administrator.

3. To elect an extension of COBRA, *you* must notify the *Plan Administrator* of the second qualifying event in writing within the 60 calendar day timeframe, by following the notification procedure as previously explained in paragraphs 1 and 2, and submitting the *Plan's* approved form; and

4. *You* must pay continuation premium *contributions*:
   a. The premium *contribution* to continue coverage is the combined Employer plus *covered employee* rate charged under the *Plan*, plus the Employer may charge an additional two percent of that rate. For a *covered person* receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium *contribution* for those additional months may be increased to 150% of the *Plan's* total cost of coverage. The election form will set forth *your* continuation premium *contribution* rates.
   b. The first premium *contribution* must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the *covered person's* monthly payments are due and payable by check at the beginning of each month for which coverage is continued.
   c. The *covered person* must pay subsequent premium *contributions* by check on or before the required due date, plus the 30 calendar day grace period required by law or such longer period allowed by the *Plan*.

Additional Notices *You* Must Provide: Other Coverages, Medicare Entitlement and Cessation of Disability

You must also provide written notice of (1) *your* other group coverage that begins after COBRA is elected under the *Plan*; (2) *your* Medicare entitlement (Part A, Part B or both parts) that begins after COBRA is elected under the *Plan*; and (3) the *covered person*, whose disability resulted in a COBRA extension due to disability, being determined to be no longer disabled by the Social Security Administration.

Your written notice for the events previously described in this section must be submitted using the *Plan's* approved notification form within 30 calendar days of the events requiring additional notices as previously described**. The notification form can be obtained from the *Plan Administrator* and must be completed by *you* and timely submitted** NOTIFTEXT In addition to providing all required information requested on the *Plan's* approved notification form, *your* written notice must also include the following:

- If providing notification of other coverage that began after COBRA was elected, the name of the *covered person* who obtained other coverage, and the date that other coverage became effective.
- If providing notification of Medicare entitlement, the name and address of the *covered person* that became entitled to Medicare and the date of the Medicare entitlement.
- If providing notification of cessation of disability, the name and address of the formerly disabled *covered person*, the date that the Social Security Administration determined that the *covered person* was no longer disabled and a copy of the Social Security Administration's determination.

If *you* do not provide this required additional notice, *you* must reimburse any claims mistakenly paid for expenses *incurred* after the following applicable date:

1. *Your* other group coverage begins;
2. *Your* Medicare Part A or Part B enrollment begins; or
3. *Your* disability ends.

CONTINUATION CHART

If coverage under this *Plan* is lost because this happens…	**Who is eligible to continue…**	**Coverage may be continued until the earliest of**: a) the date coverage would otherwise end under the *Plan*; or b) the end of the month in which the earliest of the following applicable events occurs:
The *covered employee's* leave of absence, early retirement, hours were reduced, layoff, or the *covered employee's* employment with the Employer ended for reasons other than gross misconduct.	*Covered employee* and covered dependent children	• 18 months after continuation coverage began. • Coverage begins under another group health plan after COBRA is elected under the *Plan*. • Entitlement, after COBRA is elected under the *Plan*, of the applicable *covered person* to either Part A or Part B or both Parts of Medicare.
Death of the *covered employee*. Divorce or legal separation from the *covered employee*. Entitlement of the *covered employee* to Medicare within 18 months before the *covered employee's* hours were reduced or termination of employment for reasons other than gross misconduct. *Covered person* must provide timely notice of such event in accordance with the *Plan's* notice procedures previously described for such events.	Covered dependent children	• 36 months after continuation coverage began. • 36 months after entitlement of *covered employee* to Medicare but only for an event which is the *covered employee's* Medicare entitlement within 18 months before the *covered employee's* hours were reduced or termination of employment. • Coverage begins under another group health plan after COBRA is elected under the *Plan*. • Entitlement, after COBRA is elected under the *Plan*, of the applicable *covered person* to either Part A or Part B or both Parts of Medicare.
Loss of eligibility by a covered dependent child. *Covered person* must provide timely notice of such event in accordance with the *Plan's* notice procedures previously described for such events.	Covered dependent children	• 36 months after continuation coverage began. • Coverage begins under another group health plan after COBRA is elected under the *Plan*. • Entitlement, after COBRA is elected under the *Plan*, of the applicable *covered person* to either Part A or Part B or both Parts of Medicare.
The Employer files a voluntary or involuntary petition for protection under the bankruptcy laws found in Title XI of the United States Code.	Covered dependent children	• Lifetime continuation coverage for covered retiree. • 36 months after death of covered retiree for covered dependent children. • Coverage begins under another group health plan after COBRA is elected under the *Plan*.
The *covered employee*, or covered dependent child is determined by the Social Security Administration to be totally disabled within the first 60 calendar days of COBRA continuation coverage that resulted from the *covered employee's* leave of absence, early retirement, reduction in hours, layoff, or the *covered employee's* termination of employment with the Employer for reasons other than gross misconduct. Timely notice of such disability must be provided by the *covered person* in accordance with the *Plan's* notice procedures previously described for COBRA extensions due to Social Security disability.	*Covered employee* and covered dependent children	• 29 months after continuation coverage began or until the first month that begins more than 30 calendar days after the date of any final determination that *covered employee* or covered dependent child is no longer disabled. • Coverage begins under another group health plan after COBRA is elected under the *Plan*. • Entitlement, after COBRA is elected under the *Plan*, of the applicable *covered person* to either Part A or Part B or both Parts of Medicare.

Special Enrollment Periods

If *you* are a *covered employee* or *covered dependent* who is enrolled in continuation coverage under this *Plan* due to a qualifying event (and not due to another enrollment event such as a special or annual enrollment), the Special Enrollment Period provisions of this *SPD* as referenced in the section which describes eligibility and enrollment will apply to *you* during the continuation period required by federal law as such provisions would apply to an active eligible *covered employee*. Eligible dependents that are newborn children or newly adopted children (as described in the eligibility and enrollment section) that are acquired by a *covered employee* during such *covered employee's* continuation period required by federal law and are enrolled through special enrollment, are entitled to continue coverage for the maximum continuation period required by law.

If the continuation period required by federal law has been exhausted, and *you* are enrolled for additional continuation coverage pursuant to state law, if applicable, or the eligibility provisions of this plan, *you* may be entitled to the special enrollment rights upon acquisition of a new dependent through marriage, birth, adoption, placement for adoption, or legal guardianship, as referenced in the section entitled Special Enrollment Period for *Covered Persons* due to the Acquisition of New Dependents.

Special Rule for Persons Qualifying for Federal Trade Act Adjustments

Federal trade act laws give special COBRA rights to *covered employees* who terminate employment or experience a reduction of hours, and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under federal laws, including the Trade Adjustment Assistance Reauthorization Act of 2015.

If *you* qualify or may qualify for trade adjustment assistance, contact the *Plan Administrator* for additional information. *You* must contact the *Plan Administrator* promptly after qualifying for trade adjustment assistance or *you* will lose your special COBRA rights.

Written Notices Required for COBRA Continuation

All notices, elections and information required to be furnished or submitted by a *covered person* or *covered dependent* children for purposes of COBRA continuation must be submitted in writing by U.S. mail or hand-delivery, or as previously described in this section. Oral communications, including phone calls, voice mails or in-person statements and electronic e-mail do not constitute written notice and are not acceptable for COBRA purposes under the *Plan*.

XI. Subrogation and Reimbursement

Subrogation

The *Plan* and the *Plan Administrator* have the full and unrestricted right of subrogation with respect to any *sickness* or *injury* for which any *benefit* or payment is provided, or may at any time in the future be provided, under the *Plan*. The *Plan Administrator* has delegated to the *TPA* the ability to pursue this right, and the authority to redelegate such activity to other individuals or entities. That right of subrogation also extends to any coverage or rights a *covered person* has, or may have, under any insurance coverage, including, but not limited to, any uninsured or underinsured motorist coverage. The *Plan's* and the *Plan Administrator's* right of subrogation shall in all circumstances fully apply without limitation and shall not be reduced under any circumstances, even if a *covered person* is not made whole for damages or losses, such as damages for pain and suffering, lost wages, etc.

The *Plan's* and the *Plan Administrator's* subrogation rights shall also not be reduced by any expenses *incurred* by any *covered person*, including, but not limited to, attorneys' fees. Any and all amounts recovered by or on behalf of a *covered person* by settlement, judgment, arbitration or by any means whatsoever shall be placed into a constructive trust subject to the *Plan's* and the *Plan Administrator's* right of subrogation or shall be paid over to the *Plan* without any reduction, regardless of how such amounts are characterized or allocated. The *Plan's* and the *Plan Administrator's* subrogation rights shall have priority over any rights or claims of a *covered person*, and pursuant to such right of priority, the *Plan* shall first be paid in full for its subrogation rights before any amount, regardless of how characterized or allocated, is retained by, or for, a *covered person*.

A *covered person* shall fully cooperate with the *Plan*, the *Plan Administrator*, the *TPA* and their designees in the enforcement of the *Plan's* and the *Plan Administrator's* subrogation rights, which cooperation shall include, but not be limited to, paying over to the *Plan* any and all amounts due the *Plan* and the execution of any agreements, assignments or other instruments requested by the *Plan*, the *Plan Administrator*, the *TPA* and their designees. If

information and assistance are not provided to the *Plan* upon request, no *benefits* will be payable under the *Plan* with

respect to costs *incurred* in connection with such *sickness* or *injury*. If the *sickness* or *injury* giving rise to subrogation involves a minor child or wrongful death of a *covered person*, this provision applies to the parents or guardian of the minor *covered person* and the personal representative of the deceased *covered person*. A *covered person* shall take no action which directly or indirectly adversely affects the *Plan's* and the *Plan Administrator's* rights of subrogation, and any settlement entered into by or on behalf of a *covered person* shall be subject to and shall fully recognize the *Plan's* and the *Plan Administrator's* right of priority to be fully repaid for its subrogation rights from any and all amounts, regardless of how characterized or allocated, recovered in connection with such settlement before any amounts from such settlement are retained by, or for, a *covered person*.

As a condition of receiving *benefits* under this *Plan*, *you* agree:

- To reimburse the *Plan* for any such *benefits* paid or payable to, or on behalf of, the *covered person* when said *benefits* are recovered from any form, regardless of how classified or characterized, from any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, medical payment provision or other insurance policies or funds.
- The *Plan Administrator* retains all fiduciary responsibilities with respect to the *Plan*, has the exclusive, final and binding discretionary authority to interpret and administer the *Plan*, resolve any ambiguities that exist and make all factual determinations, except to the extent the *Plan Administrator* has expressly delegated to other persons or entities one or more fiduciary responsibilities with respect to the *Plan*. The rights of subrogation and reimbursement shall bind the *covered person's* guardian(s), estate, executor, personal representative and heir(s).

Reimbursement Rights

You agree to hold in constructive trust the proceeds of any settlement or judgment for the *Plan's* and the *Plan Administrator's* benefit under this Section. If *you* fail to reimburse the *Plan* out of any recovery or reimbursement received for all *benefits* paid or to be paid as a result of *your sickness* or *injury*, *you* will be liable for any and all expenses, whether fees or costs, associated with the *Plan's*, the *Plan Administrator's*, the *TPA's* and their designees' attempts to recover such money from *you*.

XII. Coordination of Benefits

As a *covered person*, *you* agree to permit the *Plan* to coordinate obligations under this *SPD* with payments under any other health benefit plans as specified below, which cover *you* as an employee or dependent. *You* also agree to provide any information or submit any claims to other health benefit plans necessary for this purpose. *You* agree to authorize billing to other health plans for purposes of coordination of benefits.

This *Plan* does not coordinate *your prescription drug benefits* under this *SPD* with any other health plan's *prescription drug* benefits.

Unless applicable law prevents disclosure of the information without the consent of the *covered person* or the *covered person's* representative, each *covered person* claiming *benefits* under this *Plan* must provide any fact needed to pay the claim. If the information cannot be disclosed without consent, the *Plan* will not pay *benefits* until the information is given.

A. APPLICATION: This Coordination of Benefits provision applies when *you* have health care coverage under more than one plan. "Plan" is defined below.

B. DEFINITIONS. These definitions only apply to the Coordination of Benefits provision:

Allowable Expenses Means a *health care service* or expense that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense.

Claim Determination Period Means a calendar year. However, it does not include any part of a year during which a person has no coverage under this *Plan*, or before the date this Coordination of Benefit provision or a similar provision takes effect.

Closed Panel Plan Means a plan that provides health benefits to persons primarily in the form of services through a panel of *providers* that have contracted with or are employed by the plan, and that limits or excludes benefits or services provided by other *providers*, except in cases of *emergency* or referral by a panel member.

Custodial Parent Means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

Dependent A *covered employee's* eligible dependent as described in the section "Eligibility, Enrollment, and *Effective Date*" who is enrolled under the *Plan*.

Plan Means any of the following that provides benefits or services for medical or dental care or treatment. However, if separate policies are used to provide coordinated coverage for members of any group, the separate policies are considered parts of the same plan and there is no Coordination of Benefits among these policies.

a. Group, blanket, franchise, closed panel or other forms of group or group type coverage (insured or uninsured);
b. *Hospital* indemnity benefits in excess of $200 per day;
c. Medical care components of group long-term care policies, such as *skilled care*;
d. A labor-management trustee plan or a union welfare plan;
e. An employer or multi-employer plan or employee benefit plan;
f. Medicare or other governmental benefits, as permitted by law;
g. Insurance required or provided by statute;
h. Medical benefits under group or individual automobile policies;
i. Individual or family insurance for *hospital* or medical treatment or expenses;
j. Closed panel or other individual coverage for *hospital* or medical treatment or expenses.

Plan does not include any:

a. Amounts of hospital indemnity insurance of $200 or less per day;
b. Benefits for non-medical components of group long-term care policies;
c. School accident-type coverages;
d. Medicare supplement policies;
e. Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage listed above is a separate plan. If a plan has two parts and Coordination of Benefits rules apply to one of the two, each of the parts is treated as a separate plan. The benefits provided by a plan include those that would have been provided if a claim had been duly made.

Primary Plan/Secondary Plan Means the order of benefit determination rules which determine whether this *Plan* is a "primary plan" or "secondary plan" when compared to the other plan covering the person.

When this *Plan* is primary, its *benefits* are determined before those of any other plan and without considering any other plan's benefits. When this *Plan* is secondary, its *benefits* are determined after those of another plan and may be reduced because of the primary plan's benefits.

C. ORDER OF BENEFIT DETERMINATION RULES: The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

A plan that does not contain a Coordination of Benefits provision that is consistent with this section is always primary. **Exception**: Group coverage designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the employer.

A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

This *Plan* will not pay more than it would have paid had it been the primary plan. This *Plan* determines its order of *benefits* by using the first of the following that applies:

1. **Nondependent/Dependent**: The plan that covers the person other than a dependent, for example as an employee, subscriber, or retiree is the primary plan; and the plan that covers the person as a dependent is the secondary plan.

   Exception: If the person is a Medicare beneficiary and federal law makes Medicare:
   a. Secondary to the plan covering the person as a dependent; and
   b. Primary to the plan covering the person as a nondependent (e.g., a retired employee); then the order is reversed, so the plan covering that person as a nondependent is secondary and the other plan is primary.

2. **Child Covered Under More Than One Plan**: The order of benefits when a child is covered by more than one plan is:
   a. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the plan that covered either of the parents for a longer time is primary.
   b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms; then that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.
   c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is the plan of the:
      - Custodial parent;
      - Spouse of the custodial parent;
      - Noncustodial parent; and then
      - Spouse of the noncustodial parent.
   d. For a child covered under more than one plan by persons who are not the parents of such child, the order of benefits shall be determined under paragraph 2.a of this section as if those persons were parents of such child.
   e. For a dependent child who has coverage under either or both parents' plans and who also has coverage as a dependent under a spouse's plan, the rule in paragraph 5 of this section applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in paragraph 2.a of this section to the dependent child's parent(s) and the dependent's spouse.

3. **Active/Inactive Employee**: The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary to a plan that covers the person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits; then this rule is ignored. This rule does not apply if the rule under paragraph 1 can determine the order of benefits. For example: coverage provided to a person as a retired worker and as a dependent of an actively working spouse will be determined under the rule in paragraph 1.

4. **Continuation Coverage**: If a person whose coverage is provided under a right of continuation provided by the federal or state law is also covered under another plan, then:
   a. The plan covering the person as an employee, *covered person*, subscriber, or retiree (or as a dependent of an employee, *covered person*, subscriber, or retiree) is the primary plan.
   b. The continuation coverage is the secondary plan.
   c. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits; then this rule is ignored. This rule does not apply if the rule under paragraph 1 can determine the order of benefits.

5. **Longer/Shorter Length of Coverage**: The plan that covered the person as an employee, dependent or retiree for a longer time is primary.

D. THE EFFECT ON THE *BENEFITS* OF THIS *PLAN*: When this *Plan* is secondary, it may reduce its *benefits* at the time of processing, so that the total benefits paid or provided by all plans for each claim are not more than 100% of total allowable expenses for such claim. The reduction in this *Plan's benefits* is equal to the difference between:

1. The *benefit* payments that this *Plan* would have paid had it been the primary plan; and

2. The *benefit* payments that this *Plan* actually paid or provided.

When the *benefits* of this *Plan* are reduced as described above, each *benefit* is reduced in proportion to any applicable limit, such as a visit limit under this *Plan*.

E. RIGHT TO RECEIVE AND RELEASE INFORMATION: Certain facts about health care coverage and services are needed to apply Coordination of Benefit rules and to determine *benefits* payable under this *Plan* and other plans. The *TPA* may get the facts it needs from or give them to any other organization or person for the purpose of applying these rules and determining *benefits* payable under this *Plan* and other plans covering the person claiming *benefits*. The *TPA* need not tell, or get the consent of, any person to do this. Each person claiming *benefits* under this *Plan* must give the *Plan* any facts it needs to apply those rules and determine *benefits* payable.

F. FACILITY OF PAYMENT: A payment made under another plan may have included an amount that should have been paid under this *Plan*. If it does, the *Plan* may pay that amount to the organization that made the payment. That amount will then be treated as though it was a *benefit* paid under this *Plan*. The *Plan* will not pay that amount again. The term "payment made" includes providing *benefits* in the form of services. In this case "payment made" means the reasonable cash value of the *benefits* provided in the form of services.

G. RIGHT OF RECOVERY: If the *Plan* paid more than it should have paid, it may recover the excess from one or more of the following:

1. The persons the *Plan* has paid or for whom it has paid; or

2. Any other person or organization that may be responsible for the *benefits* or services provided under this *Plan* to the *covered person*.

The "amount of payments made" includes the reasonable cash value of any *benefits* provided in the form of services.

H. COORDINATING WITH MEDICARE:

If a *provider* has accepted assignment of Medicare, this *Plan* determines allowable expenses based upon the amount allowed by Medicare. This *Plan's* allowable expenses for a *participating provider* is the lesser of (1) the amount that the *participating provider* has contractually agreed to accept as reimbursement in full for *covered services* or (2) the Medicare allowable amount. This *Plan* pays the difference between what Medicare pays and the *Plan's* allowable expenses.

If *you* are eligible for Medicare Part A on the basis of ESRD but *you* defer Medicare entitlement beyond the 30-month coordination period, *we* will cover the ESRD-related *health care services* provided to *you* during the period of deferment immediately following the 30-month coordination period only to the extent *we* would cover such ESRD-related *health care services* had *you* not deferred Medicare entitlement beyond the 30-month coordination period (but *we* will not otherwise differentiate between *you* and other *members* with respect to coverage for non-ESRD-related *health care services*).

When *you* are covered under this *Plan* and if *you* are eligible for Medicare, *you* will be considered covered for benefits payable under Medicare Part B regardless of whether *you* have applied for Medicare Part B coverage. This section will apply only to the extent permitted by applicable state and federal law. Benefits will not be reduced due to *your* eligibility for Medicare where federal law requires that this *Plan* determine benefits without regard to the benefits available under Medicare.

Renal Failure. If *you* begin to have services related to renal failure, we request that *you* sign up for Medicare.

XIII. How to Submit a Bill if *You* Receive One for *Covered Services*

A. Bills from *Participating Providers*

When *you* present *your* identification card at the time of requesting services from *participating providers*, paperwork and submission of post-service *claims* relating to services will be handled for *you* by *your participating provider*. *You* may be asked by *your provider* to sign a form allowing *your provider* to submit *claims* on *your* behalf. If *you* receive an invoice or bill from *your provider* for services, simply return the bill or invoice to *your provider*, noting *your* enrollment in the *Plan*. *Your provider* will then submit the post-service *claim* under the *Plan* in accordance with the terms of its participation agreement. *Your claim* will be processed for payment according to the Employer's coverage guidelines. The *TPA* must receive *claims* within 180 calendar days after the date services were *incurred* or a longer time period, if any, specifically set forth in the *participating provider*'s agreement or the national network agreement, except in the absence of *your* legal capacity. *Claims* received after the deadline will be denied.

B. Bills from *Non-Participating Providers*

The process described in this section pertains only to medical services. For information regarding *prescription drug* services, please refer to Magellan Rx in Addendum A attached to this *SPD*.

***Claim* Submission**. *You* must submit a completed *claim* form in writing, together with an itemized bill for the services *incurred*, on the *claim* form provided and in accordance with the filing procedures for post-service *claims* outlined in the next section. The *TPA* must receive *claims* within 180 calendar days after the date services were *incurred*, except in the absence of *your* legal capacity. If the *Plan* is discontinued, the deadline for the receipt of *claims* is 180 calendar days. *Claims* received after the deadline will be denied. If *you* need *claim* forms, please contact Customer Service.

Payment of *Claims*. *Claims* for *benefits* will be paid promptly upon receipt of written proof of loss. *Benefits* which are payable periodically during a period of continuing loss will be paid on a periodic basis. All or any portion of any *benefits* provided by the *Plan* may be paid directly to the *provider* rendering the services. Payment will be made according to the Employer's coverage guidelines.

XIV. Initial *Benefit* Determinations of Post-Service *Claims*

Post-service *claims* are *claims* that are filed for payment of *benefits* under the *Plan* after medical care has been received and submitted in accordance with the post-service *claim* filing procedures for the *Plan*.

Filing Procedure for Post-Service *Claims*. To file a post-service *claim*, *you* or *your* attending *provider* must submit an itemized bill in writing and in accordance with the procedures and within the deadlines described in the section entitled "How to Submit a Bill if *You* Receive One for *Covered Services*." To be considered a properly filed post- service *claim* under the *Plan*, *your* completed *claim* form, together with an itemized bill and the essential data elements, must be submitted in writing to Customer Service at the mailing address noted inside the cover page to this *SPD*. *Your* post-service *claim* must include at least the following essential data elements:

a. The identity of the *covered person* and *provider* of services;
b. The date(s) of services;
c. A specific medical diagnosis; and
d. Specific treatment, *health care service*, or procedure codes for which *benefit*s or payment is requested.

An explanation of these essential data elements will be provided to *you*, upon request and free of charge, by calling Customer Service. If *you* or *your* attending *provider* have not submitted the post-service *claim* in accordance with these filing procedures, including a failure to submit all essential data elements, *your* post-service *claim* will be treated as incorrectly filed. Please note that the time periods for making an initial *benefit* determination begin when Customer Service receives a written post-service *claim* submitted in accordance with the *Plan's* filing procedures.

If *your* attending *provider* files a post-service *claim* on *your* behalf, the *provider* will be treated as *your* authorized representative under the *Plan* for purposes of such *claim* and associated appeals unless *you* provide the *TPA* with specific direction otherwise within three business days from the *Plan Administrator's* notification that an attending *provider* was acting as *your* authorized representative. *Your* direction will apply to any remaining appeals.

A request or inquiry that is not made in accordance with the *Plan's claim* procedures will not be treated as a *claim* under the *Plan*.

Initial *Benefit* Determination. If *your* post-service *claim* is denied, the *TPA* will communicate such denial within 30 calendar days after receipt of a post-service *claim* submitted in accordance with the *Plan's* filing procedures. If the *TPA* does not have all information it needs to make an initial *benefit* determination, it may extend the time period for the initial *benefit* determination by 15 calendar days. The *TPA* will notify *you* of the extension within the initial 30 calendar day period. *You* will then have 45 calendar days, or longer time as granted to *you* in the extension notification, to provide the requested information. The *TPA* will notify *you* of its initial *benefit* determination within 15 calendar days after the earlier of the *TPA's* receipt of the requested information or the end of the time period specified for *you* to provide the requested information. If *you* do not provide the requested information within the time period specified, *your claim* will be denied. If *you* and *your* authorized representative then submit the requested information within 180 calendar days after the date services were *incurred* (except in the absence of *your* legal capacity), the *Plan Administrator* may, but is not required to, reconsider the submitted information, and will not consider information it receives more than 365 calendar days after the date *your* services were *incurred*.

The time period for the initial *benefit* determination may also be extended for 15 calendar days for circumstances beyond the *TPA's* control.

If *your* post-service *claim* is denied, notification will be provided to *you*. This notice will explain:

e. Information sufficient to identify the *claim* involved and any information required by law.
f. The reason for the denial;
g. The part of the *Plan* on which it is based;
h. Any additional material or information needed to make the *claim* acceptable and the reason it is necessary; and
i. The procedure for requesting an appeal.

Note: Refer to the section entitled "*Claim* Appeals Process" for details on requesting an appeal or external review.

XV. Claim Appeals Processes

Internal Appeals Process

The internal review process for an appeal of a *claim* that is wholly or partially denied and for a rescission (retroactive termination) of *your* coverage, as defined by the *Affordable Care Act*, is:

1. **Acute Care Services Appeals**

   If *your* request for pre-certification of acute care services is wholly or partially denied and *you* have not received such services or if *you* are currently receiving acute care services and the continuation of these services is wholly or partially denied, *you* or *your* authorized representative may submit an appeal of that denial within 180 calendar days after receiving notice that *your* request was denied. *Your* appeal can be submitted to the *TPA* in writing, by telephone, or electronically, along with any issues, comments and additional information, as appropriate. The *TPA* will forward *your* appeal to the *Plan Administrator* for its decision.

   As quickly as *your* medical condition requires, but no later than 72 hours of receipt of *your* appeal by the *Plan Administrator*, *you* will receive notice of the *Plan Administrator's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based, and the procedure for requesting an external review. This time period may be extended if *you* agree.

2. **Non-Acute Care Services Appeals**

   a. **First Appeal**. If *your* request for pre-certification of non-acute care services is wholly or partially denied and *you* have not received such non-acute care services or if *you* are currently receiving non-acute care services and a request for the continuation of these services is wholly or partially denied, *you* or *your* authorized representative may submit an appeal of that denial within 180 calendar days after receiving notice that *your* request is denied. *Your* appeal can be submitted to the *TPA* in writing, along with any issues, comments and additional information, as appropriate.

      Within 15 calendar days after *your* written first appeal is received by the *TPA*, *you* will receive notice of the *TPA's* decision, including the specific reasons for it, references to the part of the *Plan* on which it is based, and the procedure for requesting a second appeal from the *Plan Administrator*. This time period may be extended if *you* agree subject to applicable law.

b. **Second Appeal**. Within 60 calendar days after receiving a notice that *your* first appeal was denied, *you* or *your* authorized representative may submit a second appeal. *Your* second appeal can be submitted to the *TPA* in writing, along with any issues, comments and additional information, as appropriate. The *TPA* will forward *your* second appeal to the *Plan Administrator* for its decision.

Within 15 calendar days after *your* written second appeal is received by the *Plan Administrator*, *you* will receive notice of the *Plan Administrator's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based, and the procedure for requesting an external review. This time period may be extended if *you* agree subject to applicable law.

3. **Concurrent Care *Claims***

If *your* concurrent care *claim* for *benefit*s is wholly or partially denied, *you* or *your* authorized representative may submit an appeal to the *TPA* on the same basis as described above. Acute concurrent care *claim* appeal requests should be submitted to the *TPA*, and will be processed, the same as acute care services appeals above. Non-acute concurrent care *claim* appeal requests should be submitted to the *TPA*, and will be processed, the same as non-acute care services appeals above.

4. **Post-Service Appeals**

a. **First Appeal**. If *your* post-service *claim* for *benefit*s is wholly or partially denied, *you* or *your* authorized representative may submit an appeal within 180 calendar days after receiving notice that *your claim* is denied. *Your* appeal can be submitted to the *TPA* in writing, along with any issues, comments and additional information as appropriate.

Within 30 calendar days after *your* written first appeal is received by the *TPA*, *you* will receive notice of the *TPA's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based, and the procedure for requesting a second appeal from the *Plan Administrator*. This time period may be extended if *you* agree.

b. **Second Appeal**. Within 60 calendar days after receiving a notice that *your* first appeal was denied, *you* or *your* authorized representative may submit a second appeal. *Your* second appeal can be submitted to the *TPA* in writing along with any issues, comments and additional information, as appropriate. The *TPA* will forward *your* second appeal to the *Plan Administrator* for its decision.

Within 30 calendar days after *your* written second appeal is received by the *Plan Administrator*, *you* will receive notice of the *Plan Administrator's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based. This time period may be extended if *you* agree.

5. **Access to Relevant Documents**

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* appeal. If the *Plan Administrator* or the *TPA* generates, relies upon, or considers any new or additional evidence in connection with an appeal, or identifies any new or additional rationale for a denial in connection with an appeal, it will be provided to *you* so that *you* have a reasonable opportunity to respond. *You* have the right to present written evidence and testimony as part of the appeals process.

External Review Process

If *your* request or *claim* is wholly or partially denied, reduced, or terminated based on medical judgment, as defined in the *Affordable Care Act*, or if *your* coverage is rescinded (retroactively terminated), as defined by the *Affordable Care Act*, *you* may have a right to have such decision reviewed by an independent review organization that is not associated with the *TPA*, *Plan* or *Plan Administrator*. The decision of the independent review organization is binding except to the extent other remedies may be available to the *Plan*, any person, or any entity under state or federal law. The following sections relating to Standard External Review and Expedited External Review apply only to a request or *claim* that is wholly or partially denied, reduced, or terminated based on medical judgment, as defined in the *Affordable Care Act* or if *your* coverage is rescinded (retroactively terminated), as defined by the *Affordable Care Act*:

Standard External Review. *You* may request an external review of any pre-service request or post-service *claim* based on medical judgment if *you* have exhausted all appeals available to *you* under the internal appeals process. Any denial, reduction, or termination of, or failure to provide payment for, a *benefit* based on a determination that *you* failed to meet the requirements for eligibility under the terms of the *Plan* is not eligible for external review. Within four months after receiving a notice informing *you* of *your* right to an external review by an independent review organization, *you* or *your* authorized representative may submit a written request for an external review with an independent review organization by sending it to the *TPA*. When *you* request an external review, *you* will be required to authorize release of any medical records that the independent review organization might need to review for the purpose of reaching a decision.

Within one business day after completion of a preliminary review, which may take up to five business days, to confirm whether *you* were enrolled properly in the *Plan* at the time the pre-service *claim* was requested or post-service *claim* was provided, the *TPA* will notify *you* that *your* request is:

a. Complete and eligible for external review; or
b. Not complete, and will indicate what additional information or materials are needed to make it complete; or
c. Not eligible for external review and the reasons for its ineligibility.

If *your* request is complete and eligible for external review, the *TPA* will notify *you* which independent review organization will conduct the external review. *You* will then receive more detailed information, including contact information for the independent review organization and the independent review process and timetable.

2. **Expedited External Review**. *You* may request an expedited external review if:

   a. *Your* request for pre-certification of acute care services is wholly or partially denied and *you* have not received such services, or *you* are currently receiving acute care services and the continuation of these services is wholly or partially denied, and the timeframe for completion of an expedited internal appeal would seriously jeopardize *your* life, health, or ability to regain maximum function. Nevertheless, *you* must have filed a request for an expedited internal appeal in order to request an expedited external review; or
   b. *You* exhausted the internal appeals process and *you* have a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize *your* life, health, or ability to regain maximum function; or
   c. *You* exhausted the internal appeals process for coverage that involves an admission, availability of care, continued stay or health care item or service for which *you* received *emergency* services but have not been discharged from a facility.

      When *you* request an external review, *you* will be required to authorize release of any medical records that the independent review organization might need to review for the purpose of reaching a decision. Immediately upon receipt of *your* request for an expedited external review, the *TPA* will make a determination and notify *you* that *your* request is:

      - Complete and eligible for external review; or
      - Not complete, and will indicate what information or materials are needed to make it complete; or
      - Not eligible for external review and the reasons for its ineligibility.

   If *your* request is complete and eligible for the external review process, the *TPA* will notify *you* which independent review organization will conduct the external review. *You* will then receive more detailed information, including contact information for the independent review organization and the independent review process and timetable.

3.

XVI. If *You* Have a Complaint

If the complaint involves issues relating to quality of health care rendered by a *participating provider*, *you* should also attempt to discuss the quality of care issues with the *provider*. *You* may also direct any questions or complaints to Customer Service. When Customer Service is contacted, the representative will assist *you* in trying to resolve the complaint with the *provider* on an informal basis. The representative will also document the complaint. If these discussions are not satisfactory, *you* may submit a written complaint to the *Plan Administrator*. However, the *Plan* is not responsible for the quality of care rendered by a *participating provider*.

XVII. No Guarantee of Employment or Overall *Benefits*

The adoption and maintenance of this *Plan* does not guarantee or represent that the *Plan* will continue indefinitely with respect to any class of employees and shall not be deemed to be a contract of employment between the Employer and any *covered employee*. Nothing contained herein shall give any *covered employee* the right to be retained in the employ of the Employer or to interfere with the right of the Employer to discharge any *covered employee*, at any time, nor shall it give the Employer the right to require any *covered employee* to remain in its employ or to interfere with the *covered employee's* right to terminate employment at any time not inconsistent with any applicable employment contract. Nothing in this *Plan* shall be construed to extend *benefit*s for the lifetime of any *covered person* or to extend *benefits* beyond the date upon which they would otherwise end in accordance with the provisions of the *Plan* or any

XVIII. Definitions of Terms Used

Affordable Care Act	The federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal guidance and regulations issued under these acts.
Bariatric Surgery	Surgery and related services for the treatment of obesity.
Benefits	The *health care services* covered under the *Plan* as approved by the *Plan Administrator* as *covered services*, as explained in this *SPD* and any amendments.
Calendar Year	The 12-month period beginning January 1 and ending the following December 31 for provisions based on a *calendar year*.
Claim	A request for *benefits* made by a *covered person* or the *covered person's* authorized representative in accordance with the procedures described in this *SPD*. It includes pre-certification requests
Contribution	The payment *your* Employer requires to be paid on behalf of or for *covered persons* for the provision of *covered services*. *Your* Employer will inform *you* of *your* share of the *contribution*.
Cosmetic	Services, medications, and procedures that improve physical appearance but do not correct or improve a physiological function, or are not *medically necessary*.
Covered Dependent	A *covered employee's* eligible dependent as described in the section "Eligibility, Enrollment, and *Effective Date*" who is enrolled under the *Plan*.
Covered Employee	The person: 1. On whose behalf *contribution* is paid; and 2. Whose employment is the basis for membership; and 3. Who is enrolled under the *Plan*.
Covered Person	A *covered employee* or *covered dependent*.
Covered Services	*Health care services* that are provided by *your provider* or clinic and are covered by the *Plan*, subject to all of the terms, conditions, limitations and exclusions of the *Plan*.
Educational	A *health care service*: 1. Whose primary purpose is to provide training in the *activities of daily living*, instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities; or 2. That is provided to promote development beyond any level of function previously demonstrated, except in the case of a child with congenital, developmental or medical conditions that have significantly delayed speech or motor development as long as progress is being made towards functional goals set by the attending *physician*.
Effective Date	The date *your* coverage under this *SPD* is effective, which depends on the date that *you* timely complete all applicable enrollment requirements imposed by the *Plan Administrator*.
Eligible Charges	A charge for *health care services*, subject to all of the terms, conditions, limitations and exclusions of the *Plan* for which the *Plan* or *covered person* will pay.
ERISA	The Employee Retirement Income Security Act of 1974 and the implementing regulations, as amended from time to time.
Essential Health Benefits	The categories of services that qualified health plans are required to cover, as defined and required by the *Affordable Care Act*. The *benefits* covered by this *SPD* may include some *essential health benefits*, but this *SPD* is not and is not intended to be a qualified health plan and does not, and is not required to, cover all *essential health benefits*.
Formulary	A list, which may change from time to time, of preferential *prescription drugs* that is used by the *Plan*.
Gravie	Gravie Administrative Services, which is a *third party administrator* (*TPA*) providing administrative services to *your* Employer in connection with the operation of the *Plan*.

Health Care Service(s)	*Medical or behavioral services including pharmaceuticals, devices, technologies, tests, treatments, therapies, supplies, procedures, hospitalizations, or provider visits.*
Incurred	*Health care services* rendered to *you* shall be considered to have been *incurred* at the time or date the *health care service* was actually purchased or provided.
Injury	Bodily damage other than *sickness* including all related conditions and recurrent symptoms.
Investigative	As determined by the *Plan Administrator*, a drug, device or medical treatment or procedure is *investigative* if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. The *Plan Administrator* will consider the following categories of reliable evidence, none of which shall be determinative by itself: 1. Whether there is a final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the FDA; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and 2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in any authoritative compendia as identified by the Medicare program such as, the National Comprehensive Cancer Network Drugs and Biologics Compendium, as appropriate for its proposed use; and 3. Whether there are consensus opinions of national and local health care *providers* in the applicable specialty as determined by a sampling of *providers*, including whether there are protocols used by the treating facility or another facility, studying the same drug, device, medical treatment or procedure.
Medically Necessary	Any *health care services*, *preventive health care services*, and other preventive services that the *Plan Administrator*, in its discretion and on a case-by-case basis, determines are appropriate and necessary in terms of type, frequency, level, setting, and duration, for *your* diagnosis or condition; and the care must: 1. Be consistent with the medical standards and generally accepted practice parameters of *providers* in the same or similar general specialty as typically manages the condition, procedure or treatment at issue; 2. Help restore or maintain *your* health; 3. Prevent deterioration of *your* condition; 4. Prevent the reasonably likely onset of a health problem or detect an incipient problem.
Named Fiduciary	The person or organization that has the authority to control and manage the operation and administration of the *Plan*. The fiduciary has discretionary authority to determine eligibility for *benefits* or to construe the terms of the *Plan* and may delegate such discretion to other individuals or entities.
Non-Participating Provider	A clinic, *physician, provider,* or facility that is licensed but is not a *participating provider.*
Orthognathic Surgery	Surgical manipulation of the elements of the facial skeleton to restore the proper anatomic and functional relationship in patients with dentofacial skeletal anomalies.
Participating Provider	A licensed clinic*, physician, provider* or facility that is directly contracted to participate in the specific *TPA participating provider* network designated by *Plan Administrator* to provide benefits to *covered persons* enrolled in this *SPD*. The participating status of *providers* may change from time to time.

	Participating providers may also be offered from other Preferred Provider Organizations that have contracted with *TPA*.
Physical Disability	A condition caused by a physical *injury* or congenital defect to one or more parts of *your* body that is expected to be ongoing for a continuous period of at least two years from the date the initial proof is supplied to the *Plan Administrator* and as a result *you* are incapable of self-sustaining employment and are dependent on the *covered employee* for a majority of financial support and maintenance. An illness by itself will not be considered a *physical disability* unless adequate separate proof is furnished to the *Plan Administrator* for the *Plan Administrator* to determine that a *physical disability* also exists as defined in the preceding sentence.
Physician	A licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), or Doctor of Chiropractic (D.C.).
Plan	The self-insured employee welfare benefit plan, as defined by *ERISA*, established by the *Plan Sponsor* for the benefit of *covered persons*.
Plan Administrator	The entity, as defined under Section (3)(16) of *ERISA*, that has the exclusive, final and binding discretionary authority to administer the *Plan*, to make factual determinations, to construe and interpret the terms of the *SPD*, *Plan*, and amendments (including ambiguous terms), and to interpret, review and determine the availability or denial of *benefits*. The *Plan Administrator* may delegate discretionary authority and may employ or contract with individuals or entities to perform day-to-day functions, such as processing claims and performing other *Plan*-connected administrative services.
Plan Sponsor	The entity that establishes and maintains the *Plan*, has the authority to amend and/or terminate the *Plan* and is responsible for providing funds for the payment of *benefits*.
Prescription Drug	A drug approved by the FDA for use only as prescribed by a *provider* properly authorized to prescribe that drug
Preventive Health Care Services	The *covered services* that are listed and covered in this *SPD* as shown under the *Preventive Health Care Services* and/or Preventive Contraceptive Methods and Counseling for Women sections of the *Benefit* Schedule.
Provider	A health care professional, *physician*, clinic or facility licensed, certified, or otherwise qualified under applicable state law to provide *health care services* to *you*.
Sickness	Presence of a physical or mental illness or disease.
Summary Plan Description (SPD)	The document describing, among other things, the *benefits* offered under the MEC Medical Option of the *Plan* and *your* rights and obligations under such *benefit* option as required by *ERISA*.
Third Party Administrator (TPA)	*Gravie* provides administrative services to the Employer in connection with the operation of the *Plan*, including processing of claims, as may be delegated to it.
Vocational Rehabilitation	*Health care services* for a *covered person* designed to obtain or regain skills or abilities beyond those *activities of daily living*, including but not limited to, a device or an enhanced device or service requested or needed to enable the *covered person* to perform activities for an occupation.
Waiting Period	The period of time that an individual must wait before being eligible for coverage under the *Plan*
You/Your/Yourself	Refers to *covered employee, covered dependent* or *covered.* .

XIX. Specific Information About *Your Plan*

The federal government requires that the following information be furnished for the MEC Medical Option of the *Plan*:

Name of the *Plan*:	This *Plan* shall be known as AJE Holdings, LLC Group Health Plan. This SPD replaces in full any previously issued *SPD*. This *SPD* is effective January 1, 2023.
Address of the *Plan*:	AJE Holdings, LLC «Adr1» «Adr2»
Type of *Plan*:	Welfare Benefit Plan providing group health benefits
Group Number, as assigned by the *TPA*: **Employer Identification Number:**	
IRS *Plan* Identification Number:	501
***Plan* Year:**	January 1 through December 31
***Third Party Administrator* or *TPA*:** The company that provides certain administrative services in connection with the *Plan*. *TPA* shall not be deemed an employer with respect to the administration of or provision of *benefits* under *Plan Sponsor's Plan*.	Gravie Administrative Services P.O. Box 211543 Eagan, MN 55121
***Plan Sponsor* and Sponsor's Address:**	AJE Holdings, LLC «Adr1» «Adr2»
***Plan Administrator* and Administrator's Address:** *Plan Administrator* retains all fiduciary responsibilities with respect to the *Plan*, except to the extent it has delegated one or more such responsibilities to others.	Benefits Committee AJE Holdings, LLC «Adr1» «Adr2» «Phone»
***Named Fiduciary*:**	AJE Holdings, LLC «Adr1» «Adr2»
***Participating Provider*:**	Aetna network
Agent for Service of Legal Process:	Attention: Human Resource Department AJE Holdings, LLC «Adr1» «Adr2»
Funding:	This is a level-funded plan, not insured by the *TPA* or an insurance carrier; the Employer provides funds from its general assets to pay *claims* under the *Plan*.

Contributions **and Other Cost Sharing:**	The Employer and the employee share the cost of coverage. This cost sharing involves *contributions*, *deductibles*, *copayments,* and *coinsurance*. *Your* Employer funds and provides contributions for the cost of coverage and will inform *you* of *your* share of the *contribution*, which will be used to reimburse the Employer for the cost of coverage it provided. *Your* share of *deductibles*, *copayment* and *coinsurance* are described elsewhere in this *SPD*.

Addendum A

Magellan Rx

Prescription Drug Appeals

Plan Sponsor delegates to Magellan Rx (MRx) the authority to perform administrative and/or clinical initial *prescription drug* coverage determinations and appeals (whether first level, second level or urgent) filed by or on behalf of *covered persons*. In the event MRx issues a denial in connection with the final level of internal (*Plan*) appeal, MRx will, on *Plan Sponsor's* behalf, provide the *covered person* access to a panel of Independent Review Organizations (IROs) for the purpose of obtaining an external review if desired. MRx may offer the services of different IROs, or otherwise change the composition of the panel, during the term of the Agreement. MRx offers access to such IROs as a convenience to *Plan Sponsor*, and *Plan Sponsor* at all times retains the responsibility and authority to determine the IROs that will perform external reviews for the *Plan*.

Magellan Rx Contact Information:

Website: www.magellanrx.com

Telephone: 1.800.424.0472

Address: 15950 N 76th Street

Scottsdale, AZ 85260