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

By: Robert Arnold
Robert Arnold (May 13, 2025 10:04 CDT) **Date:** May 13, 2025

The Celarity Group Health Plan
Summary Plan Description

December 01, 2024

QUICK REFERENCE GUIDE

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** **CVS Caremark: 833.847.8881** **Aetna: 855.451.8365**
Website	**Gravie member website:** https://member.gravie.com **Aetna Provider directory:** www.aetna.com/asa
Mailing Address	**Claims, appeal requests, and written inquiries should be mailed to:** **Customer Service Department** **Gravie Administrative Services** **P.O. Box 211543** **Eagan, MN 55121**
Prescription Drugs **CVS Caremark**	**Telephone: 833.847.8881** **Website: www.gravie.com**
Identification Cards	The Third Party Administrator (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. If any Covered Person permits the use of their Identification Card by any other person, such card may be retained by this Plan, and all rights of such Covered Person pursuant to this Plan may be terminated.

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I. Introduction

A. 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 for Covered Services from its general assets.

The Plan Administrator retains all fiduciary responsibilities with respect to the Plan and 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.

The Plan Sponsor, by action of its governing body or an authorized officer or committee, reserves the right to change or terminate the Plan. This includes, but is not limited to, changes to Contributions, Copayments, Deductibles, Coinsurance, and Out-of-Pocket Limits and any other terms or conditions of the Plan. The decision to change the Plan may be due to changes in federal laws governing welfare Benefits, or for any other reason.

B. Gravie Administrative Services (Gravie, TPA)

Your Employer has contracted with Gravie, as an external Third-Party Administrator (TPA), to provide certain administrative services, including Claim processing services, subrogation, utilization management, and complaint resolution assistance. Please note that your Employer is solely responsible for payment of your eligible Claims. Gravie has no power to change or delete any of the terms of the Plan, or to waive or fail to apply any eligibility requirements for a Benefit under the Plan without direction from the Plan Administrator.

C. Summary Plan Description (SPD)

Please read this entire SPD and review its attachments 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 Schedule of Benefits attached to this SPD has specific information on covered Benefits, exclusions, and cost-sharing amounts.**

Capitalized words used in this SPD have special meanings and are defined at the back of this SPD in Section XI. Keep this SPD in a safe place for future reference.

This document serves as the Summary Plan Description and includes important information about your benefits under the Plan. The Plan Administrator has, to the fullest extent permitted by law, the sole, final, and exclusive discretion to determine Benefits available under the Plan. Amendments that are included with this SPD or adopted by the Plan Sponsor are fully made a part of this SPD.

II. When Am I Eligible?

A. Eligibility

You are eligible to enroll for coverage if you are:

1. Classified by the Plan Sponsor as a full-time employee under the Plan Sponsor's Full-Time Employee Policy, which is maintained separately by the Plan Sponsor and available upon request.

2. An Eligible Dependent of the employee. An employee must elect coverage for themselves if they want to enroll eligible dependents. If both parents are covered as employees under this Plan, a child may be covered as a dependent of either parent, but not both.

B. Enrollment and Coverage Commencement

New Enrollment. The eligible employee must apply to enroll themselves and any dependents they wish to enroll within 31 calendar days after the date the employee first becomes eligible. Coverage will commence on the first of the month after a waiting period of 60 days.

Annual Enrollment. Subject to all eligibility and enrollment provisions, the employee may elect to enroll themselves and any eligible dependents during the Employer's annual enrollment period. Coverage will commence on the date indicated by your Employer during the annual enrollment period.

III. Are There Other Times When I Can Add or Drop Coverage?

Special Enrollment Period

If you are an eligible employee, but not enrolled for coverage under this Plan, you may enroll yourself and your eligible dependents for coverage under the terms of this Plan if the following conditions apply:

1. You were covered under a group health Plan , covered under a state public health program, or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

2. You experienced a qualifying life event such as marriage, birth, adoption, or placement for adoption.

3. The eligible employee stated in writing at the time that coverage was previously offered that the other health coverage was the reason for declining enrollment.

4. 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 a state public health program; 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

5. The eligible employee requested such enrollment not later than 30 calendar days after the date of the event described in paragraphs 4.a, 4.b or 4.d above, or not later than 60 calendar days after the date of loss of eligibility for a state public health program described in paragraph 4.c above.

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.

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.

Coverage will commence on the date of the event described above.

IV. When Does My Coverage End?

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

- The date the Plan is terminated;
- The end of the month in which the Covered Employee retires;
- The end of the month in which your eligibility under the Plan ends;
- 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;
- For a dependent, the end of the month due to the dependent's enrollment in Medicare or another group health Plan;
- 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
- The date you performed an act that constitutes fraud, made an intentional misrepresentation or omission of material fact, under the terms of the Plan.
- The end of the month following the date you enter active military duty for more than 31 days.
- The date of the death of the Covered Person. Coverage for the Covered Employee's dependents will terminate the end of the month in which the death occurred.
- For a spouse, the end of the month following the date of divorce.
- For a dependent domestic partner (if covered), the end of the month in which the individual no longer meets the criteria to be a dependent domestic partner.
- When the maximum period for coverage under COBRA Continuation Coverage expires for a Covered Person.
- For a child who is entitled to coverage through a QMCSO, the end of the month in which the earliest of the following occurs:
    a. The QMCSO ceases to be effective; or
    b. The child is no longer a child as that term is used in ERISA; or
    c. The child has immediate and comparable coverage under another Plan; or
    d. The Covered Employee who is ordered by the QMCSO to provide coverage is no longer eligible as determined by the Employer; or
    e. The Employer terminates family or dependent coverage; or
    f. 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.

V. How Do I Submit a Claim For Payment?

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 365 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. Out-of-network pharmacy services are not covered. To locate an in-network pharmacy, please visit www.gravie.com.

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.

C. 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 above. 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 of this SPD. Your post-service Claim must include at least the following essential data elements:

- The identity of the Covered Person and Provider of services;
- The date(s) of services;
- A specific medical diagnosis; and
- Specific treatment, health care service, or procedure codes for which Benefits 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:

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

VI. How Do I Submit An Appeal?

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.

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.

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 Benefits 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 Benefits 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.

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.

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:

1. **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.

Prescription Drug Appeals

Plan Sponsor delegates to CVS Caremark (CVS) 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 CVS issues a denial in connection with the final level of internal (Plan) appeal, CVS 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. CVS may offer the services of different IROs, or otherwise change the composition of the panel, during the term of the Agreement. CVS 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.

CVS Information:

Website: www.caremark.com
Telephone: 833-847-8881
Address: CVS Caremark Claims Department
PO Box 52136
Phoenix, AZ 85072-2136

VII. 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.

B. ORDER OF BENEFIT DETERMINATION RULES: The plan that covers the Covered Person as the Covered Employee is the primary plan. The plan that covers the Covered Person as a dependent is the secondary plan. 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.

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 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. If the parents are married, the following rules apply:
      - The primary plan is the plan of the parent whose birthday is earlier in the year;
      - 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.
   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.

4. **Continuation Coverage**: If a person whose coverage is provided under a right of continuation provided by the federal or state law and 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.

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

C. 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.

D. 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. Each person claiming Benefits under this Plan must give the Plan any facts it needs to apply those rules and determine Benefits payable.

E. 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 payment will count as a valid payment under the plan.

F. 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.

G. 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's Allowable Expenses for a Non-Participating Provider is the lesser of (1) the Usual and Customary Amount 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).

VIII. 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.

IX. Information About Your Plan

A. Conflict with Existing Law

It is intended that this Plan meet all applicable requirements of the Code and ERISA and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

B. 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.

C. Anti-Assignment

Without limiting the foregoing, no Claim for Benefits under the Plan, and no rights related directly or indirectly to any such Claim (including, without limitation, the right to pursue an internal Claim or appeal, the right to pursue litigation for payment of Benefits, the right to pursue litigation for breach of fiduciary duty, the right to pursue litigation to recover any statutory penalties, or the right to assign payment), may be assigned to an out-of-network hospital, facility, or other health care Provider without the Plan Administrator's written consent. In its discretion, the Plan Administrator may voluntarily pay (or cause to be paid) Benefits directly to an out-of-network hospital, facility, or other health care Provider on behalf of a Covered Individual, and such payment will not constitute an assignment of rights or Benefits and will not be deemed a waiver of this anti -assignment provision as to that Covered Individual or any other Covered Individual.

D. Rights of Covered Persons

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 180 days of your request.

In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a Claim for Benefits under the Plan that is denied or ignored, in whole or in part, you may file suit in a state or Federal court, within 180 days of the Claim denial, (if any), or if there is no Claim denial within 180 days 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 180 days 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 180 days 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, including emergency services, 24 hours a day, 7 days a week.
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 treatment options for your conditions, 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.

X. Specific Information About Your Plan

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

Name of the Plan:	This Plan shall be known as Celarity Group Health Plan.
Address of the Plan:	Celarity 8120 Penn Ave S Bloomington, MN 55431
Type of Plan:	Welfare Benefit Plan providing group health Benefits
Group Number, as assigned by the TPA:	FHMQL
Employer Identification Number:	41-1790178
IRS Plan Identification Number:	501
Plan Year:	December 01 2024 through November 30 2025
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:	Celarity 8120 Penn Ave S Bloomington, MN 55431
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 Celarity 8120 Penn Ave S Bloomington, MN 55431
Named Fiduciary:	Celarity 8120 Penn Ave S Bloomington, MN 55431
Participating Provider:	Aetna
Agent for Service of Legal Process:	Attention: Human Resource Department Celarity 8120 Penn Ave S Bloomington, MN 55431
Funding:	This is a self-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 Covered 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.
COBRA Administrator:	Self-Administered -- -- -- --

XI. Definitions of Capitalized Terms

Allowable Expenses	Means a health care service or expense, including deductibles, Coinsurance, and Copayments, 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, 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.
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.
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
Coinsurance	A portion of eligible charges from Non-Participating Providers that is paid by you. Your Coinsurance is a percentage of those eligible charges that are: 1) calculated at the time the Claim is processed, 2) subject to the Usual and Customary Amount or (3) the amount you must pay after satisfying your Deductible for emergency services provided by a Non-Participating Provider.
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.
Copayment	The fixed amount of eligible charges you must pay to the Provider for covered health care services received. The Copayment may not exceed the charge billed for the covered health care service.
Covered Dependent	A Covered Employee's Eligible Dependent as described in the section "When Am I Eligible? " 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.
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.

Effective Date	December 01, 2024
Eligible Dependent	An Eligible Dependent include a Covered Employee's: 1. Lawful spouse whose marriage to the Covered Employee is valid under applicable state law. 2. Children, from birth through end of the month in which the child reaches age 26, including: i. Natural child; ii. Child who is legally adopted by or placed with Covered Employee for legal adoption; iii. Stepchild; iv. Child for whom Covered Employee is designated a foster parent by an authorized social services agency or by a court of law; v. Child for whom Covered Employee is the legal guardian appointed by a court of law; vi. Child covered under a valid Qualified Medical Child Support Order (QMCSO), as defined under section 609 of the Employee Retirement Income Security Act (ERISA) 3. Same-sex or Opposite-sex domestic partner solely for the purpose of eligibility for coverage under this SPD but excluding eligibility for COBRA Continuation Coverage. 4. 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. 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: i. Became disabled before age 26; ii. Was a Covered Dependent under the Plan prior to reaching age 26; iii. 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; iv. Is dependent on Covered Employee for a majority of financial support and maintenance; and v. Is unmarried.
ERISA	The Employee Retirement Income Security Act of 1974 and the implementing regulations, as amended from time to time.
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.
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.
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.

Non-Participating Provider	1. A physician or other health care Provider who, when providing health care services, is acting within the scope of practice of that Provider's license or certification under applicable State law; or 2. A facility, like a clinic or hospital; That is not a Participating Provider.
Out-of-Pocket Limit	The maximum amount of money you must pay for health care services from Participating Providers before this Plan pays your eligible charges at 100%. If you reach Benefit, day, or visit maximums, you are responsible for amounts that exceed the Out-of-Pocket Limit. Expenses you pay for Copayments will apply to the Out-of-Pocket Limit.
Participating Provider	1. A physician or other health care Provider who is acting within the scope of practice of that Provider's license or certification under applicable State law; or 2. A facility, like a hospital or clinic: 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.
Plan	The Celarity Group Health Plan, as amended from time to time.
Plan Administrator	Celarity. The Plan Administrator retains ultimate authority for this Plan including final appeal determinations. The Plan Administrator is also the Named Fiduciary for purposes of ERISA.
Plan Sponsor	Celarity.
Plan Year	The period following the Effective Date of the Plan and each subsequent 12-month period this Plan remains in force.
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.
Summary Plan Description (SPD)	The document describing, among other things, the Benefits offered under the Medical Option of the Plan and your rights and obligations under such Benefit option as required by ERISA.
Third Party Administrator (TPA)	Gravie Administrative Services.
Usual and Customary Amount	The average amount for each covered service or supply that by discretion of the Plan Administrator is customary in the geographic area in which the health care service is provided.

For more information about Plan benefits and required annual Notices, please reference the following documents, which are incorporated herein by reference:

Attachment A: Schedule of Benefits

Attachment B: Annual Compliance Notices