IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

UNIVERSITY OF NOTRE DAME, Plaintiff-Appellant v. KATHLEEN SEBELIUS, in her official capacity as Secretary, United States Department of Health and Human Services, *et al.*, Defendants-Appellees v. JANE DOE 1, *et. al.* Intervenors-Appellees	No. 13-3853

INTERVENORS-APPELLEES' OPPOSITION TO PLAINTIFF-APPELLANT'S RENEWED MOTION FOR INJUNCTION PENDING APPEAL

The University has renewed its motion for an injunction pending appeal (Doc. No. 35-1). Intervenors-Appellees oppose that motion for the following reasons:

1. Issuing an injunction pending appeal would create considerable confusion because the provision of contraceptive coverage to Notre Dame's employees is already underway. The University premises its motion on the Supreme Court's order in another case, *Little Sisters of the Poor v. Sebelius*, 13A691, 571 U.S. __ (Jan. 24, 2014) ("*Little Sisters*"). But the *Little Sisters* plaintiffs sought and received an injunction before the regulations required them to self-certify. Accordingly, the provision of contraceptive coverage to their employees

had not yet begun. *See* Jennifer Haberkorn, *Sonia Sotomayor Halts Contraceptive Rule for Denver Center*, Politico.com, December 31, 2013, http://politi.co/1gmSabf. Here, in contrast, rather than seeking relief from the Supreme Court, the University chose to comply with the portion of the law concerning self-certification (Univ. Br. at 15), and so the provision of contraceptive coverage to Notre Dame's employees is already underway. *See* Ex. A (Letter from Meritain to Notre Dame employees describing contraceptive benefits and how to obtain them). Issuing an injunction pending appeal would therefore create extraordinary confusion both for Meritain (which is not itself a party to this suit) and for University employees (who have already begun receiving coverage). What, for example, is to be done with respect to medical procedures already scheduled and expenses already incurred? The University's employees have already experienced such uncertainty once. *See* Does' Br. (Doc. No. 34) at 7-8 (explaining that, prior to filing this lawsuit, Notre Dame had decided to comply with the Accommodation, and that employees had been informed in October 2013 that they would be receiving contraceptive coverage). There is little reason to subject them to such whiplash again—let alone to expose Meritain and University employees to the risk of yet a third reversal if the Court were to rule against the University on the merits of the preliminary-injunction appeal—especially given that a final appellate ruling is now in sight.

2. Granting an injunction pending appeal, at this late date, would be prejudicial to the other litigants. The University's motion—like its earlier motion for a remand (Doc. No. 27)—is an attempt at a second bite at the apple.

Unlike the plaintiffs in *Little Sisters*, the University did not to seek Supreme Court review of this Court's denial of an injunction pending appeal. Rather, it chose to comply with the Accommodation. As a result, this Court granted the University an expedited briefing schedule—a schedule that has nearly run its course after an exhausting six-week sprint to the finish. The United States, the Intervenors, and the federal judiciary have all strained their resources to mitigate the University's purported injury during this appeal. For what purpose would that race have been run if the University were now to be given this additional measure of relief? Particularly in light of its recent motion to remand or dismiss (Doc. No. 27), the University cannot credibly claim any hardship due to the few days left in its appeal. It certainly cannot claim any injury warranting the "extraordinary relief" of an injunction. *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008).

3. The injunction in *Little Sisters* involved no prejudice to the organizations' employees. The plaintiffs in *Little Sisters*—unlike the University—are effectively exempt from the challenged regulations. *See Little Sisters of the Poor Home for the Aged v. Sebelius*, No. 13-CV-2611-WJM-BNB, 2013 WL 6839900, *13 (D. Colo. Dec. 27, 2013). The *Little Sisters* plaintiffs utilize a church health-insurance plan that is exempt from ERISA, so the government is unable to pursue any action that would result in contraceptive coverage for their employees. Because there is at present no set of circumstances under which employees of the *Little Sisters* plaintiffs will receive contraceptive coverage, the

Supreme Court's order serves only to preserve the status quo without prejudice to third parties.

4. The *Little Sisters* injunction lends no guidance on the merits, so the legal landscape has not changed since this Court denied an injunction pending appeal. The Supreme Court's order expressly reserves judgment on the legal issue in this case, concluding with a statement that "[t]he Court issues this order based on all of the circumstances of the case, and this order should not be construed as an expression of the Court's views on the merits." *Little Sisters of the Poor v. Sebelius*, 13A691, 571 U.S. __ (Jan. 24, 2014).Thus, as a legal matter, nothing has changed since this Court refused the University's first request for an injunction pending appeal. Particularly given the factual disparity between the two cases, the order offers no reason for this Court to reverse itself.[1]

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[1]The University claims that the Intervenors cannot legitimately oppose its motion because the University's student health-insurance plan will not become subject to the Accommodation until the Fall of 2014. *See* Renewed Mot. (Doc. No. 35-1) at 1 n.1. But nothing in the law precludes a litigant from taking issue with a course of action that would have a deleterious impact on the related interests of absent third parties. *Cf. Santa Fe Indep. Sch. Dist. v. Doe*, 530 U.S. 290, 311-12 (2000) (allowing plaintiffs to take issue with impact of challenged practice on cheerleaders, band members, and football players, even though there was no showing that any of the plaintiffs themselves fell into any of these categories); *Marin-Garcia v. Holder*, 647 F.3d 666, 670 (7th Cir. 2011) (noting the relevance of "hindrance to [a] third party's ability to protect his or her own interest" to the third-party-standing analysis). In any event, the undersigned counsel represents a University employee. *See* Mot. to Add Intervenor (Doc. No. 25). Even if she was denied the ability to participate as a full-fledged litigant, her interests—and the interests of other employees—cannot be ignored.

Respectfully submitted,

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February 4, 2014

CERTIFICATE OF SERVICE

I hereby certify that, on February 4, 2014, I electronically filed a true and correct copy of the foregoing using the CM/ECF system, which will send notification of such filing to all counsel of record.

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EXHIBIT A

Dear member,

Your group health plan qualifies for an adjustment for the federal requirement to cover all Food and Drug Administration–approved contraceptive services for women, as prescribed by an in-network healthcare provider, without cost sharing. This means that your employer or institution of higher education will **not** contract, arrange, pay or refer you to a provider for contraceptive coverage. In some cases, your employer plan may cover some level of contraceptive or sterilization services. Check your policy for details.

To the extent required by applicable law, Meritain Health will provide separate payments for contraceptive services that you use, without cost sharing and at no other cost, for as long as you are enrolled in your group health plan. Your employer or institution of higher education will not administer or fund these payments. Attached is a document that explains the coverage included under the Meritain Health Contraceptive Services Payment Program (the *Program*).

This Program is only for females with reproductive ability covered by the qualifying group health plan coverage, including any female dependents also covered under the medical plan.

Using your coverage

If you choose to use your coverage under the Program, you must request a Contraceptive Services Payment Program ID card by calling the member services number on your current medical ID card, and requesting that a Contraceptive Services Payment Program ID card be sent to you.

Use the Contraceptive Services Payment Program ID card for coverage of contraceptive services and items. **Please note:** Do **not** use your regular medical ID card for the benefits under this Program; that could result in unpaid claims.

If you require services prior to receiving your Contraceptive Services Payment Program ID card, call the member services number on your medical ID card and request assistance.

We're here to help you

If you have any questions, please call Meritain Health customer service. The toll-free number is on your medical ID card.

This document is available in other languages at no cost to you.

Si necesita asistencia lingüistica en español, llámenos al número que figura en su tarjeta de identificación (ID) médica.

如需中文协助，请拨打您医疗 ID 卡上的电话号码与我们联络。

Para sa tulong sa wikang Tagalog, tawagan kami sa numero na nasa iyong Medical na ID card.

Dinék'ehji t'áá háida shíká adoolwoł nínízingo. azee'ál'į́įjí naaltsoos nitł'izí béésh bee hane'é biká'igíįjį' béésh bee hodíílnih.

Do you need this letter in another language? Call us.

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Meritain Health Contraceptive Services Payment Program Summary Plan Description

Providers are independent contractors and are not agents of Meritain Health. Provider participation may change without notice. Meritain Health does not provide care or guarantee access to contraceptive services. Not all contraceptive services are covered. Information is believed to be accurate as of production date; however, it is subject to change.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

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I. Overview of Meritain Health's Contraceptive Services Payment Program

This is not health insurance coverage. It is a program that provides payments for contraceptive services under a federal law. There is no premium or contribution that you are required to pay in order to receive payment of contraceptive services under this program. There is no cost sharing (such as copayments or coinsurance) for payment of contraceptive services under this program.

II. Eligibility

A. **Eligible for Contraceptive Services Payments:** You are eligible for contraceptive services payments if you are:

1. Female, with reproductive capacity and
2. Currently enrolled in an employer-sponsored group health plan that is offered by an *eligible organization.*

B. *Eligible Organizations* include nonprofit organizations that hold themselves out as religious organizations and that oppose providing coverage for some or all contraceptive services on account of religious objections.

C. Eligibility terminates when either:

1. Your employer no longer qualifies as an *eligible organization,* or
2. You or your female dependents are no longer enrolled in the group health plan that is offered by an eligible organization.

III. Covered contraceptive services and terms for coverage for contraceptive services

This program covers certain contraceptive services (as required by the Health Resources Services Administration [HRSA]) that are provided in-network without cost share to eligible individuals.

A. **Coverage for Contraceptive Medical Services: Contraceptive services, in accordance with the HRSA, will be covered in-network, including:**

1. Counseling services provided by a physician, in either a group or individual setting, on contraceptive methods. Services are subject to visit maximums (see the Schedule of Benefits in Section III C).
2. Female voluntary sterilization procedures, and related services and supplies, including tubal ligation and sterilization implants. Coverage does not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.
3. Related medical procedures for contraceptive services, such as contraceptive device implantation and removal.

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B. Schedule of Benefits

Contraceptive Services—Medical Services Features	Network	Out-of-Network
Female Contraceptive Counseling Services—Office Visits	100% per visit; no copay or other cost sharing applies Limited to 2 visits per calendar year	Not covered
Female Voluntary Sterilization—Inpatient	100% per admission; no copay or other cost sharing applies	Not covered
Female Voluntary Sterilization—Outpatient	100% per visit/surgical procedure; no copay or other cost sharing applies	Not covered
Female Contraceptive—Devices* IUDs, Implants, Diaphragms, Cervical Caps	100% per prescription or refill Limit: 1 per year	Not covered

*Please see the formulary to find out which contraceptives are covered. You may call customer service for more information.

C. When can I receive coverage for contraceptive services?

You are eligible for this contraceptive services program during the coverage period of your group health plan, as long as you are enrolled in the group health plan (e.g., if your employer-sponsored group health plan was effective beginning January 1, that is when you can receive services through the contraceptive services program).

D. How do I get coverage for contraceptive services?

You can receive payments for your contraceptive services program by requesting an ID Card by calling the member services number on your current ID Card and requesting that a Contraceptive Services Program ID Card be sent to you.

This ID Card is different than the ID Card you use for your other medical benefits that are offered through your employer group health plan.

You should go to one of our participating providers. To see who is a participating provider, call us at using the member services number on your ID Card.

If you require care prior to receiving your ID Card, call the customer services number on your medical ID Card and request assistance.

If you get contraceptive services from a provider that is not a participating provider, you will not receive payments for those services under this program. Exceptions may apply (e.g., if you live in an area where Meritain Health does not have participating providers, identified by your home zip code). If you have questions on whether an exception may apply, how to request an exception or whether prior approval is needed prior to getting services from a non-participating provider, please call the member services number on your ID Card for assistance.

IV. Claims and Appeal Procedure—Contraceptive Services

Information on how to file an initial claim for benefits is described in this section, including the maximum timeframes for deciding a claim, appealing a denied claim, deciding an appeal and requesting external review.

You may file claims for benefits and appeal adverse benefit determinations either yourself or through an authorized representative. An *authorized representative* means a person you authorize, in writing, to act on your behalf. A court order giving a person authority to submit claims on your behalf will be recognized. Any reference to *you* in this section includes you and your authorized representative.

Claims must be submitted to Meritain in writing. Claims must give proof of the nature and extent of the loss. All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss. If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

A. Initial claims decisions

If your claim for contraceptive services is wholly or partially denied, you will receive a written notice of the denial within a certain number of days. The timeframes may be extended for an additional number of days, if special circumstances require an extension of time for processing your claim. In that case, you will receive an extension notice that explains the special circumstances and indicates the date on which the plan expects to make a determination. The extension notice will be provided to you before the end of the initial timeframe for providing notice of a denied claim. If there is not sufficient information to decide your claim, you will be given a period of time to provide the requested information before a decision is made. The maximum timeframes are described in the chart that follows.

Ongoing course of treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the pre-authorized course of treatment is intended to be terminated or reduced, so that you will have an opportunity to appeal the decision and receive a decision on the appeal before the termination or reduction takes effect. If the course of treatment involves urgent care and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Contraceptive Service Claims			
Event	Urgent Care[1]	Pre-Service[2]	Post-Service
Notice of Incomplete Claim	24 hours	N/A (may extend initial claim decision in deadlines described below)	N/A
Timeframe to provide additional information if requested	Not less than 48 hours	45 days	45 days
Initial claim decision (measured from receipt of initial claim)	24 hours[3]	15 days, plus one 15 day extension[4]	30 days, plus one 15-day extension
Information included in notice of an adverse benefit determination	▪ The specific reason for the denial ▪ Reference to the specific plan provisions on which the denial is based ▪ A description of any additional information necessary to correct the claim and an explanation of why such information is necessary ▪ A description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA if the claim is denied on review (statement to be applicable only if your employer's group health plan that you have medical benefits through is a self-funded plan)		

B. Appealing a denied claim

If your claim has been denied, you may submit a request for review of the denied claim, and a decision will be rendered, in accordance with the timeframes in the chart that follows. The timeframes for deciding an appeal may be extended for an additional number of days, if special circumstances require an extension of time for processing your claim. In that case, you will receive an extension notice that explains the special circumstances and indicates the date on which the plan expects to make a determination. The extension notice will be provided to you before the end of the initial timeframe for deciding the appeal.

[1] Urgent care means any "pre-service claim" for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or your health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without care or treatment that is the subject of this claim.

[2] If your plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, the claim is considered a pre-service claim.

[3] Notice may be given orally by the deadline, with written notice three days after oral notice.

[4] For pre-service claims that name a specific claimant, medical condition and service or supply for which approval is requested and which are submitted to a plan representative for handling benefit matters, but which otherwise fails to follow the plan's procedures for filing pre-service claims, you will be notified of the failure within five days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Your request must be submitted in writing and include reasons for requesting the review. You may also submit written comments, documents, records and other information relating to your claim, even if the comments, documents, records, or information were not submitted in connection with the initial claim. You may also request that the plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

Generally, you are required to complete all appeal processes before being able to obtain External Review or bring an action in litigation, as applicable. However, if we do not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the plan's appeal requirements (*Deemed Exhaustion*) and may proceed with External Review or may pursue any available remedies under §502(a) of ERISA. There are limits, though, on what sends a claim or appeal straight to External Review. Your claim or internal appeal may not go straight to External Review if:

- A rule violation was minor and is not likely to influence a decision or harm you;
- It was for good cause or was beyond our control; and
- It was part of an ongoing good faith exchange between you and Meritain Health.

C. Expedited appeals process for appeals of urgent care claims

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to customer service. Meritain Health's customer service telephone number is on your ID Card. You may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be shared between you and the plan by telephone, facsimile, or other similar method. You will be notified of the decision no later than 36 hours after the appeal is received.

		Contraceptive Services Appeals	
Event	Urgent Care	Pre-Service	Post-Service
Deadline for filing an appeal (measured from receipt of adverse benefit determination)	180 days (see expedited appeal process)	180 days	180 days
Appeal decision (measured from receipt of appeal)	36 hours	15 days	30 days
Deadline for filing a second level appeal (measured from receipt of appeal)	ASAP	60 days	60 days
Second-level appeal decision (measure from receipt of appeal)	36 hours	15 days	30 days
Deadline for requesting External Review (measured from date of receipt of appeal decision)	123 days	123 days	123 days
Information included in notice of a denied claim	▪ The specific reason for the denial ▪ Reference to the specific plan provision on which the denial is based		

on appeal

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits
- A statement describing any voluntary appeal procedures, including external review
- A statement of your right to bring a civil action under Section 502(a) of ERISA, where applicable

D. Voluntary External Review

The External Review process gives you the opportunity to receive review of an adverse benefit determination conducted pursuant to applicable law. *External Review* is a review of an eligible adverse benefit determination by an Independent Organization/External Review Organization (ERO).

Your request will be eligible for External Review if the claim decision involves medical judgment and the following are satisfied:

- Aetna does not strictly adhere to all claim determination and appeal requirements under federal law (except for minor violations); or
- The standard level of appeal has been exhausted.

An adverse benefit determination based on your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external reviewer is binding on you and the plan unless otherwise allowed by law.

<u>Process for requesting an External Review</u>

You must complete all of the levels of standard appeal described in this section before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that Meritain Health may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any adverse benefit determination that qualifies as set forth below:

- The notice of adverse benefit determination that you receive will describe the process to follow if you wish to pursue an external Review and will include a copy of the Request for External Review Form.
- You must submit the Request of External Review Form within 123 calendar days of the date you received the adverse benefit determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. You must also include a copy of the notice and all other pertinent information that supports your request.
- If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other

benefits. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.
- If you choose not to file for the voluntary review, the plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Preliminary Review

Within five business days following the date of the request, Meritain Health will provide a preliminary review determining: you were covered for contraceptive services at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all necessary paperwork and you are eligible for External Review.

Within one business day after completion of the preliminary review, Meritain Health will issue you a notification in writing. If the request is complete but not eligible for External Review, such notification will include reasons for ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 1.866.444.EBSA ([3272]). If the request is not complete, such notification will describe the information or materials needed to make the request complete and Meritain Health will allow you time to perfect the request for External Review within the 123-calendar-day filing period, or within 48 hours following the receipt of the notification, whichever is later.

Referral to ERO

Meritain Health will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one business day after making the decision, the ERO will notify you and Aetna. The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

(i) Your medical records;

(ii) The attending healthcare professional's recommendation;

(iii) Reports from appropriate healthcare professionals and other documents submitted by the plan, you, or your treating provider;

(iv) The terms of your plan to ensure that the ERO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;

(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(vi) Any applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with the terms of the plan or with applicable law; and

(vii) The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO will provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO will deliver the notice of Final External Review Decision to you and the plan. A *Final External Review Decision* is a determination by an ERO at the conclusion of an External Review.

After a Final External Review Decision, the ERO will maintain records of all claims and notices associated with the External Review process for six years. An ERO will make such records available for examination by the claimant, plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the adverse benefit determination, the plan immediately must provide payment (including immediately authorizing or immediately paying benefits) for the claim.

Where to file claim appeals

Appeals for contraceptive services claim denials are reviewed by Meritain Health. Call the customer service number on your ID Card for the appeals address.

V. COBRA Rights

A. Eligibility and other plan information

Coverage for contraceptive services payments may continue to apply if:

- The plan you are enrolled in through your employer is subject to COBRA; and
- You elect COBRA coverage (as permitted and described below) under the eligible organization's group health plan.

Coverage for contraceptive services payments would no longer be available once the COBRA coverage ends, or if the group health plan is no longer sponsored by an eligible organization.

18-month continuation

If you lose healthcare coverage under your employer-sponsored group health plan due to termination of employment (other than gross misconduct) or reduced work hours, you will be eligible to purchase COBRA continuation coverage under your employer-sponsored group health plan for yourself and/or your eligible dependents. You and your eligible dependents will continue to receive coverage for contraceptive services under this program for up to 18 months following your termination of employment or reduction of work hours.

If your dependent loses coverage due to your entitlement to enroll in Medicare, your covered dependents may be eligible to continue coverage under COBRA related to your group medical benefits for up to 36 months. You and your eligible dependents will continue to receive coverage for contraceptive services for up to this 36 months as well.

29-month continuation

If the Social Security Administration (SSA) determines that you or any of your eligible dependents are disabled during your first 60 days of COBRA coverage, you may extend your COBRA coverage under your employer-sponsored group health plan for an additional 11 months, for a total of 29 months of coverage. You must notify your COBRA plan administrator under your employer-sponsored group health plan within 60 days of the SSA determination and before the end of the original 18-month COBRA continuation period. If you experience a second qualifying event during the 29-month period, coverage may be extended from 29 to 36 months. You must notify your COBRA Plan Administrator under your employer-sponsored group health plan, within 60 days of the second qualifying event.

36-month continuation

If your dependent loses coverage owing to one of the following events, he or she is eligible to purchase COBRA continuation coverage under your employer-sponsored group health plan for up to 36 months from the date of the event. Qualifying events are:

- Death of the covered employee (first 12 months is at deceased employee's rate).
- Divorce or legal separation from the employee.
- A child ceasing to be considered an eligible dependent under the plan.

Your entitlement to enroll in Medicare

If one of these events occurs during the 18- or 29-month continuation period, the continuation period can be extended from 18 or 29 months to 36 months for your covered dependents. Your COBRA Plan Administrator under your employer-sponsored group health plan must be notified before the end of the 18- or 29-month continuation period if a qualifying event occurs.

Your responsibilities

If you terminate employment, you automatically will receive notification of the right to continue COBRA coverage at the applicable COBRA premium rates within 44 days of the date you lose coverage. You have a 60-day period to elect COBRA coverage, otherwise your COBRA rights to continue coverage are waived. The 60-day period starts from the later of the date your coverage ends or the date of your notice of COBRA rights.

Early termination of COBRA coverage

Continued coverage for contraceptive services payments under this program will terminate early for you or your dependents if you or your dependents cease to be enrolled in your group health plan-sponsored COBRA coverage.

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VI. ERISA Rights

A. Your ERISA rights

If your employer-sponsored group health plan is self-funded, you have additional ERISA rights.

As a participant in any benefit plan subject to ERISA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to the following:

- You can examine, without charge, at the plan administrator's headquarter office and at other specified locations, such as worksites, all documents governing the plan.
- You can obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, and the updated summary plan description. The plan administrator may make a reasonable charge for the copies.
- The plan administrator is required by law to furnish each participant with a copy of the summary of his/her annual financial report, if applicable.

Continue group health plan coverage

You may be able to continue to be eligible for contraceptive services payments for yourself, spouse, or dependents if there is a loss of coverage under group health plan that is sponsored by your employer, as a result of a qualifying event. If you enroll in such continuation coverage for your employer-based group health plan benefits, you and your dependents may be eligible to continue to receive payments for contraceptive services during the time you are enrolled. Review this summary plan description governing the plan on the rules governing your COBRA continuation coverage rights for contraceptive services payments.

Enforce your rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if applicable) from the plan and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance with your questions

If you have any questions about your plan, you should contact Aetna. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or 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.

Administrative Details

Plan Administrator:
Meritain Health

If you have any questions, call the member services number on your Contraceptive ID Card or send paper correspondence to the address on the reverse side of your ID Card.

Plan name: Meritain Health Contraceptive Services Payment Program

Agent for service of legal matters:
General Counsel, Meritain Health
300 Corporate Parkway
Amherst, NY 14226

VII. Other Important Information

Meritain Health has the sole right to exercise its discretion to construe and interpret the provisions of the programs described in the summary plan description, and its decisions shall be binding and conclusive. Meritain Health has the sole right to make rules and procedures necessary or proper for the administration of these programs and the transaction of business there under. Meritain Health retains the right to amend or terminate some or all of its benefits at any time.