ascend
TO WHOLENESS
HEALTHCARE PLANS

NORTH AMERICAN DIVISION
Healthcare Assistance Plan

Ascend to Wholeness Plans

SUMMARY PLAN DESCRIPTION (SPD)

JANUARY 01, 2018

PLAN ADMINISTRATOR
Adventist Risk Management, Inc.
P.O. Box 4288
Silver Spring, MD 20914-4288
www.adventistrisk.org

MEMBER AND PROVIDER SERVICE
1-888-276-4732
healthcare@adventistrisk.org

PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK (MEDICAL AND DENTAL)
Aetna Signature Administrators PPO by Aetna
https://asalookup.aetnasignatureadministrators.com

MEDICAL, DENTAL, AND VISION CLAIMS PROCESSING
HealthSCOPE Benefits
P.O. Box 16203
Lubbock, TX 79490-6203
EDI: 71063
1-888-276-4732

PRESCRIPTION CLAIMS PROCESSING
Express Scripts
1-800-841-5396

UTILIZATION REVIEW MANAGER (MEDICAL NECESSITY APPEALS)
Adventist Health Benefits Administration
P.O. Box 619031
Roseville, CA 95661-9031
1-888-276-4732

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 85 for more details.

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Welcome

This *Plan* is intended to be, and has been since its establishment, a church plan within the meaning of Internal Revenue Code Section 414(e) and ERISA Section 3(33). The Seventh-day Adventist Organizations of the North American Division of the Seventh-day Adventist Church established this *Plan* for its *participating employers* for their eligible employees (and employees' dependents) in order to fulfill a key tenet of the Seventh-day Adventist Church (the "Church") in furthering the healing ministry of Jesus and, through his love and healing power, promoting prevention, whole-person care, and physical, mental, and spiritual health. As a church plan, the Plan is exempt from ERISA and is subject to the Church Plan Parity and Entanglement Prevention Act of 1999.

The *Plan* provides a broad range of benefits for medical, vision, dental, and prescription expenses which you and your eligible dependents may incur in the United States. The *Plan* also pays a portion of the cost of *emergency* medical expenses incurred anywhere in the world for outpatient care, hospital care, surgery, pre-admission services, and prescription drugs. (Non-*emergency* medical services outside the United States are excluded from coverage.)

The *Plan* is self-funded by means of *employer* and *employee* contributions. Each *participating employer* is responsible for funding only the claims of its own *employees* and its own *employees*' dependents. Each *participating employer* (including your *employer*) has designated the Church to administer the *Plan*, which it does via Adventist Risk Management, Inc. (which is part of the Church), the *plan administrator* of this *Plan*. Adventist Risk Management, Inc (ARM) and its representatives and delegates administer the *Plan*.

This Summary Plan Description (**SPD**) is designed to provide you with important information about your *Plan*'s benefits, limitations and procedures. Benefits described in this document are effective January 1, 2018. This SPD is also the *Plan* document. This SPD describes the benefits available to all *enrollees* of the *Plan*; however, depending on your state of residence, you may be entitled to additional benefits by state law.

Your benefits are affected by certain limitations and conditions, which require you to be a wise consumer of health services and to use only those services you need. Also, benefits are not provided for certain kinds of treatments or services, even if your health care provider recommends them. Many items are not covered by the *Plan* even though they may provide significant patient convenience or personal comfort. The *Plan* does not, and is not intended to, cover all healthcare services and products that are available, particularly treatment that is not *medically necessary*.

In order to participate in this *Plan*, you are required to make "employee-share contributions," which you may think of as premiums. However, this *Plan* is not an insurance program or policy.

In this SPD, the terms, "you" and "your" refer to the *covered employee*. The terms "we," "us" and "our" refer to the *plan administrator*.

Questions about the *Plan* should be directed to the phone numbers on the front of your benefit ID cards or to

Thank you for choosing us as your healthcare plan.

Translation Services are Available

Spanish (Español): Para obtener asistencia en Español, llame al 888-276-4732.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-276-4732.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**: 888-276-4732.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-276-4732.

Key Plan Information

Plan Name:
Healthcare Assistance Plan for Employees of Seventh-day Adventist Organizations of the North American Division Aka Ascend To Wholeness Healthcare Plans (the "*Plan*")

Plan Sponsor:
The *Plan* is sponsored by its *participating employers*, who are Seventh-day Adventist Organizations of the of the Seventh-day Adventist Church, based in the United States.

Plan Year: January 1 through December 31

Plan Administrator:
Adventist Risk Management, Inc.
www.adventistrisk.org
healthcare@adventistrisk.org
(888) 276-4732

The *plan administrator* reserves the right to monitor telephone conversations and e-mail communications between its employees and its customers for legitimate business purposes as determined by the *plan administrator*. The monitoring is to ensure the quality and accuracy of the service provided by employees of the *plan administrator* to their customers.

Funding Medium and Type of Plan Administration: The *Plan* is self-funded by means of *employer* and *employee* contributions. The portion the *employee* pays toward the total contribution is at a rate determined by the *participating employer*. Each *participating employer* funds the *Plan* only for its own *employees* and their *dependents*. The *plan administrator* provides *claim* processing and other administrative services to the *Plan*. This is not an insured plan.

Medical, Dental, and Vision Claims Processing:
HealthSCOPE Benefits
P.O. Box 16203
Lubbock, TX 79490-6203
EDI: 71063
(888) 276-4732
www.AscendToWholeness.org

Medical Necessity Pre-Certification/Utilization Review Manager:
Adventist Health Benefits Administration
P.O. Box 619031
Roseville, CA 95661-9031
(888) 276-4732

Amendment and Termination

This *Plan* may be terminated or this SPD may be changed or replaced at any time without notice, by a resolution of the North American Division Committee of the General Conference of Seventh-day Adventists or by the North American Division Risk Management Committee. The right to amend/terminate includes the right to curtail or eliminate coverage for any treatment, procedure, or service, regardless of whether any *covered employee* is receiving such treatment for an *injury*, defect, *illness*, or disease contracted prior to the effective date of the amendment/termination. Amendments may be made retroactively.

Schedule of Benefits

The tables below summarize your *Plan* benefits under your *Plan* election (Accelerate Plan or Access Plan), applicable deductibles, the annual out-of-pocket maximums, and the *co-payments* and *co-insurance* applicable to your coverage. This section only provides a summary of benefits available. For a complete discussion of the services covered under the *Plan*, as well as applicable benefit limitations, exclusions from coverage, and conditions of service that apply to your coverage, please refer to the subsequent chapters in this SPD.

If you do not follow the *pre-certification* procedures set forth in the Pre-Certification Program section of the *Plan*, no benefits will be provided (except in the case of *emergency services).* Additionally, the expenses you incur due to not following the Pre-Certification Program procedures will not be applied to your deductibles or out-of-pocket maximums.

Plan Coverage Levels – PPO Network

Generally, the *Plan* only covers services rendered by *PPO facilities* and *PPO providers*. Exceptions to this rule are detailed in the Schedule of Benefits.

Deductibles and Annual Out-of-Pocket Maximum

Deductible

A deductible is the amount of *covered service* expenses you must pay each year before the *Plan* will consider expenses for reimbursement. An additional deductible applies for each *enrollee* you cover (except as limited by the *Plan*'s out-of-pocket maximum). The annual deductible amount for each *enrollee* is shown in the table below. Expenses incurred for services that are not *covered services*, even if received from a *PPO provider*, do not count toward your deductible. There is a separate deductible for dental expenses.

There are deductibles for most medical and dental services. Certain benefits are not subject to a deductible and the expenses incurred for such benefits do not count toward your deductible. The benefits that are not subject to a deductible are those that do not require PPO access (see Schedule of Benefits, "No PPO Network Utilization Required"), office visits, preventive care services, vision, and prescription drug expenses.

The individual deductible is the amount of an individual's covered expenses for dates of service within the *Plan Year* period that must be paid by the *enrollee* before benefits are paid by the *Plan* for that *enrollee*. Each individual enrollee is subject to a separate deductible until the family deductible is reached. The family deductible is the amount of the family's collective covered expenses for dates of service within the *Plan Year* period that must be paid by the *enrollee* before benefits are paid by the *Plan*.

Deductible responsibilities are calculated and accrued based on dates of service, not dates paid. Benefit reductions due to non-compliance with the *Plan* or policy guidelines will not be credited toward the deductibles.

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the most you pay during the year (January 1 through December 31) before the *Plan* begins to pay 100% of the cost of *covered services*. The *Plan* maintains separate out-of-pocket maximums for medical benefits and pharmacy benefits. Each out-of-pocket maximum is listed in the Schedules of Benefits below.

Generally, payments you make toward *Plan* coverage and benefits, such as *co-payments*, *co-insurance* and expenses incurred in meeting deductibles, apply toward the applicable annual out-of-pocket maximum. However, the following amounts do not apply toward the annual out-of-pocket maximums:

- Your required *employee-share contributions*
- Disallowed charges
- Balance billed charges (that is, amounts above the *usual, reasonable, and customary charge* billed by an *out-of-network provider* directly to an *enrollee*)
- Amounts paid or credited under drug manufacturer patient assistance programs; for example, copay coupons (these are not true out-of-pocket costs)

- Amounts you pay for services listed in the Schedule of Benefits under "No PPO Network Utilization Required," such as alternative therapies, refractive eye surgery, hearing aids, and infertility treatment
- Amounts you pay for dental and vision benefits

You will be required to continue paying your *employee-share contributions* even after the annual out-of-pocket maximum is reached.

Out-of-pocket maximums are applied to each individual, regardless of whether the coverage is self-only or other than self-only (family coverage). For example, if one individual in a family reaches the individual out-of-pocket maximum, then the *Plan* will cover any additional costs for that individual's *covered services* for the remainder of the *plan year*. The remaining members of the family will still be subject to their own individual out-of-pocket maximums until the total family out-of-pocket maximum has been reached, at which point the *Plan* will cover the costs of *covered services* for all of the members of the family for the remainder of the *plan year*.

Co-Insurance and Co-Payments

After you pay your deductible, the *Plan* will pay 100% of the *usual, reasonable, and customary charge* for *covered services* less your required co-insurances and co-payments until you reach your out-of-pocket maximum.

The percentages the *Plan* pays apply only to *covered service* expenses that do not exceed *usual, reasonable and customary charges*. You are responsible for all non-*covered service* expenses and any amount that exceeds the *usual, reasonable and customary charge* for *covered service* expenses.

The Schedule of Benefits lists your *co-insurance* percentage of the cost of *covered services* (up to the *usual, reasonable, and customary charge*). *Co-insurance* percentages are the portions of *covered service* expenses paid by you after satisfaction of any applicable deductible. For example, if the listed percentage in the chart below is 20%, then for *in-network providers* your *co-insurance* would be 20% of the *network rate.*

Co-payments are fixed dollar amounts of *covered service* expenses to be paid by the *enrollee*. *Co-payments* apply per visit/admission/occurrence. If the *usual, reasonable, and customary charge* is less than the co-payment, then the co-payment is *usual, reasonable, and customary charge*. **Please note that fixed dollar *co-payments* do not apply toward your annual deductible.**

For *PPO providers* and *PPO facilities,* the *usual, reasonable, and customary charge* is the negotiated *network rate.* For *out-of-network providers* and *out-of-network facilities*, there is no negotiated fee. Therefore, if you use an *out-of-network provider* or *out-of-network facility* in one of the limited circumstances in which *out-of-network* services are covered, please note that you might be "balance-billed" by the *out-of-network provider* or *facility* (*i.e.,* charged more than the *usual, reasonable, and customary charge*) and therefore could owe more than your *co-payment* plus your *co-insurance*.

Lifetime and Annual Maximum Dollar Benefit Amounts

Lifetime maximum benefits are the maximum dollar amount of covered *Plan* benefits for certain categories of services that will be paid on behalf of each Member by the *Plan* in the Member's lifetime while covered by the *Plan*. Annual maximum benefits are the maximum amount of covered *Plan* benefits for certain categories of services that will be paid on behalf of each Member by the *Plan* in the *Plan Year* while covered by the *Plan*. Examples of services that are subject to annual maximums are dental and vision benefits.

Lifetime and annual maximum benefits apply only to the specific benefits so stated in the Schedules of Benefits, and they do not apply to essential health benefits, as defined by Federal regulations under the Affordable Care Act of 2010.

Please see the Schedules of Benefits for the specific benefit categories with lifetime and annual dollar limits and their respective maximum payable benefit amounts.

SCHEDULE OF BENEFITS

NOTE: For all *Plan* benefits, the following apply:

- *Co-payments* do not accrue toward deductible
- All other charges apply to deductible and out-of-pocket maximum unless otherwise noted
- After you pay your deductible, the *Plan* will pay 100% of the *U&C* for *covered services* less your required co-insurances and co-payments until you reach your out-of-pocket maximum
- *Pre-certification* is required for some services and expenses incurred due to non-compliance do not accrue toward deductible or out-of-pocket maximum
- *Out-of-network* services are only covered in very limited circumstances. Where the below chart says "not covered" in the Out-of-Network column, services will not be covered without an approved Unavailable Service Request Form ("USRF").
- Charges in excess of *Usual, Reasonable, & Customary* are member responsibility. This means if you get care from an *out-of-network* provider, you may owe amounts in excess of your co-payment and co-insurance.
- The Schedule of Benefits is only a brief summary. You should read the appropriate *Plan* sections for additional information about your coverage.

See the Pre-Certification Program section for details regarding services that require *pre-certification*.

MEDICAL BENEFITS

Benefits	Accelerate	Access	Out-of-Network
	MEMBER RESPONSIBILITY		
PREVENTIVE SERVICES	0%	0%	Not covered
DEDUCTIBLE • Individual/Family	$300 / $600	$600 / 1200	Same, depends on selected plan option
CO-INSURANCE (AFTER DEDUCTIBLE) PAID BY MEMBER	20%, unless otherwise noted	20%, unless otherwise noted	Not covered unless otherwise specified below
OUT-OF-POCKET MAXIMUMS • Individual/Family	$2,750 / $5,500	$5,600 / $11,200	Same, but applies only when services are covered; depends on selected plan option
OFFICE VISIT (APPLIES ONLY TO OFFICE VISIT CHARGE)	$25 copay	$50 copay	Not covered
URGENT CARE CENTERS • May be paid as an office visit or as an Emergency room visit according to provider contract • Facility fees for office visits are not paid	$25 or $100 copay + 20%	$50 or $100 copay + 20%	Same, depends on selected plan option
OUTPATIENT SERVICES (INCLUDES SERVICES/SUPPLIES RECEIVED AT OFFICE VISITS BEYOND OFFICE VISIT CHARGE) • For dialysis benefits, see the Dialysis Benefit Preservation Program section of this SPD	20%	20%	Not covered
INPATIENT / OUTPATIENT HOSPITAL STAYS: OFFICE / AMBULATORY SURGICAL PROCEDURES	20%	20%	Not covered

Benefits	Accelerate	Access	Out-of-Network
	MEMBER RESPONSIBILITY		
EMERGENCY ROOM • Copay waived if admitted	20% after $100 copay	20% after $100 copay	Same, depends on selected plan option
EMERGENT IN-PATIENT HOSPITAL ADMISSION • Out-of-network services are only covered until the patient's medical condition is stable, at which point the patient must consent to a transfer to an in-network facility	20%	20%	20% until stable; then not covered
AMBULANCE SERVICES	20%	20%	20%
MATERNITY & OBSTETRICS	20%	20%	Not covered
DURABLE MEDICAL EQUIPMENT • $8,000 maximum payment per Plan Year	20%	20%	Not covered
MENTAL HEALTH COUNSELING SESSIONS	$25	$50	Not covered
MENTAL HEALTH OUTPATIENT SERVICES / PARTIAL HOSPITALIZATION	20%	20%	Not covered
MENTAL HEALTH INPATIENT SERVICES	20%	20%	Not covered
RESIDENTIAL CARE AND TREATMENT	20%	20%	Not covered
SUBSTANCE ABUSE/CHEMICAL DEPENDENCY COUNSELING SESSIONS	$25	$50	Not covered
SUBSTANCE ABUSE/CHEMICAL DEPENDENCY OUTPATIENT SERVICES	20%	20%	Not covered
SUBSTANCE ABUSE/CHEMICAL DEPENDENCY INPATIENT TREATMENT	20%	20%	Not covered
HEARING CARE PROFESSIONAL TESTING/SCREENING	20%	20%	Not covered
HOME HEALTH CARE • Maximum of 120 visits per Plan Year	20%	20%	Not covered
SKILLED NURSING FACILITY • Maximum of 120-day stay per Plan Year	20%	20%	Not covered
HOSPICE CARE • To receive full Plan benefits, Precert is required	0%	0%	Requires Prior Auth
ORGAN/TISSUE TRANSPLANTS	20%	20%	Not covered
THERAPEUTIC SERVICES Physical Therapy Occupational Therapy Speech Therapy • Maximum of 60 visits for any therapeutic category • Maximum of 90 visits collectively for all therapeutic categories • Precert is required	20%	20%	Not covered
VISION THERAPY • Maximum of 30 visits per Plan Year	20%	20%	Not covered
UNAVAILABLE SERVICES • Only covered with approved Unavailable Service Request Form	N/A	N/A	20% if approved; otherwise not covered

MEDICAL BENEFITS – NO PPO NETWORK UTILIZATION REQUIRED

Benefits	Accelerate	Access
	MEMBER RESPONSIBILITY	
ALTERNATIVE THERAPIES For Accelerate Plan, benefits are bundled and have a collective limit of 45 alternative therapy visits per Plan Year, with no single therapy category to exceed 30 visits per Plan Year. For Access Plan, only Chiropractic Services are covered and there is a maximum of 30 visits per Plan Year.		
CHIROPRACTIC SERVICES • Does not apply to Plan Year deductible or out-of-pocket maximum	20%	50%
ACUPUNCTURE THERAPY • Does not apply to Plan Year deductible or out-of-pocket maximum	50%	Not covered
MASSAGE THERAPY • Maximum allowable charge is $90 per visit • Does not apply to Plan Year deductible or out-of-pocket maximum	50%	Not covered
REFRACTIVE EYE SURGERY • Lifetime maximum payable benefit of $2,400 • Does not apply to Plan Year deductible or out-of-pocket maximum	20%	50%
HEARING AIDS • Plan Year annual maximum payable benefit of $3,200 • Does not apply to Plan Year deductible or out-of-pocket maximum	20%	20%
INFERTILITY TREATMENT • Lifetime maximum benefit $16,000 • Does not apply to Plan Year deductible or out-of-pocket maximum	20%	50%
OUTPATIENT DIABETES SELF-MANAGEMENT TRAINING (DSMT) • Up to 10 hours (1 hour private and 9 hours group) training from a certified DSMT provider in the first Plan Year and then up to 2 hours of follow-up training in subsequent Plan Years	0%	0%
LIFESTYLE PROGRAMS • 1 completed session/program per plan year • Physician referral required with claim submission • Member Reimbursement • Does not apply to Plan Year deductible or out-of-pocket maximum	0% with proof of 80% completion	100%
LIFESTYLE PROGRAMS **CHIP** **FULL PLATE** **WEIGHT WATCHERS – GROUP MEETINGS ONLY** • Does not apply to Plan Year deductible or out-of-pocket maximum		Not covered

DENTAL BENEFITS – ACCELERATE PLAN

Benefits	In-Network	Out-of-Network
	MEMBER RESPONSIBILITY	
PLAN YEAR DEDUCTIBLE • Individual/Family	$100 / $300	$150 / $450
CO-INSURANCE (AFTER DEDUCTIBLE)	20%	25%
ANNUAL MAXIMUM PAYABLE BENEFIT PER PLAN YEAR • Individual/Family	$2,500 / $7,500	
DENTAL CARE **PREVENTIVE CARE** • Deductible does not apply • Does apply to Plan Year annual maximum payable benefit **RESTORATIVE CARE** • Applies to correlating Plan Year deductible	0% 20%	0% 25%
ORTHODONTIC CARE • $2,300 maximum lifetime payable • Eligible up to age 24 (through age 23)	50%	

VISION BENEFITS – ACCELERATE PLAN

Benefits	NO NETWORK REQUIRED
	MEMBER RESPONSIBILITY
VISION CARE • No deductible • Plan Year annual maximum payable benefit $450 per member	20%

PRESCRIPTION BENEFITS – ACCELERATE PLAN

Prescription Drug	
Out-of-Pocket Maximums Individual/Family	$1,250 / $2,500
Prescription co-payment responsibility*	

RETAIL – 30 DAY SUPPLY		MAIL ORDER – 90 DAY SUPPLY	
Generic	**$10**	**Generic**	**$20**
Brand (Preferred)	**$20**	**Brand (Preferred)**	**$40**
Non-Formulary	**$40**	**Non-Formulary**	**$80**

- This benefit only covers services/supplies received from Express Scripts (ESI) or from a pharmacy contracted with ESI
- Brand (also known as "preferred" or "formulary") drugs can be obtained from ESI or from a pharmacy contracted with ESI
- Prescription co-payments apply to the prescription benefit out-of-pocket maximum
- Penalties for non-compliance do not apply toward Plan Year out-of-pocket maximum
- The Plan pays 100% (and Members pay $0) for preventive prescription drugs received from ESI or from a pharmacy contracted with ESI (as described in the section of this document entitled **PREVENTIVE PRESCRIPTION DRUGS)**

Out-of-pocket for prescription benefits will be tracked by Express Scripts. Your pharmacy will be notified if you reach the Plan Year out-of-pocket maximum.

***Your employer may apply a 20% co-payment rather than a flat-dollar co-payment.**

DENTAL BENEFITS – ACCESS PLAN

Benefits	In-Network	Out-of-Network
	MEMBER RESPONSIBILITY	
PLAN YEAR DEDUCTIBLE • Individual/Family	$250 / $750	$500 / $1,500
CO-INSURANCE (AFTER DEDUCTIBLE)	20%	50%
ANNUAL MAXIMUM PAYABLE BENEFIT PER PLAN YEAR • Individual/Family	$2,500 / $7,500	
DENTAL CARE **PREVENTIVE CARE** • Does not apply to Plan Year deductible • Does apply to Plan Year annual maximum payable benefit **RESTORATIVE CARE** • Applies to correlating Plan Year deductibles	0% 20%	0% 50%
ORTHODONTIC CARE • $2,300 maximum lifetime payable • Eligible up to age 24 (through age 23)	50%	

VISION BENEFITS – ACCESS PLAN

Benefits	NO NETWORK REQUIRED
	MEMBER RESPONSIBILITY
VISION CARE • No deductible • Plan Year annual maximum payable benefit $225 per member	20%

PRESCRIPTION BENEFITS – ACCESS PLAN

Prescription Drug			
Out-of-Pocket Maximums Individual/Family	$1,550 / $3,100		
Prescription co-payment responsibility*			
RETAIL – 30 DAY SUPPLY		**MAIL ORDER – 90 DAY SUPPLY**	
Generic	**$10**	**Generic**	**$20**
Brand (Preferred)	**$50**	**Brand (Preferred)**	**$100**
Non-Formulary	**$100**	**Non-Formulary**	**$200**

- This benefit only covers services/supplies received from Express Scripts (ESI) or from a pharmacy contracted with ESI
- Brand (also known as "preferred" or "formulary") drugs can be obtained from ESI or from a pharmacy contracted with ESI
- Prescription co-payments apply to the prescription benefit out-of-pocket maximum
- Penalties for non-compliance do not apply toward Plan Year out-of-pocket maximum
- The Plan pays 100% (and Members pay $0) for preventive prescription drugs received from ESI or from a pharmacy contracted with ESI (as described in the section of this document entitled **PREVENTIVE PRESCRIPTION DRUGS**

Out-of-pocket for prescription benefits will be tracked by Express Scripts. Your pharmacy will be notified if you reach the Plan Year out-of-pocket maximum.

***Your employer may apply a 20% co-payment rather than a flat-dollar co-payment.**

Definitions

The following are definitions of some important terms used in this SPD. Wherever used in this SPD, unless the context provides otherwise, whether italicized, highlighted, capitalized, or not, the terms have the meaning set forth in this section.

Affordable Care Act ***means The Patient Protection and Affordable Care Act (PPACA) – also known as the Affordable Care Act or ACA,***

ACA Full-Time Employee means as follows: (1) If you are an *ACA ongoing employee*, you will be an ACA full-time employee for the *plan year* if your *hours of service* during the applicable *standard measurement period* when divided by 12 are equal to or greater than 130. (2) If you are an *ACA new variable-hour employee* or an *ACA new part-time employee,* you will be an ACA full-time employee for your *initial stability period*, if your *hours of service* during your *initial measurement period* were equal to or greater than 130 hours per month. This definition applies to all *employees*, including *employees* who are classified by their human resources department as either temporary or per diem.

ACA Ongoing Employee means an *employee* who has been continuously employed by one *participating employer* who employs 50 or more people for at least one complete *standard measurement period*.

ACA New Part-Time Employee means a new *employee* of one *participating employer* who employs 50 or more people whom, based on the facts and circumstances on the *employee's* first day of *active employment*, the *employer* reasonably expects to be employed by that *participating employer* on average less than 130 *hours of service* per month during the *employee's initial measurement period.*

ACA New Variable-Hour Employee means a new *employee* of one *participating employer* who employs 50 or more people for whom, based on the facts and circumstances on the *employee's* first day of *active employment*, the *employer* cannot determine whether the *employee* is reasonably expected to be employed by that *participating employer* on average at least 130 *hours of service* per month during the *initial measurement period* because the *employee's hours of service* are variable or otherwise uncertain.

Actively At Work (Active Employment). You are considered to be *actively at work* when performing in the customary manner all of the regular duties of your occupation with the *plan sponsor*, either at one of the employer's regular places of business or at some location to which the *plan sponsor*'s business requires you to travel to perform your regular duties or other duties assigned by your *plan sponsor*. You are also considered to be *actively at work* on each day of a regular paid vacation or non-working day but only if you are performing in the customary manner all of the regular duties of your occupation with the *plan sponsor* on the immediately preceding regularly scheduled work day. You are also considered to be *actively at work* if you are absent from work due to your *injury*, *illness*, disability or other *medical condition*. However, if coverage under the *Plan* is available from your first day of employment, you must actually start work in order for coverage to begin.

Adventist Health Benefits Administration is the name of the delegated *medical necessity pre-certification utilization review manager* for non-prescription drug benefits for the *Plan.*

Adventist Health Benefits Administration
P.O. Box 619031
Roseville, CA 95661-9031
Phone: (888) 276-4732
Fax: (503) 261-6741

Adverse Benefit Determination. An *adverse benefit determination* is any of the following (i) a denial, reduction, or termination of a *Plan* benefit, (ii) a failure to provide or make payment (in whole or in part) for a *Plan* benefit, or (iii) a rescission of coverage (whether or not the rescission has an adverse effect on any particular *Plan* benefit at the time of the rescission).

Ambulatory Services means medical care provided on an outpatient basis. Ambulatory care is given to persons who are not confined to a *hospital*.

Ancillary Services are support services provided to a patient in the course of care. They include such services as laboratory and radiology.

Approved Leave means any leave of absence that is approved by your *employer*. *Approved leave* includes summer vacation and other similar vacation periods for an *employee* working for a *participating employer* who is a school, college, university, or other educational institution, until such *employee* is terminated.

Authorized Representative means the individual named on a completed Appointment of Authorized Representative form that is submitted by a *claimant*. See the Claims Procedures chapter for more information.

Child or Children means (1) a natural child; (2) a step-child (i.e., the child of an *employee's spouse*); (3) a child who has been legally adopted by the *employee* or the *employee's* spouse, or placed for adoption with the *employee* or the *employee's* spouse, by either a court of competent jurisdiction or appropriate state agency; (4) an individual for whom an *employee* or the *employee's spouse* has been awarded legal guardianship by a court; and (5) an individual for whom the *employee* is required to provide coverage pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO") as defined in applicable federal law originally enacted as part of the Child Support Performance and Incentives Act of 1998 [PL 105-200, 7/16/1998; Section 401(f)(1)].

Claim means any request for a *Plan* benefit or benefits made in accordance with the Claims Procedures. A communication regarding benefits that is not made in accordance with the procedures will not be treated as a *claim*.

Claimant is an individual who has made a *claim* in accordance with the Claims Procedures.

Claim Determination Period means the *plan year* or portion thereof.

CMS means the Center for Medicare and Medicaid Services, the agency that administers Medicare, Medicaid, and Child Health Insurance Program.

Co-insurance means the shared percentage cost of *covered services* that the *enrollee* pays.

Co-payment means the fixed dollar amounts of *covered services* to be paid by the *enrollee*.

Condition means a *medical condition*.

Cost Effectiveness Services means services or supplies which are not otherwise benefits of the *Plan*, but which *plan administrator* determines, in its sole discretion, to be *medically necessary* and cost effective.

Covered Dependent means an *eligible dependent* of a *covered employee* of a *participating employer* whose application has been accepted by the *plan administrator* and who has elected to cover such *eligible dependent*.

Covered Employee means an eligible *employee* of a *participating employer* who is covered by this *Plan* following acceptance by the *plan administrator* of that person's application. For new *employees*, coverage is contingent upon enrolling within 30 days (or a longer period if required by state law) of the first day the *employee* is eligible to participate in the *Plan*. (See Waiting Period and Effective Date section.) See the Open Enrollment section below for the rules applicable to ongoing *employees* beginning and maintaining coverage. For both new *employees* and ongoing *employees*, if you do not timely enroll in accordance with this SPD, you will be required to wait until the next open enrollment period unless either the Change in Status section or the Loss of Other Coverage—HIPAA Special Enrollment Rights section applies.

Covered Service is a service or supply that is specifically described as a benefit of this *Plan*.

Custodial Care means care that helps a person conduct such common activities as bathing, eating, dressing or getting in and out of bed. It is care that can be provided by people without medical or paramedical certification or license. *Custodial care* also includes care that is primarily for the purpose of separating a patient from others, or for preventing a patient from harming himself or herself. Custodial care and services are services and supplies that are furnished mainly to train or assist a person in personal hygiene and other activities of daily living rather than to provide therapeutic treatment. Activities of daily living includes such things as bathing, feeding, dressing, walking, and taking oral medicines and any other services which can safely and adequately be provided by persons without the technical skills of a nurse or healthcare professional. Such care is considered to be custodial regardless of who recommends, provides or directs the care, where the care is provided and whether or not the individual family member can be or is being trained to care for him or herself. The *Plan* also considers any care or services to be custodial if they are or would be considered custodial for Medicare purposes.

Day, when used in the Claims Procedures, means calendar day.

Dental Implant means a device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement; endosteal (endosseous); eposteal (subperiosteal); transosteal (transosseous).

Divorce or Divorced means a judgment (i) of dissolution or annulment of a marriage or (ii) for legal separation of the *spouses* in a marriage as ordered by a court of competent jurisdiction. The effective date of a *divorce* for purposes of the *Plan* is the later of the divorce or separation effective date set by the court in its divorce/ separation order or the date on which the order is entered.

Durable Medical Equipment is equipment and related supplies which the *Plan* determines (1) are able to stand repeated use, and be of a type that could normally be rented and used by successive patients, (2) are used primarily and customarily to serve a medical purpose (e.g., not items like humidifiers, exercise equipment, gel pads, water mattresses, heat lamps, etc.), (3) are not generally useful to a person in the absence of an *injury* or illness, (4) are appropriate for home use, and (5) meet the guidelines used by the CMS. Examples of *durable medical equipment* include a wheelchair, a hospital-type bed and oxygen tanks.

Eligible Dependent means your *spouse* and/or *child* who is eligible for coverage under this medical *Plan*. The eligibility provisions are set forth in the Eligibility, Enrollment and End of Coverage chapter.

Eligible Literature Evangelist means a literature evangelist who meets the qualifications required by his or her *participating employer* according to North American Division Working Policy Section FP 70.

Eligible Seminary Student means a seminary student who meets the qualifications required by his or her *participating employer.*

Emergency Medical Condition means a *medical condition* that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would (i) place the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn *child*) in serious jeopardy, (ii) cause serious impairment to bodily functions or (iii) cause serious dysfunction of any bodily organ or part.

Emergency Services means, as provided in 26 CFR §54.9815-2719AT, or any successor law or regulation, with respect to an *emergency medical condition*, a medical screening examination which is within the capability of the emergency department of a *hospital*, including *ancillary services* routinely available to the emergency department to evaluate such *emergency medical condition*, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the *hospital*, as are required to stabilize the patient (including in-patient services). For purposes of this section, the term "to stabilize," with respect to an *emergency medical condition*, means to provide such medical treatment of the *condition* as may be necessary to assure, within reasonable medical probability, that no material deterioration of the *condition* is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman who is having contractions, to deliver (including the placenta).

Employee means an individual who is engaged by the *employer* to perform services for the *employer* in a relationship that the *employer* characterizes as an employment relationship. The following individuals are not *employees*:

- Individuals working for the *employer* under a lease arrangement.
- Individuals who are engaged by the *employer* to perform services for the *employer* in a relationship that the *employer* characterizes as other than an employment relationship. For example, individuals engaged to perform services in a relationship which the *employer* characterizes as that of an "independent contractor" with respect to the *employer*.
- Any individual described in this definition as not an *employee* is not eligible to participate in the *Plan* even if a determination is made by the Internal Revenue Service, the United States Department of Labor, another governmental agency, a court or other tribunal that the individual is an employee of the *employer*. An individual who has not met the definition of *employee* shall become an *employee* eligible to participate in the *Plan* (subject the individual's meeting all other eligibility requirements of the *Plan*) effective on the date the *employer* characterizes the individual as an *employee* in the *employer*'s employment records.

Employee-share contribution means the contribution you must make for coverage under the *Plan*. This

amount is separate from the deductible and any *co-payment*s or *co-insurance* you are required to pay for *covered services*. See the Employee-Share Contribution chapter for further discussion.

Employer means the *participating employer* at which you work.

Enroll (*enrolled, enrolling, enrollment*) means to submit, and be accepted by the *plan administrator,* a complete and signed application for *Plan* coverage in accordance with the rules in the Eligibility, Enrollment and End of Coverage chapter.

Enrollee means a *covered employee* or a *covered dependent*.

Full-Time Employee means an *employee* who is classified by his or her *employer* as a full-time, exempt or non-exempt, regular *employee* either working in his or her position or on an *approved leave* of absence. A *full-time employee* also includes regular *employees* working for two or more *participating employers* whose total number of hours equals or exceeds the number of hours per week required to be considered full time. (Such *employees* will *enroll* through one *participating employer*, but the *participating employers* will share the *employer* portion of the cost of coverage.) The final determination of whether an *employee* is a *full-time employee* under the terms of the *Plan* will be made by the *plan administrator*.

Genetic Information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Home Hospice means a program licensed and operated according to the law, which is approved by the attending *physician* to provide palliative, supportive and other related care in the home for a covered person diagnosed as terminally ill.

Hospice Facility a public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one *physician*, one registered nurse, one social worker, one volunteer and a volunteer program. A *hospice facility* is not a facility or part thereof which is primarily a place for rest, *custodial care*, the aged, drug addicts, alcoholics or a hotel or similar institution.

Hospital means a facility that is licensed as an acute care general hospital and provides in-patient surgical and medical care to persons who are acutely ill. Additionally, the facility's services must be under the supervision of a staff of licensed *physicians* and must include 24-hour-a-day nursing service by registered nurses. Facilities that are primarily rest, old age or convalescent homes are not considered to be *hospitals*. Facilities operated by agencies of the federal government are not considered *hospitals*. However, the *Plan* will cover expenses incurred in facilities operated by the federal government where benefit payment is mandated by law.

Hour of Service means each hour for which you are paid, or entitled to payment, for the performance of duties for your *employer*, any entity that is treated as a single employer with your *employer* under Internal Revenue Code section 414(b), (c), (m), or (o), or any other *participating employer;* and each hour for which you are paid, or entitled to payment by your *employer*, any entity that is treated as a single employer with your *employer* under Internal Revenue Code section 414(b), (c), (m), or (o), or any other *participating employer* for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. Your hours of service during an unpaid leave of absence will be calculated in accordance with 26 CFR § 54.4980H-3(d)(6)(i). The term "hour of service" will be interpreted in a manner consistent with Code Section 4980H and its regulations.

Illness means a disease or bodily disorder.

Implant means a material inserted or grafted into tissue.

Incorrectly Filed Claim means any request for *Plan* benefits that is not made in accordance with the Claims Procedures.

Independent Review Organization (IRO) means an entity that conducts independent external reviews of *adverse benefit determinations* in accordance with the Patient Protection and Affordable Care Act of 2010 and associated regulations and is accredited by URAC or a similar nationally-recognized accrediting organization

to conduct external review.

Infusion Therapy is the administration of fluids, nutrients or medications by means of a catheter or needle into a vein. *Infusion therapy* is not the same as an injection.

Initial Administrative Period means the 2-calendar-month period beginning immediately after an ACA *new variable-hour employee's* or *ACA new part-time employee's initial measurement period.* The initial administrative period also includes any days from an *ACA new variable-hour employee's* or *ACA new part-time employee's* first day of *active employment* to the start of the employee's *initial measurement period*.

Initial Measurement Period means the 11-calendar-month period beginning on the first day of the month coincident with or following an *ACA new variable-hour employee's* or *ACA new part-time employee's* first day of *active employment*.

Initial Stability Period means the 12-month period beginning immediately after an *ACA new variable-hour employee's* or *ACA new part-time employee's initial administrative period.*

Injury means a personal bodily injury to you or your *covered dependent*.

In-Network - The terms *network* and *in-network* refer to *PPO providers* and *PPO facilities*.

In-Network Facility means a *hospital*, *hospice facility*, *skilled nursing facility, or* mental health or *substance abuse* residential facility that is a *PPO facility*.

In-Network Provider means a *physician* or *professional provider* who is a *PPO provider*.

Medical Condition means any condition of an *enrollee* resulting from *illness*, *injury* (whether or not the *injury* is accidental), pregnancy or congenital malformation. However, *genetic information* is not a *medical condition*.

Medical Necessity Pre-Certification refers to obtaining the *utilization review manager's* determination in advance that proposed medical services requiring *pre-certification* are *medically necessary*, appropriate, and neither Experimental nor Investigational Procedures as defined in the Limitations and Exclusions chapter.

Medically Necessary/Medical Necessity means those services and supplies that are required for diagnosis or treatment of *illness* or *injury* and which, in the judgment of the *utilization review manager*, are:

- Appropriate and consistent with the symptoms or diagnosis of the *enrollee*'s *condition*.
- Appropriate with regard to standards of good medical practice in the area in which they are provided as supported by peer reviewed medical literature.
- Not primarily for the convenience of the *enrollee* or a *physician* or provider of services or supplies.
- The least costly of the alternative supplies or levels of service that can be safely provided to the *enrollee*. This means, for example, that care rendered in a *hospital* inpatient setting is not *medically necessary* if it could have been provided in a less expensive setting, such as a skilled nursing facility, or by a nurse in the patient's home without harm to the patient.
- Likely to enable the *enrollee* to make reasonable progress in treatment.

Please Note: The fact that a *physician* or provider prescribes, orders, recommends or approves a service or supply does not, of itself, make the service *medically necessary* or a *covered service.*

Member means *enrollee*.

Mental Health Condition for the purposes of this *Plan* means those conditions listed in the "Diagnostic and Statistical Manual of Mental Disorders Fifth Edition" (DSM-5), or any successor volumes, except as stated herein, and no other conditions. *Mental health conditions* include Severe Mental Illness and Serious Emotional Disturbances of a child but do not include any services related to the following:

(i) Diagnosis or treatment of conditions represented by V codes in the DSM-5, or any successor volumes.

(ii) Diagnosis or the treatment of any conditions listed in DSM-5 with the following codes: 294.8, 294.9, 301.9, 302.2 through 302.4, 302.6, 302.70 through 302.79, 302.81 through 302.85, 302.89, 302.9, 307.3, 307.9, 312.9, 312.30 through 312.34, 315.00 through 315.2, and 315.39 through 316.0.

Mental Health Services means services provided to treat *a mental health condition*.

Network – The terms *network* and *in-network* refer to *PPO providers* and *PPO facilities*.

Network rate – The *network rate* is the negotiated amount for each service/supply that is pre-contracted and agreed upon between the *PPO Network* and its participating providers and facilities. A *network rate* is also known as a "negotiated rate."

Non-Protected Leave (or Non-Protected Approved Leave) means an *approved leave* that is not a *protected leave*. See the Reinstatement of Coverage and Special Situations, Extension of Coverage sections in the Eligibility, Enrollment and End of Coverage chapter for special rules pertaining to coverage during and following a *non-protected leave.*

Out-of-Network Facilities refers to any health care facility that is not an *in-network facility*. With the exception of *emergency services*, *urgent care*, and approved Unavailable Service Request Form services, care received at o*ut-of-network facilities* is not covered.

Out-of-Network Providers refers to *physicians* and *professional providers* that are not *in-network providers*. Except for the following exceptions, services received from *out-of-network providers* are not covered:

(i) *Emergency services*,

(ii) *Urgent care*,

(iii) Approved Unavailable Service Request Form ("USRF") services, and

(iv) Service received at an *in-network facility* that is prescribed by an *PPO provider* (in which case the service will be covered at the PPO level).

Outpatient Surgery means surgery that does not require an inpatient admission or overnight stay.

Part-Time Employee means an *employee* who is not a *full-time employee*. The final determination of whether an *employee* is a *part-time employee* will be made by the *plan administrator*.

Participating Employer means the Seventh-day Adventist Organizations of the North American Division that participate in the *Plan.* All *participating employers* are required to be listed in the most recent version of the Adventist Organizational Directory or the most recent version of the Seventh-day Adventist Yearbook. Employer entities are added and subtracted from time-to-time by amendment. If you are unsure as to whether your *employer* is a *participating employer*, please call the *plan administrator* at 888-276-4732.

Physician means a doctor of medicine or osteopathy.

Plan means this Healthcare Assistance Plan aka Ascend to Wholeness Plans for Employees of the Seventh-day Adventist Chruch Organizations based in the United States.

Plan Administrator means Adventist Risk Management (ARM). ARM shall have full discretionary power to administer the *Plan* and to interpret, construe, and apply all of its provisions, determine eligibility, and adjudicate claims as provided herein. ARM may delegate any of these duties as it deems reasonable and appropriate. In administering the *Plan*, the *plan administrator* shall be guided by and adhere to the teachings and tenets of the Seventh-day Adventist Church.

Plan Sponsor is your *participating employer*.

Plan Year means a calendar year (January 1 through December 31) or portion thereof. See definition for Claim Determination Period.

PPO Facility means a *hospital*, *hospice facility*, *skilled nursing facility*, or mental health or *substance abuse* residential facility that is a participating provider in the *PPO Network*.

PPO Network means the preferred provider networks arranged by Aetna Signature Administrators PPO for medical services and Aetna Dental Administrators for your *Plan*.

PPO Provider means a *physician* or *professional provider* who is in the *PPO Network*.

Pre-Certification/Pre-Certified/Pre-Certify (Medical Necessity Pre-Certification) refers to obtaining approval from the *utilization review manager* prior to the date of service for services that have been ordered by a *physician* or *professional provider*.

Primary Care Providers are *physicians* and *professional providers* specializing in family practice, general practice, internal medicine, and pediatrics. Note: You are not required to designate a *primary care provider* under this *Plan*.

Professional Provider means a licensed professional, when providing *medically necessary* services within the scope of their license. In all cases, the services must be *covered services* under this *Plan* to be eligible for benefits.

Protected Leave means an *approved leave* during which your *employer* is required by state or federal law to continue to offer you health plan coverage for a statutorily specified period of time. A leave is a *protected leave* only during the time period during which health plan coverage is statutorily required to be maintained. See the Reinstatement of Coverage and Special Situations, Extension of Coverage sections in the Eligibility, Enrollment and End of Coverage chapter for special rules pertaining to coverage during and following a *protected leave.* A workers' compensation leave of absence does not meet the definition of *protected leave*. However, an *employee* who is off on a workers' compensation leave is treated exactly the same as an *employee* who is off on a comparable non-workers' compensation leave.

Qualifying Change in Status refers to one of the following events:

- Marital Status: Your legal marital status changes for reasons of marriage, death of a *spouse*, *divorce*, legal separation, or annulment.
- Dependents: Your number of *eligible dependents* changes due to birth, adoption, placement for adoption, or death of an *eligible dependent*.
- Employment Status: You or your *eligible dependent* experience a change in employment status, including: commencement or termination of employment, a change from part-time to full-time, , or full-time to part-time status, commencement or return from an unpaid leave of absence, or any other change in employment status that affects benefits eligibility.
- Change in Dependent Status: Your dependent satisfies or ceases to satisfy the eligibility requirements for coverage.
- Residence: You or your *eligible dependent* change geographic residence provided that the change in residence affects your or your *eligible dependent*'s eligibility for coverage under this *Plan* or another plan or policy.
- Change in Coverage of Eligible Dependents. Your *eligible dependent* is entitled to make a change to his or her coverage (or the coverage of another of your *eligible dependents*) under his or her employer's plan due to a permitted election change or during his or her plan's annual enrollment period, if different from the *Plan*'s annual enrollment period.
- Overall Reduction in Benefits: You or your *eligible dependent* experience a significant overall reduction or termination of benefits under the *Plan* or under another employer's plan, as determined in the sole discretion of the *plan administrator*. In general, for a group health plan, a significant overall reduction includes a significant increase in the deductible, *co-payment*, or out-of-pocket maximum, but does not include your *physician* or provider ceasing to be an *in-network provider*.
- Significant Reduction in Coverage: Your or your *eligible dependent*'s coverage under this *Plan* or another employer's plan is significantly reduced or limited causing you or the *eligible dependent* to lose coverage, as determined at the sole discretion of the *plan administrator*. An example of a significant reduction in coverage is if there is a substantial reduction in providers available under your or your *eligible dependent*'s elected benefit option.
- Significant Change in Cost: The cost of coverage for you and/or your *eligible dependents* significantly increases or decreases under the *Plan* or another employer's plan.
- Addition of Benefit Options: A new benefit package option or coverage option is added to the *Plan* or to another employer's plan under which you or one of your *eligible dependents* is covered.

- Medicare or Medicaid Entitlement: You or your *eligible dependent* gain or lose entitlement for Medicare or Medicaid.

SPD means Summary Plan Description. See the Welcome chapter.

Specialist means *physicians* and *professional providers* who are not defined as primary care providers.

Spouse means your opposite sex lawful spouse under the applicable law of the state in which the *participating employer* facility at which you work is located (or if you are not assigned to a specific facility, then the state of *employer*). Some states allow common law marriage, which is a legally recognized marriage that lacks formal marriage proceedings; *spouse* does not include a spouse through common law marriage.

Standard Measurement Period means, for a given *plan year*, the period beginning on the first day of the pay period that includes October 4 of the year that is two years prior to the *plan year* and ending on the last day of the pay period that ends before October 4 of the year preceding the *plan year*. For example, for the 2015 *plan year*, the standard measurement period is the period beginning on the first day of pay period #21 for the year 2013 (which includes October 4, 2013) and ending on the last day of pay period #20 for the year 2014 (which is the last pay period ending before October 4, 2014).

Substance Abuse means substance abuse as defined in the most recent version of the Diagnostic and Statistical Manual, as published by the American Psychological Association. For purposes of this *Plan*, *substance abuse* does not include addiction to, or dependency on, foods, tobacco or tobacco products.

Totally Disabled (Total Disability) means a person who has been determined to be disabled by the Social Security Administration. The Social Security Administration currently defines disability as an *illness* or *injury* expected to result in death or that has lasted or is expected to last for a continuous period of at least 12 months, and makes the individual unable to engage in any employment or occupation, even with training, education, and experience (or, for *children*, makes the *child* unable to substantially engage in any of the normal activities of *children* in good health of like age). *Physician* certification of continued *total disability*, based on the Social Security Administration standard, is required upon request from the *plan administrator.* Additionally, the *plan administrator* reserves the right to require at its expense an independent medical, psychiatric, or psychological evaluation to verify an individual's continued *total disability*.

Urgent Care means the provision of immediate, short-term medical care for minor but urgent *medical conditions* that do not pose a significant threat to life or health at the time the services are rendered.

Usual, Reasonable, & Customary Charge ("***U&C***") means:

(i) For *out-of-network providers*, the normal and necessary charges submitted or made for similar services or supplies provided by other providers of medical or dental services with like experience, education and training in the same geographical area. The term "geographic area" as it applies to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a statistically representative cross-section of the level of charges. Determination of the *U&C* for a medicine, service, or supply shall be made by the *U&C* contract administrator, using the 90th percentile of all charges for the same service or supply in the geographic area based on survey data collected and maintained by the *U&C* contract administrator. (The "*U&C* contract administrator" is the entity with which the *plan administrator* or *PPO Network* has contracted to provide usual and customary rate services and access to usual and customary rate databases.)

However, if a lower rate is negotiated between a provider and the *plan administrator*, the *PPO Network*, or their delegates, then the negotiated rate is the *U&C*.

For purposes of *emergency services* only, if either the *network rate* for an *emergency service* or the amount that would be paid under Medicare (Part A or B) (the "Medicare Rate") for the *emergency service* is higher than the *U&C* as determined under this section, then such higher *network rate* or Medicare Rate, as applicable, will be the *U&C* for the *emergency service*.

(iii) For *in-network providers*, the *network rate*. If no *network rate* is in place for the service or supply, the *U&C* will be determined as though it was provided by an *out-of-network provider*.

(iv) After hours surcharges in any 24-hour facility are not *U&C* and will not be covered by this *Plan*. This applies to both *in-network providers* and *out-of-network providers*.

(v) Note on alternative phraseology: In some *Plan* materials, the *usual, reasonable, & customary charge* may be referred to as the Usual and Customary Charge, the Usual and Customary Rate, the Reasonable and Customary Charge, the Reasonable and Customary Rate, the UCR, or some other, similar phrase.

Utilization Review Manager/Utilization Management means Adventist Health Benefits Administration's in-house utilization review department, which is responsible for determining whether requested medical care is *medically necessary*. However, for all prescription drug benefits, the *utilization review manager* is Express Scripts and for dental benefits the *utilization review manager* is Aetna Dental.

Eligibility, Enrollment and End of Coverage

ELIGIBILITY REQUIREMENTS FOR THE ACCELERATE PLAN IN 2019

The Accelerate Plan offers the best benefit at the best value in exchange for your engagement and accountability for your health and wellness. This plan encourages active participation in health coaching and care coordination.

To be eligible for the Accelerate Plan in 2019, both the employee and covered spouse must meet the established point requirements as displayed below. Completion of these activities will result in a total of 200 points. Failure to meet these requirements by both the employee and covered spouse will result in both of them only being eligible for the Access Plan in 2019.

1. Wellness Assessment; complete an online assessment between April 1 and July 31. The online Wellness Assessment is a secure online tool that you use to provide information about your health and can be accessed at the Wellness Portal at **www.ascendtowholeness.org**. After you complete the Wellness Assessment, you will receive a summary report that identifies areas you are doing well in and areas of potential health risks as well as what you can do to reduce those risks. Completion of the Wellness assessment will result in 60 points.

2. Biometric Screening; complete your biometric screening between April 1 and July 31. The confidential Biometric Screening will provide you with vital numbers (such as cholesterol, blood glucose, blood pressure, and more) that you can compare to recommended healthy guidelines to help determine your risk for disease and chronic health conditions. Biometric events will be conducted at many locations throughout the United States. Employees of Church organizations covered on the Plan will not be required to take paid leave for up to 1 hour to participate. Completion of the Biometric screening will result in 60 points.

3. Activity Points; earn 80 points by August 31. A complete list of activities that are approved by the Plan can be found through the Wellness Portal at **www.ascendtowholeness.org.**

If your effective date of coverage on the Plan is not January 1, 2018, the 200-point requirement will be prorated based on the month in which you are enrolled in the Plan during 2018, according to the following schedule:

Date Employee Joins the Plan	Biometric Screening / Wellness Assessment Points	Activity Points	Total Points Required
JAN 1 - MAR 31	120	80	200
APR 1 - JUN 30	120	40	160
JUL 1 - DEC 31	0	0	0

ELIGIBILITY FOR THE ACCESS PLAN IN 2019

There are no wellness requirements for this plan. To be eligible you must select the Access plan during open enrollment.

Who is Eligible

Full-time employees, eligible literature evangelists, eligible seminary students, and any *employee* not fitting within these categories who is an *ACA full-time employee* are eligible to participate in this *Plan*, and will have an effective date of coverage as explained in the "Waiting Period and Effective Date" section. However, except for any *ACA full-time employee,* any *employee* who is classified by his or her *employer*'s human resources department as either temporary or per diem is not eligible to participate in this *Plan*. The determination of whether you are a *full-time employee, part-time employee*, or neither is usually determined initially by your *employer*, but ultimately the *plan administrator* may make a different determination. (Some determinations, such as disability determinations, may be made initially by the *plan administrator*.)

If it is determined that your status (full-time, part-time, or neither) has changed, your *employer* will provide you with a notice of the change in status and the change in status will take effect on the date stated in the notice. Review of *employee* status (full-time, part-time, or neither) will be performed monthly. If you are miscategorized as not a *full-time employee*, you will not be treated as an *employee* or *enrollee* for purposes of the *Plan* until after you *enroll* in the *Plan* (even if a court, the IRS, or other administrative agency later determines that you were miscategorized).

Eligible Dependents

If you are eligible for and elect coverage under the *Plan*, your *eligible dependents* may also participate in the *Plan*. *Eligible dependents* include:

- Your unemployed *spouse* (or your employed *spouse* if your *employer* so allows) who is living with you. A *spouse* who is not living with you may continue to be covered (1) for up to six months during a trial separation, (2) if you and your *spouse* are living at separate locations because of a job, or (3) if you have a court order to provide coverage for your *spouse*.
- Your *child* from birth to attainment of age 26. *Children* are eligible to participate in the *Plan* until the date on which they turn 26 years of age. This maximum *child* coverage age supersedes any inconsistent provisions in the *Plan*.
- Your unmarried *child* of any age so long as the *child* is *totally disabled,* the *total disability* commenced before the *child* reached age 26, and the child is primarily dependent on you for support and maintenance. In order to obtain coverage for such a child, you must submit evidence of *total disability* within 31 days of the child's 26th birthday.

The term *eligible dependent* does not include any dependent who is on active full-time military duty in the armed forces of any country.

The term *eligible dependent* does not include parents of *enrollees* regardless of whether the *enrollee* has assumed legal guardianship of the parent.

No person may be covered as both an *employee* and as a dependent, nor can a person be covered as a dependent of two *employees*.

You will be required to obtain and provide your *employer* with a Social Security number for each *covered dependent*. The *Plan* will not pay any claims incurred by a *covered dependent* unless and until the Social Security number is provided. There are, however, three exceptions to this rule:

(i) If your dependent is a newborn baby, you will have until the *child*'s first birthday to provide the *child*'s Social Security number;

(ii) If a *child* is placed in your care for purposes of adoption, you have one year from that date to provide the *child*'s Social Security number; and

(iii) If your dependent does not have a Social Security Number or you refuse to disclose the dependent's Social Security number to the *Plan*, you can obtain coverage for the dependent by (i) certifying to the *Plan* that the dependent does not have a Social Security number or that you are refusing to disclose the dependent's Social Security number, (ii) completing the Center for Medicare and Medicaid Services HICN/SSN form (or any successor form), and (iii) indemnifying the Plan for any losses sustained due to your inaccurately or incompletely filling out the HICN/SSN form.

If the *plan administrator* determines that your separated or *divorced spouse* or any state child support or Medicaid agency has obtained a qualified medical child support order ("QMCSO"), and your current plan offers dependent coverage, you will be required to provide coverage for any *child*(*ren*) named in the QMCSO directed specifically at you. A QMCSO directed at your *spouse* but not at you will not be applicable nor sufficient. If a QMCSO requires that you provide health coverage for your *child*(*ren*) and you do not *enroll* the *child*(*ren*), your *employer* must *enroll* the *child*(*ren*) upon application from your separated/*divorced spouse*, the state child support agency, or Medicaid agency, and withhold from your pay your share of the cost of such coverage. Although the *Plan* does not normally provide dependent-only coverage, dependent-only coverage is allowed if you are required to provide coverage for one or more *child* and you are not currently enrolled in the *Plan*. You may not drop coverage for the *child*(*ren*) unless you submit written evidence to your *employer* that the child support order is no longer in effect. The *Plan* may make benefit payments for the *child*(*ren*) covered by a QMCSO directly to the custodial parent or legal guardian of such *child*(*ren*).

Waiting Period and Effective Date

New *employees* have an effective date for coverage to start as of their first day of employment (unless their *employer* has a waiting period, in which case the maximum waiting period is 90 days and the latest date that coverage would start would be the first day of the fourth full calendar month following the first day of employment). To enroll, an *employee* must be *actively at work* and *enrollment* must be completed no later than 30 days (or a longer period if required by state law) after this effective date. Coverage for your *eligible dependents* begins on the later of when your coverage begins or the first day an *eligible dependent* is legally acquired if properly *enrolled*.

Depending on your *employer*'s policy, a shorter waiting period or no waiting period may apply for an *employee* who transfers from the employ of another Seventh-day Adventist entity. Please call your new *employer*'s human resources department for details. For these purposes, "Seventh-day Adventist entity" means any United States based entity that is listed in either the most recent version of the Adventist Organizational Directory or the most recent version of the Seventh-day Adventist Yearbook.

The waiting period may be waived in certain other instances as determined by the *plan administrator*.

During a waiting period, new *employees* may be able to elect short-term medical plan coverage at their own expense. Such *employees* should contact the human resources office of their *employer*. Certain conditions may apply.

If your status changes to full-time, your *employer* will provide you with a notice of the change in status and you will be offered coverage that begins on the date stated in the notice.

If you are determined to be an *ACA full-time employee* following your *initial measurement period*, you will be offered coverage that begins on the first day of your *initial stability period.*

Initial Enrollment Requirements

You must *enroll* within 30 days (or a longer period if required by state law) of the date you are first eligible for the *Plan*. You are first eligible for the *Plan* as of the first day of your employment unless your employer has a waiting or probationary period. (The maximum waiting period is 90 days and the latest your coverage would start would be the first day of the fourth full calendar month following your date of hire.)

If you also desire coverage for your *eligible dependent*(*s*), you must *enroll* your *eligible dependent*(*s*) at this time. When you enroll your dependents, you will be required to provide documentation, within the 30-day

period, verifying dependent status. If you do not *enroll* within the time requirement set forth in this paragraph, you will be required to wait until the next open enrollment period unless either the Change in Status section or the Loss of Other Coverage—HIPAA Special Enrollment Rights section applies.

If you and your *dependents* meet the eligibility requirements for the *Plan* and wish to enroll in the *Plan*, you either must complete and sign a paper enrollment form or submit a completed electronic form to your *employer*. When enrolling, you must give accurate and complete information. If you do not, your benefits will be adjusted and you will be required to refund the *Plan* any benefits you and your *dependents* should not have received. Once you are *enrolled*, you will receive your health plan identification card in the mail to your home address.

If you do not have any *eligible dependents* at the time of initial *enrollment*, but acquire *eligible dependents* at a later date, you must *enroll* the *eligible dependent*(*s*) within 30 days (or a longer period if required by state law) of the date you acquire them. Coverage for newly-acquired *eligible dependents* will be effective on the first day an *eligible dependent* is legally acquired if you *enroll* them for coverage within the 30-day period and provide the required dependent verification documentation. Contact your *employer* to determine what documents are required to verify dependent status.

If you are *enrolled* for coverage under the *Plan* as a participating *employee* or *spouse*, your newborn or adopted *child* will be retroactively covered to the date of birth (or adoption or placement for adoption) if you notify your *employer* of the birth/adoption, complete an enrollment form, pay the increased *employee-share contribution* amount, and provide the required dependent verification documentation within 30 days of the date of birth (or adoption or placement for adoption). If notice is not provided, you do not pay your *employee-share contribution*, you do not complete an enrollment form, or you do not provide the required dependent verification documentation within 30 days (or a longer period if required by state law), then your newborn or adopted *child* will not be covered. Your (or your *spouse's*) *claim* for maternity expenses is not considered as notification to your *employer*. Placement for adoption means you have assumed and retained a legal obligation for full or partial support of the *child* in anticipation of adoption. Placement for adoption is evidenced by a fully executed adoption placement agreement.

Notification regarding the addition of the new *eligible dependent* should be made to your *employer*'s human resources department as soon as possible.

ALL NEWLY-ELIGIBLE DEPENDENTS MUST BE ENROLLED WITHIN 30 DAYS. THIS INCLUDES NEWBORNS WHO MUST BE ENROLLED WITHIN 30 DAYS OF BIRTH, ADOPTION OR PLACEMENT FOR ADOPTION. THIS DEADLINE APPLIES EVEN IF YOU ALREADY HAVE FAMILY COVERAGE.

Change in Status

If you have a *qualifying change in status*, you may change your *enrollment* decision regarding yourself and/or *eligible dependents* within 30 days (or such longer period as provided by state law) of the *qualifying change in status*. You can only change your benefit elections if the requested change is on account of and corresponds with the permitted election change event you experience.

If application is made on a timely basis and is accepted by the *plan administrator* as a *qualifying change in status*, medical coverage will become effective on the date provided by your *employer*, except that in the case enrollments due to HIPAA Special Enrollment Rights, coverage will be effective on the date of the event as described in the below section. If application is not made within 30 days (or such longer period as provided by state law) of the *qualifying change in status*, you will be required to wait until the next open enrollment period unless you experience another *qualifying change in status* or the HIPAA Special Enrollment Rights section applies.

If you and your *spouse* are both eligible *employees* and are *enrolled* as such in the *Plan* and one of you terminates employment, the terminating *spouse* and any *covered dependents* will be permitted to immediately *enroll* under the remaining *spouse employee's* coverage. The new coverage will be a continuation of prior coverage and any waiting period will not apply.

It is your responsibility to report changes in eligibility or general family or other status changes to your *employer.* This includes divorces and *children* turning age 26. It is considered fraud on the *Plan* if you fail to report events that result in an individual ceasing to be eligible for the *Plan* and, in such cases, you would be required to repay to the *Plan* any benefits that were erroneously paid.

HIPAA Special Enrollment Rights

As required by federal law, the *Plan* provides a special enrollment right in the following two circumstances:

A. **Loss of Other Coverage:** If you decline coverage under this *Plan* for yourself or your *eligible dependents* because of other health plan coverage, and provide written notice to the *Plan* that you are declining coverage due to the existence of other coverage, and such other health plan coverage is later terminated because of:

- A loss of eligibility for such coverage (loss of eligibility does not include a loss because of: failure to pay premiums when due; failure to exhaust COBRA continuation coverage, if elected; or cases such as making a fraudulent *claim* or misrepresentation); or
- Termination of any company contributions for such coverage;
    - Then you and/or your *eligible dependents* that have lost such coverage may *enroll* in the *Plan*.

B. **New Dependents.** If you acquire a new *eligible dependent* as a result of marriage, birth, adoption or placement for adoption, you and/or your newly *eligible dependents* may *enroll* in this Plan. In the case of the birth, adoption, or placement for adoption of a *child*, your spouse may also *enroll* if he/she is otherwise eligible for coverage.

To *enroll* under either of these special enrollment rights, you must notify the *plan administrator* and complete and return any required forms within 30 days of the underlying event, (e.g., loss of other coverage, date of the marriage, birth, adoption or placement for adoption). If you do so, then coverage will begin on the date of the loss of other coverage, or for a new dependent *child*, the date of birth, adoption or placement for adoption, or for a new *spouse*, the date of marriage.

Federal law also provides special enrollment rights in the following two circumstances:

(i) Loss of eligibility under Medicaid or a State Child Health Insurance Program (CHIP). If you or an *eligible dependent* is covered under a Medicaid plan or a state CHIP plan, and that coverage is terminated because you are no longer eligible, then you and your *eligible dependent* may *enroll* in the Plan if you are otherwise eligible for coverage.

(ii) Becoming eligible under a State CHIP Premium Subsidy Program. If you or an *eligible dependent* are determined to be eligible for a state CHIP premium assistance program, then you and your *eligible dependent* may *enroll* in the Plan if you are otherwise eligible for coverage.

To *enroll* under either of these two latter special enrollment rights, you must notify your *plan sponsor* and complete and return any required forms within 60 days of the date you lose coverage under the Medicaid or state CHIP plan, or the date you are determined to be eligible for a premium assistance program. If you do so, then coverage will begin on the date of loss of Medicaid/CHIP eligibility or on the date you are determined to be eligible for a premium assistance program.

Open Enrollment

Open enrollment occurs once a year on dates to be determined by the *plan administrator*. Typically, open enrollment for a *plan year* occurs in the fall of the prior *plan year*. During open enrollment, eligible *employees* who are not covered may elect to begin coverage effective the first day of the upcoming *plan year* and *covered employees* may change their coverage effective the first day of the upcoming *plan year*.

If you do not timely enroll in accordance with this SPD, you will be required to wait until the next open

enrollment period unless either the Change in Status section or the Loss of Other Coverage—HIPAA Special Enrollment Rights section applies.

Pre-Existing Conditions

This *Plan* does not have any exclusions for pre-existing *conditions*.

Dual Coverage

If you and/or your spouse are both enrolled as *employees* under this *Plan*, you and/or your *spouse* have the option to *enroll* your *eligible dependents* for coverage. In no event may the combined maximum benefits for you and/or your *spouse* and your *dependents* exceed 100% of the *usual, reasonable, and customary charge* for eligible expenses.

Reinstatement of Coverage

If you are called to active duty by any of the armed forces of the United States of America, released under honorable conditions and return to employment with your *employer*: (1) on the first full business day following completion of your military service of 30 days or less, (2) within 14 days of completing military service of 31 to 180 days, or (3) within 90 days of completing military service of more than 180 days, coverage will be reinstated. You will not be subject to any new waiting period; however, all accumulated annual and lifetime maximums will apply.

If coverage ends while you are on a *protected leave*, coverage for you and your *eligible dependents* will be reinstated on the day you return to work as long as you return immediately upon the end of the *protected leave*. When coverage is reinstated, your prior permission for salary reductions to pay the *employee-share contribution* will be resurrected. If coverage ends while you are on a *non-protected approved leave*, coverage for you and your *eligible dependents* will be reinstated on the first of the month following the month in which you return to *active employment* as long as you timely re-*enroll* for reinstatement upon your return from the *non-protected approved leave*. You will not be subject to any new waiting period; however, all accumulated annual and lifetime maximums will apply.

If you are in an eligible status, but coverage had never become effective or had terminated because of failure to make the required *employee-share contribution*, you will be required to wait until the next open enrollment period unless either the Change in Status section or the Loss of Other Coverage—HIPAA Special Enrollment Rights section applies.

If you have a termination of employment and are rehired by and are credited with an *hour of service* with your *employer* or any other *participating employer* within 13 weeks of your termination of employment, then (1) your *ACA full-time employee* status will be determined upon rehire as if you did not incur such termination of employment, (2) you will receive credit for your pre-termination *hours of service*, and (3) your period with no *hours of service* is taken into account as a period of zero *hours of service* during the measurement period. If you transfer from one *participating employer* to another *participating employer*, for purposes of determining of your *ACA full-time employee* status, you will be treated as continuously employed and will continue to receive credit for your pre-transfer *hours of service*.

Special Situations, Extension of Coverage

Coverage of Adult Children with Disabilities

If a *child* is unmarried, is *totally disabled,* and is primarily dependent on the *employee* parent for support and maintenance, the *child*'s eligibility will be extended past attainment of age 26 for as long as the *employee* parent is covered under this *Plan*, the *total disability* continues, and the *child* continues to qualify for coverage

in all aspects other than age. You must provide evidence of *total disability* within 31 days of the child's 26th birthday. In no event will coverage under this section extend beyond the last day of the month of the *child*'s marriage.

Leaves of Absence

The following provisions apply to coverage during a period when you are absent from work:

(i) **Paid time off**. If you were covered under the *Plan* on the day before you began taking paid time off (PTO) (including paid sick leave and paid vacation leave), you (and any *covered dependents*) will continue to be eligible for *Plan* coverage during the PTO and you will be required to pay the same *employee-share contribution* during the PTO that you were paying the day before the PTO began.

(ii) ***Protected leave* other than USERRA leave.** If you qualify for a *protected leave* of absence (other than USERRA) and you are covered under the *Plan* on the day before the leave begins, you will be eligible to continue your coverage (and the coverage of any *covered dependents*) for the duration of the *protected leave* at the *employee-share contribution* rate you were paying the day before the *protected leave* began (if so required by the relevant statute). You should talk to your human resources department to determine how to pay your *employee-share contribution* during your *protected leave.* Subject to certain exceptions, if you fail to return to work after the *protected leave*, your *employer* has the right to recover from you any contributions toward the cost of coverage made on your behalf during the leave. The rules for different types of *protected leaves* vary and some are dealt with under state law and within *participating employer* policies.

(iii) **USERRA leave.** Notwithstanding any other provision of the *Plan*, for USERRA continuation coverage, *enrollees* can receive up to 30 days of coverage at the active-employee rate followed by up to 24 months of USERRA continuation coverage at 102% of the total cost of coverage (which is the employer contribution plus the *employee-share contribution*). Coverage will end sooner if you (1) are required to apply for or return to a position of employment and fail to do so; or (2) fail to make the required contributions for *Plan* coverage. In most cases, USERRA requires election of coverage within 30 days of the beginning of leave and requires that you give advance notice of your leave. If you are unable to give advance notice and/or complete the election within 30 days, you must make an election for retroactive coverage within 30 days of the date that giving the notice is possible, reasonable, or nor longer precluded by military necessity and the election must be accompanied by (1) a statement of the reason(s) why you were unable to give advance notice, and (2) payment in full for the unpaid contribution amounts due for each month of coverage beginning as of the date you were first absent from work due to the USERRA leave and including the contribution amount due for the month of the election. If the election is given after the maximum USERRA period has elapsed, coverage will be only for the USERRA period and payment must be for the entire period. Your first payment for USERRA coverage is due no later than the last day of the month the *plan administrator* or your employer receives your USERRA election, and if full payment is not received by the due date, then USERAA continuation coverage will cease retroactively effective as of the last day of the month for which a payment was received in a timely manner. Dependents who join the military are ineligible for USERRA coverage under this *Plan*.

(iv) **All *approved leaves*.** You may continue to participate in the *Plan* during an *approved leave*. If you take a paid *approved leave*, any *employee-share contributions* you are required to make to the *Plan* will be made by payroll deduction. If you take an unpaid, *non-protected approved leave*, you will be required to pay any required *employee-share contribution* by the last day of each month or your coverage under the *Plan* will end. You should talk to your human resources department to determine how to pay your *employee-share contribution* during your *approved leave.* If you use PTO while on a *non-protected approved leave*, the **Paid time off** paragraph above will apply. An *employee* on an *approved leave* may add *dependents* to the *Plan* under the same rules and at the same time as *employees* who are not on leaves of absences. Dependents are ineligible to participate in the *Plan* unless the *employee* elects to participate. There is no waiting period to enroll in the *Plan* for *employees* returning from an *approved leave* of absence and their dependents, even if coverage under the *Plan* terminated during the *approved leave* of absence. Unless specified elsewhere in the *Plan*, a failure to pay your *employee-share contribution* within 30 days of the due date established

by your *employer* will result in termination of the coverage as of the last day of the month in which occurs the 30th day after such due date. (For *protected leaves*, termination of coverage will not occur until after the payment is 30 days late and a 15-day notice of termination of coverage is mailed to the *employee*.)

When Coverage Ends

Your coverage ends the earliest of:

- the latter of (a) the end of the month in which your employment with your *employer* ends, or (b) the end of the month in which you cease to be paid for *full-time* work;
- the end of the period for which your last required *employee-share contribution* was made; or
- the end of the month in which you are no longer eligible to participate in this *Plan*. (See "Special Situations, Extension of Coverage" for additional information.)

Coverage for your *covered dependents* ends the earliest of:

- the date your coverage ends;
- the date the *covered dependent* no longer meets the eligibility requirements, including, if applicable, the date you are no longer legally required to provide medical coverage for the *covered dependent*;
- the end of the month for which the last *employee-share contribution* was made; and
- the date the *covered dependent* enters into active military service or obtains permanent residence outside the United States. (See "Special Situations, Extension of Coverage" for additional information.)

Following one of the events listed above, your *covered dependents* may be eligible for Continuation Coverage. See the Coverage Continuation Options section for more information.

If the *Plan* is terminated, coverage ends for you and your *covered dependents* on the date the *Plan* ends unless an extension of coverage in required under state law. Expenses incurred prior to the *Plan* termination will be paid as provided under the terms of the *Plan* prior to its termination.

See the Special Situations, Extension of Coverage section above for the end of coverage provisions that will apply while you are on an *approved leave*. Also, see the Reinstatement of Coverage section above for special rules for *employees* whose coverage ends while on a *protected leave* or a *non-protected approved leave*.

If this SPD otherwise allows you to terminate your coverage or coverage for any *covered dependents*, you may do so by giving written notice to your *employer*'s human resources department. If you terminate your own coverage, coverage for your *covered dependents* also ends at the same time.

Continuation Coverage

The *Plan* does not generally provide continuation coverage, such as coverage under COBRA. As a church plan, the *Plan* is not required by law to provide COBRA coverage. However, the *Plan* may provide limited continuation coverage in the following situations:

A. Short-Term Post-Termination Coverage

If other healthcare coverage is not available at the time coverage terminates for an *employee*, the former *employee* and *covered dependents* of the former *employee* may be eligible for continued benefits under this *Plan* for a short period after coverage terminates, provided that the *employer* offers such coverage. The coverage may be granted for a period of up to two months (60 days) or until the former *employee* has obtained other health coverage (including Medicare), whichever comes first. The *employer* may require the former *employee* to pay a contribution for the cost of providing such coverage. In lieu of this coverage, an *employer* may choose to offer the former Member short-term medical plan coverage at his or her expense or may not offer either type of coverage.

B. Certain Divorce Situations

The *employer* may, in its sole discretion, allow the *spouse* or ex-*spouse* of *employee* or ex-*employee* and certain *children* to remain on the *Plan* after legal separation or *divorce* from the *employee* or ex-*employee*, if the separation or *divorce* was due to unlawful actions of the *employee* or ex-*employee* or to circumstances beyond the control of the *spouse* or ex-*spouse* of the *employee* or ex-*employee* or in other situations approved by the *employer*. The following persons who were participating in the *Plan* prior to the *divorce* or separation may continue to participate in the *Plan* for a period not to exceed twelve (12) months if allowed to do so by the *employer* and they would otherwise meet the eligibility rules for the *Plan* if the separation or divorce and, if applicable, the ex-*employee's* termination of employment, had not occurred: (1) the *spouse* or ex-*spouse* of the *employee* or ex-*employee*; (2) *children* of the *spouse* or ex-*spouse* of the *employee* or ex-*employee*; and/or (3) *children* of the *employee* or ex-*employee*. The *employer*, however, is not obligated to extend coverage under this provision and the *employer* may charge a contribution for participation.

C. Disability

If you are no longer eligible for coverage under this *Plan* due to your *total disability* (such as your employment is terminated due to your disability or you are no longer on an approved leave of absence due to your disability), and you and/or your *covered dependents* are not eligible for coverage under another plan, coverage under this *Plan* for you and/or your *covered dependents* in effect at the time of your loss of eligibility for the *Plan* may continue for up to 24 months following the date you lost eligibility for the *Plan*.

Your continuation coverage for you and your *covered dependents* will cease under this paragraph prior to such periods as soon as any other healthcare coverage (including Medicare) is available to you. The right to continuation coverage for your *covered dependents* will cease under this paragraph prior to the end of such 24 month period as soon as your *dependents* are eligible for other healthcare coverage (including Medicare).

If you have applied for a Social Security Administration determination of disability, you may request coverage under this section while the determination is pending and the *plan administrator*, in its sole discretion, may allow you to continue coverage under this *Plan* until the determination is received. In no event will the entire period of coverage under this Disability continuation coverage period be greater than a total of 24 months.

D. Death

If you die and your covered *dependents* are not eligible for coverage under another plan, coverage under this *Plan* that is in effect at the time of your death will continue for your *covered dependents* for up to six months following the date of your death. The right to continuation coverage will cease under this paragraph prior to the end of such six month period as soon as your *covered dependents* are eligible for other healthcare coverage (including Medicare).

Marketplace Coverage Continuation Option

You may be eligible to buy an individual plan through the Health Insurance Marketplace when you lose group health *coverage*. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a *spouse*'s plan), even if that plan generally doesn't accept late enrollees.

Employee-Share Contribution

The *Plan* is self-funded by means of *employer* and *employee* contributions. The contribution *enrolled employees* are required to make is called the *employee-share contribution*. Your *employer* is responsible for paying all of the benefits due to you under this *Plan* that are not covered by your *employee-share contributions* and other required cost-sharing. This *Plan* is not insured, and neither the *plan administrator* nor any other *participating employer* is responsible for paying any part of your benefits.

Your *employee-share contribution* is based on the number of *enrollees* you elect to cover. Each additional *enrollee* will require an increase in your *employee-share contribution*.

The *employee-share contribution* is different for full-time *employees* and part-time *employees*.

The *employee-share contribution* amount is determined by your *employer*. You may contact your human resources department for information on the *employee-share contribution*.

Pre-Certification Program

The *Plan* has certain procedures that must be followed to reduce the cost of *Plan* benefits, such as a pre-admission/pre-service review process called *pre-certification*, which is performed by the *Plan*'s *utilization review manager*. The *Plan*'s *utilization review manager* can be reached by calling the number on the front of your benefit ID card.

The purpose of *pre-certification* is to contain the cost of *Plan* benefits by encouraging prudent and reasonable use of health care and health care facilities. These measures are only decisions as to whether a particular treatment or service is *medically necessary* within the meaning of the *Plan* (and not, for example, what course of medical treatment may be appropriate or desired, whether a patient is eligible for or enrolled in the *Plan*, or whether the services are subject to *Plan* limitations or exclusions).

The *Plan* does not provide medical advice and is not to be considered a substitute for the medical judgment of your attending *physician* or other health care provider. In all instances, the final and ultimate decisions concerning appropriate and desired medical treatments are up to you and the *physician* or other professional providing your treatment. The *Plan* only decides whether a particular admission, treatment or service is *medically necessary* within the meaning of the *Plan*.

Your *employer*, the *Plan*, the *plan administrator*, and their *employees*, members, agents and representatives, are not liable for any act or omission by any *hospital, physician*, other providers or suppliers, their agents or *employees*, in caring for a person covered by this *Plan*, and no responsibility attaches under this *Plan* for any error or inability of any provider or supplier to furnish accommodations, services or supplies to you.

The *utilization review manager* performs *medical necessity pre-certification* only; it does not guarantee benefits or payment for services rendered, nor does it validate *PPO Network* participating status of the provider or facility.

Medical Necessity Pre-Certification

Medical necessity pre-certification is a process that takes place when a *physician* or other provider recommends hospitalization or other types of medical services/supplies and the *Plan* requires that *pre-certification* staff members evaluate a proposed hospital admission or other services/supplies in order to verify whether the proposed admission or service/supply is *medically necessary* within the meaning of the *Plan* and/or to analyze and discuss other care options that may exist.

Your Responsibility

You do not need to obtain *medical necessity pre-certification* for routine *in-network* health care performed in a provider's office, urgent care center, or emergency room.

It is your responsibility to obtain *medical necessity pre-certification* for diagnostic testing, out-patient procedures, non-emergency hospitalizations, surgeries, etc., in accordance with the below list. Your provider can request *medical necessity pre-certification* by calling the number on the back front of your benefit card. If your *emergency* care results in a hospital admission, your provider must call the *utilization review manager* no later than the next business day after the admission.

When you know in advance that you or a *covered dependent* needs to be hospitalized, you or your provider must contact the *utilization review manager* at the telephone number on the front of your benefit ID card before the hospitalization.

In the case of an emergency hospital admission or other urgent situation that did not allow the provider to contact the *utilization review manager* in advance of the admission and/or treatment, you or your provider must notify the *utilization review manager* within 24 hours of the admission/treatment or on the next business day. The *utilization review manager* will carry out retrospective *medical necessity pre-certification*.

Services Requiring Pre-Certification

There are services under the *Plan* for which you will not receive benefits if you fail to obtain *pre-certification* before obtaining the service or incurring the expense.

You or your provider should call the *utilization review manager* at the phone number on the back of your benefit card to fulfill any *pre-certification* requirements and obtain *pre-certification* or guidance for those services. The *Plan*'s *utilization review manager* handles all *pre-certifications* and follows the guidelines set forth by the American Medical Association (AMA) in determining *medical necessity* and appropriateness of services. However, in so doing, the *Plan*'s *utilization review manager* has discretionary authority.

The following services requires pre-certification, but this list is not inclusive of all services that require *pre-certification*; the list is subject to additions or deletions at the discretion of the *plan administrator;* additional services are listed in this SPD and may change at the *Plan*'s discretion.

All Inpatient Admissions

- Acute
- Long-Term Acute Care
- Hospital
- Rehab
- Skilled Nursing Facility
- Mental Health / Substance Abuse

Ambulance Transport for Non-Emergencies

Outpatient – Surgeries

- Back Surgeries
- Bowel and gastric surgeries (except : (1) EGDs (2) Diagnostic Colonoscopy (3) Screening Colonoscopy > age 50)
- Cataract Surgeries
- Osteochondral Allograft, knee
- Hysterectomy (including prophylactic)
- Hearing Implants
- Procedures related to Chiari's malformation
- Cosmetic Procedures (including but not limited to)
    - Abdominosplasty
    - Blepharoplasty
    - Facial skin lesions (MOHS, photo therapy, laser therapy)
    - Hernia repair, abdominal and incisional (only when associated with a cosmetic procedure)
    - IDET (Thermal Intradiscal Procedures)
    - Liposuction/lipectomy
    - Mammoplasty, augmentation and reduction (includes removal of implant)

- Mastectomy, gynecomastia and prophylactic
- Morbid obesity procedures
- Orthognathic procedures (ex: Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
- Otoplasty
- Palatopharyngoplasty (UPP for snoring)
- Panniculectomy
- Rhinoplasty
- Rhytidectomy
- Scar revisions
- Septoplasty
- Varicose vein surgery/sclerotherapy

Outpatient Diagnostic Services

- Mammography Screening (<age 40)

Organ/Tissue Transplant Services

Outpatient – Continuing Care Services

- Chemotherapy
- Radiation
- Dialysis
- Hyperbaric Oxygen
- *Infusion Therapy* in a Home Setting
- *Infusion Therapy* Drugs
- Prosthetics over $1,500
- Outpatient Subacute
  - Home Health Care (will require submission of Home Health Care Plan)
  - Hospice
  - Durable Medical Equipment over $1,500
- Vision Therapy
- Intensive Outpatient/Partial Hospitalization

Outpatient Therapeutic Services

- Physical/Occupational/Speech Therapy (after the initial 12 visits)

Residential Care and Treatment

If you are not sure whether your provider has requested *pre-certification*, you should call the *utilization review manager* at the number on the front of your ID card to verify that *pre-certification* has been initiated.

Failure to Obtain Pre-Certification

If services or supplies that require *pre-certification* are not *pre-certified*, the *Plan* will not reimburse you for expenses incurred. The expenses you incur due to not receiving *pre-certification* will not be applied to your deductible or out-of-pocket maximums. If medical services that require *pre-certification* are not *pre-certified*, the *Plan* will also not reimburse you for any associated services. (For example, if a surgery requiring *pre-certification* is denied, associated anesthesia fees will not be covered and the expense you incur will not be applied to your deductible or out-of-pocket maximums.)

It is your responsibility to follow the Pre-Certification Program procedure and it is your responsibility to make sure *pre-certification* is successfully obtained prior to hospital admission or other treatment.

Effect on Deductibles and Out-of-Pocket Limit

If you assume additional expenses due to your failure to adhere to the *pre-certification* requirements in this SPD, any additional expenses you assume will not be applied toward your deductibles and out-of-pocket maximums.

Required Second Surgical Opinion

The *Plan* may require that you or your *covered dependent* be examined by another *physician* to determine that the surgery proposed by your own *physician* is *medically necessary*. The *Plan* pays the full cost of this required second surgical opinion with the *co-payment* waived.

Facilitation of Patient Transfer to Participating Facilities Following Medical Emergency

The *utilization review manager* will facilitate the medical transfer of patients who were hospitalized at an *out-of-network hospital* or other facility as a result of an *emergency medical condition*. Transfer of the patient to an *in-network facility* will only be initiated once the patient's *medical condition* is stabilized.

If the patient refuses medical transfer once the *utilization review manager* determines that the transfer is safe and appropriate, benefits for subsequent services provided by *out-of-network providers* will not be provided. The expenses you incur for refusing medical transfer will not be applied to your deductible or out-of-pocket maximums.

Determination of Where Needed Medical Services are Available

The *utilization review manager* staff is very knowledgeable about the availability of medical services from *in-network providers* and *in-network facilities*.

If you or your provider believes that needed medical services are not available from an *in-network provider* or *in-network facility*, you or your provider can call the *utilization review manager* at 1-888-276-4732. The *utilization review manager* staff will obtain medical information from your provider describing the *condition* of you or your *covered dependent* and the needed medical services. If it is determined that *covered services* are not available within the *network*, you may make application to the *plan administrator* to apply the special

Unavailable Services coverage level listed in the Schedule of Benefits to *covered services* provided by the *out-of-network providers* by using the Unavailable Service Request Form and procedure as outlined in the Unavailable Services section of the Physician and Provider System chapter.

Pre-Certification for Prescription Drugs

Pre-certification is required for some prescription drugs. Express Scripts manages *pre-certification* for prescription drugs. Your doctor or pharmacist will request *pre-certification* through the Express Scripts Contact Center, which is available 24 hours a day, seven days a week. Contact information is below:

Express Scripts
Member Services: 800-841-5396
Pharmacists: 800-922-1557

Providers and Facilities Available Under the Plan

Choice of Providers and Facilities

You have a choice of obtaining provider services (*physician* and other licensed *professional providers*) from any *PPO provider*. You have a choice of obtaining facility services (including *hospital*, *outpatient* laboratory, radiology, home health care, and mental health inpatient and outpatient) and supplies from any *PPO facility*.

If you have cancer or are receiving dialysis services, your choice of providers/facilities may be subject to case management. See the Case Management section for details.

In the case of an *emergency*, benefits will apply as discussed in the Emergency Services section of the Benefits Description chapter.

Primary Care Provider

The *Plan* does not require you or your *covered dependents* to designate a *primary care provider* (PCP). You and your *covered dependents* may seek treatment from any *physician* or *professional provider* without referral by a PCP.

Membership Card

After enrolling, you and your *covered dependents* will receive your benefit ID card which will include your *employer* and identification numbers, and instructions for *medical necessity pre-certification*. You will need to present your card each time you receive services from a *physician* or *professional provider*.
If you lose your benefit ID card, we will issue a replacement. Contact the *plan administrator* at 888-276-4732, or by requesting through the **www.Ascendtowholeness.org** website.

Unavailable Services

If *covered services* cannot be rendered at a *PPO facility* or by a *PPO provider* due to the unavailability of the service needed, a request may be made for coverage at a non-*PPO facility* or with a non-*PPO provider* at the special Unavailable Services coverage level listed in the Schedule of Benefits. Your personal *physician* not being part of the *PPO Network* or on the medical staff at a *PPO facility,* or your *PPO provider* leaving the *PPO Network* will not be considered valid unavailable services situations.

Unless the *covered service* is urgent or emergent, a coverage request must be made prior to services being rendered. If the service is urgent or emergent the coverage request should be submitted as soon as possible after the service has been provided. The *plan administrator* must approve the request.

Emergency Care and Hospitalization due to an Emergency Medical Condition

Claims for *emergency* care that are ultimately determined by the *utilization review manager* to be *medically necessary* will be paid even without *medical necessity pre-certification* by the *Plan*. However, you or your provider must notify the *Plan* of your *hospital* admission within 24 hours or the next business day of your emergent in-patient *hospital* admission following a *hospital* emergency department visit. Upon notification, the *utilization review manager* will work with the *hospital* and your *physician* to facilitate transfer, as appropriate, to an *in-network facility* as soon as you are stabilized and able to be transferred.

It is your responsibility to make sure that the *pre-certification* process elaborated in this section has been followed.

Hospitalization not due to an emergency medical condition

For care not due to an *emergency medical condition*, should your *physician* determine that hospitalization is needed, arrangements will be made for you to be admitted to a *hospital* if, and after, *medical necessity pre-certification* has been granted by the *utilization review manager*. The *utilization review manager* will review elective admissions and work with the *physician* to assure that the patient avoids unnecessary time in the *hospital*.

It is your responsibility to make sure that the pre-admission process elaborated in the Pre-Certification Program section has been followed.

Cost-Effectiveness Services

At our sole discretion and under unique and unusual circumstances, the *plan administrator* may approve benefits for *cost effectiveness services* not otherwise covered by the *Plan*.

Payment of benefits for *cost effectiveness services* shall be at the sole discretion of the *plan administrator* based on its evaluation of the individual case. The fact that the *Plan* has paid benefits for *cost effectiveness services* for a covered person shall not obligate the *Plan* to pay such benefits for any other covered person, nor shall it obligate the *Plan* to pay benefits for continued or additional *cost effectiveness services* for the same covered person. All amounts paid for *cost effectiveness services* under this provision shall be included in computing any benefits, limitations, *co-payments* or *co-insurance* under the *Plan*.

Case Management

Participation in case management is required for *enrollees* who have cancer or who are receiving dialysis services. The purpose of case management is to improve outcomes while containing cost.

Oncology Case Management

The primary objective of oncology case management for cancer patients is to identify and coordinate cost-effective medical care alternatives meeting accepted standards of medical practice. Special case management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among health care providers, patients and others.

Your *Plan* has entered into an arrangement with Adventist Health whose oncology case managers will assist you and your oncologist during the course of cancer treatment when administered either in an outpatient setting (e.g., in the physician's office or other covered outpatient setting) or in an inpatient setting. The program applies to the plan of treatment for all cancer types and stages and begins with a treatment planning phase (including drug and/or radiation treatment) and continues through active treatment and transitional care.

A Registered Nurse will be assigned to you and will contact you to provide support, education, and answer any questions you might have about your disease and your treatment plan and will remain in contact with you and your oncologist for the duration of your cancer journey.

Unless your oncologist has entered into an agreement with HealthSCOPE Benefits to accept other reimbursement rates, the payment for all drugs used in the treatment of cancer will be limited to the rate of Average Sales Price plus 10%. Average Sales Price is the price calculated by pharmaceutical manufacturers and submitted to CMS on a quarterly basis.

Dialysis Benefit Preservation Program

This Section describes the *Plan*'s Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of *Plan* benefits to be provided to *Plan* members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

1. Reasons for the Dialysis Program.

    a. The concentration of dialysis providers in the market in which plans reside may allow such providers to exercise control over prices for dialysis-related products and services;

    b. The potential for discrimination by dialysis providers against the *Plan* because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to *Plan* members;

    c. Evidence of: (i) significant inflation of the prices charged to plans by dialysis providers, (ii) the use of revenues from claims paid on behalf of plans to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of non-governmental and non-commercial plans, such as the *Plan*, by dialysis providers as profit centers; and

    d. The fiduciary obligation to preserve *Plan* assets against charges which: (i) exceed reasonable value due to factors not beneficial to *Plan* members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the interests of *Plan* members, such as subsidies for other plans and discriminatory profit-taking.

2. Dialysis Program Components.

    a. Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, *Plan*

members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").

b. Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the *Plan* for expenses incurred on or after January 1, 2016, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the *Plan* with respect to the *Plan* member.

c. Mandated Cost Review. All dialysis-related claims will be subject to cost review by the *plan administrator* to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the *plan administrator* shall consider factors including:

   i. Market Concentration: The *plan administrator* shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

   ii. Discrimination in Charges: The *plan administrator* shall consider whether the claims reflect potential discrimination against the *Plan*, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

d. In the event that the *plan administrator's* charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the *plan administrator* may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the *plan administrator* may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the member, to the following payment limitations, under the following conditions:

   i. Where the *plan administrator* deems it appropriate in order to minimize disruption and administrative burdens for the member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face value or otherwise applicable rate.

   ii. Maximum Benefit. Except as provided in the preceding subsection or where an acceptable provider agreement is entered into, the maximum *Plan* benefit payable to dialysis-related claims subject to the payment limitation shall be the *Usual and Reasonable Charge* for covered services and/or supplies, after deduction of all amounts payable by *co-insurance* or deductibles.

   iii. Usual and Reasonable Charge. With respect to dialysis-related claims, the *plan administrator* shall determine the *Usual and Reasonable Charge* based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The *plan administrator* may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

   iv. Additional Information Related to Value of Dialysis-Related Services and Supplies.

The member may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the *plan administrator*, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the *plan administrator* shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the *plan administrator* based upon credible information from identified sources. The *plan administrator* may, but is not required to, review additional information from third-party sources in making this determination.

v. All charges must be billed by a provider in accordance with generally accepted industry standards.

3. Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the *Plan* member is available, the *plan administrator* may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the *Plan* and clearly state that such agreement is intended to supersede this Section.

4. Discretion. The *plan administrator* shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law. It is the express intent of this *Plan* that the *plan administrator* shall have maximum legal discretionary authority to construe and interpret the terms and provisions of this Section, to make determinations regarding issues which relate to eligibility for benefits under this Section, to decide disputes which may arise relative to a Plan's rights under this Section, and to decide questions of interpretation of this Section and those of fact relating to the application of this Section. The decisions of the *plan administrator* will be final and binding on all interested parties.

5. Secondary Coverage. *Plan* members who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the member incurring costs which are not covered by the *Plan* and which would otherwise be covered by the secondary coverage. The *Plan* will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by the *Plan*.

6. Provider Acceptance. A provider that accepts the payment from the *Plan* under this Section will be deemed to consent and agree that: (i) such payment shall be for the full amount due for the provision of services and supplies to a *Plan enrollee*; and (ii) it shall not "balance bill" a *Plan enrollee* for any amount billed but not paid by the *Plan*.

General Benefit Rules

When all of the provisions of this *Plan* are satisfied, the *Plan* will provide benefits as outlined on the Schedule of Benefits for the services and supplies listed in this section. As to all benefits described herein, only *medically necessary* services are covered up to the *usual, reasonable, and customary charge*, when provided, ordered, or referred by a *physician* or *professional provider* practicing within the scope of their licenses.

The *Plan* only pays for expenses covered by the *Plan* if the expenses:

1. are *medically necessary* or are for preventive services (listed in Appendix A) covered by the *Plan*;
2. represent a commonly accepted form of treatment and meet professionally recognized national standards of quality;
3. are recognized as generally accepted by the American medical community;
4. result from a non-occupational *illness*, *injury* or other event or cause;
5. are of a type specifically listed in the Benefits Description sections of this document;
6. are a type of expense for which the *Plan* does not otherwise limit or exclude payment; and
7. do not exceed *Plan Year* or Lifetime Maximum limits.

All *covered services*, other than preventive care services, must be *medically necessary*. The *Plan* determines what is *medically necessary* and the decision is final and conclusive. Even though your provider may recommend a procedure, service or supply, the recommendation does not always mean the care is *medically necessary*. (See Definitions section for definition of *medically necessary*.)

Failure to obtain required *pre-certification* will result in non-payment by the *Plan.*

Any services performed by a provider must be performed by a *physician* or *professional provider*.

There may be alternative procedures, services, or supplies that meet *medical necessity* criteria for diagnosis and treatment of your condition. If the alternatives are substantially equal in clinical effectiveness and use similar therapeutic agents or regimens, the *Plan* reserves the right to approve the least costly alternative.

Many items are not covered by the *Plan* even though they may provide significant patient convenience or personal comfort. Such items may include raised toilet seats or sauna baths. Such items do not meet the *medical necessity* requirement that the item be expected to make a meaningful contribution to the treatment of the *illness* or *injury*.

In addition, expenses must be incurred while the coverage is in effect. All expenses are treated as being incurred on the date that the service or supply is provided to the patient, not on the date the bill was sent or paid. Expenses incurred before your *Plan* coverage becomes effective or after your *Plan* coverage has terminated will not be covered.

Benefits Description - Medical

NOTE: *Plan* provisions may vary based on your *employer* and the location of your employment. Your benefits and other *Plan* provisions under the *Plan* may vary from state to state and from *employer* to *employer*, depending upon:

1. Specifications in the *PPO Network* contract with the provider;
2. State or local laws that apply to the *Plan* or benefits provided under the *Plan* in only one state or city.

Ambulance Services

The *Plan* pays a percentage of the charges for necessary professional emergency ambulance transportation to the hospital for inpatient treatment or outpatient treatment of an accident, and any medical services provided en route. It is expected that ambulance services will be used only when *medically necessary* and involving life threatening conditions such as severe bleeding, severe breathing difficulty, unconsciousness or serious injury.

Your *Plan* will cover Ambulance Transport Services (professional air or ground) to the nearest adequate hospital, urgent care center, or nursing facility to treat your illness or injury. Local air and ground ambulance means that you or your eligible dependents are transported to a hospital, urgent care center, or nursing facility in the surrounding area where your ambulance transportation began.

The *Plan* will cover your ambulance transport provided the following criteria are met:

1. No other method of transportation is appropriate.
2. The services necessary to treat this *illness* or *injury* are not available in the hospital or nursing facility where you are an inpatient.
3. The *hospital* or other facility is nearby and the *hospital* or facility is adequate and available to treat your medical condition.
4. Coverage for air ambulance services has been *pre-certified* by the utilization review manager or, if not *pre-certified*, the *utilization review manager* determined that ground transportation would have endangered the life of the *enrollee*.
5. Any ambulance transportation other than to a facility for emergency treatment must have pre-certification or it will not be paid.

Diabetic Education

The *Plan* provides outpatient diabetes self-management training (DSMT) to teach you to cope with and manage your diabetes. The *Plan* may cover up to ten hours of initial DSMT by a certified DSMT provider. This training may include one hour of individual training and up to nine hours of group training. You may also qualify for up to two hours of follow-up training each year if it takes place in a calendar year after the year you got your initial training.

This training is for covered *enrollees* who are at risk for complications from diabetes. You must have a written order from a *physician* or other healthcare provider.

Dialysis

See the Case Management section.

Emergency/Urgent Care Services

If an enrollee receives *emergency* medical care for an accidental *injury* or medical *emergency* the *Plan* will cover physician services in the emergency room, urgent care center, office, or hospital outpatient department including x-rays, MRIs, laboratory, and machine diagnostic tests. Please refer to the Schedule of Benefits section of this document for the amount of coverage provided and deductible provision for emergency care. If an Urgent Care Center is available and you choose to use its services for your care, the *physician* charges may be paid as office visits, or as an ER visit. This is dependent on the facility and its billing process, the treatment diagnosis and services rendered. Facility charges for office visits are not covered.

Hospitalization and Surgery

Hospital, Skilled Nursing Facility, Ambulatory Surgery Center

When this *Plan* refers to an inpatient, it means a person admitted as a bed patient to a hospital or skilled nursing facility for treatment and charges made for room and board to the *enrollee* as a result of such treatment. An outpatient is an *enrollee* who receives treatment while not admitted as a bed patient in a hospital.

Payment for inpatient care is limited to semi-private room rate charges. If you voluntarily elect to occupy a private room instead of a semi-private room, you are responsible for paying the difference in cost between the private room rate and the hospital's most common semi-private room rate. There is one exception to this rule: isolation or private room charges will be covered if a private room is essential due to the patient's severely compromised defenses against infection, due to a contagious disease, or otherwise *medically necessary* to protect the patient's life.

In order for the *Plan* to cover charges as those of a hospital, the institution must meet state and Federal regulatory and credentialing guidelines.

Oncology

See Case Management section.

Organ/Tissue Transplant

A "recipient" is a person who receives a body organ or tissue transplant. A "donor" is a person, either living or deceased, who donates tissue or a body organ for transplant.

In order to receive benefits under this provision, the type of transplant must not be experimental or investigative and must be from a human donor.

Recipient Benefits

If an *enrollee* is receiving a transplant, the *Plan* covers inpatient hospital and professional services and supplies furnished to the recipient during the hospital stay in which the transplant is performed.

Benefits for bone marrow/stem cell transfer transplants include coverage for chemotherapy and radiation therapy that is a part of the inpatient care under this provision.

Donor Costs for Enrollees

The *Plan* also provides benefits for the medical expenses of *enrollees* in this *Plan* who act as organ or tissue donors or are evaluated as a potential donor, but only if the recipient is an *enrollee*. The *Plan* will cover the evaluation, removal and transport of the donor organ or tissue, including expenses of the surgical/harvesting team. The *Plan* will also cover donor testing and typing of a potential donor, if the potential donor is an *enrollee* in the Plan. The *Plan* covers medically necessary expenses of a donor who is not an *enrollee* in the Plan who donates to a covered *enrollee*. *Pre-certified* services and charges are paid only on the matched donor.

Home Health Care

The *Plan* provides benefits for Home Health Care if provided by an appropriately licensed entity staffed by licensed and credentialed home health care professionals meeting all state and Federal requirements.

The Home Health Care benefit provides for medically warranted continued care and treatment after discharge from a hospital and must be in lieu of hospitalization.

Specific Limitations

Home Health Care does not include charges made for:

1. services or supplies that are not a part of the Home Health Care Plan;
2. services of a person who usually lives with you or is a member of you or your spouse's family;
3. transportation; or
4. *custodial care*.

Skilled Nursing Facilities

In order for the charges to be covered under the *Plan*, the Skilled Nursing Facility must meet all of the following requirements:

1. The Skilled Nursing Facility must be licensed to provide and be engaged in providing 24-hour- per-day professional nursing services on an inpatient basis for persons recovering from injury or disease by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of an R.N.
2. Physical restoration services must be provided to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
3. A Skilled Nursing Facility confinement must take place within 14 days from a hospital discharge and must represent care for the same condition for which the hospitalization was required.
4. The care provided must not be custodial in nature.
5. The Skilled Nursing Facility must maintain a complete record on each patient.
6. The Skilled Nursing Facility must have an effective utilization review plan.
7. Limitation: 120 day stay per *Plan Year*.

Hospice Care

Hospice care is an alternative to hospitalization. It is care that offers a coordinated program of home care and inpatient care for a terminally ill patient and the patient's family. The program provides supportive care to meet the special needs from physical, psychological, spiritual, social, and economic stresses often experienced during the final stages of life and during dying and bereavement. For purposes of this *Plan*, a "terminally ill patient" is someone who has a life expectancy of approximately six months or less, as certified in writing by the *physician* in charge of the patient's care and treatment. The *Plan* provides benefits for covered charges for:

1. services of a *physician*; and
2. healthcare services as an inpatient or at home, including part-time nursing care, part-time or intermittent home health care aid, use of medical equipment, rental of wheelchairs, and hospital- type beds; and
3. emotional support services and physical and chemical therapies.

Specific Limitations

The *Plan* only covers those services provided by a qualified hospice program that meets the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Durable Medical Equipment

The *Plan* covers durable medical and surgical equipment that meets all of the following requirements. The equipment must:

1. be recommended for you by your *physician*;
2. be able to stand repeated use, and be of a type that could normally be rented and used by successive patients;
3. be primarily and customarily used to serve a medical purpose (examples of items that do not primarily and customarily provide a "medical purpose" include, for example, humidifiers, exercise equipment, gel pads, water mattresses, heat lamps);
4. generally not be useful to a person in the absence of an injury or illness;
5. be appropriate for home use; and
6. meet the guidelines used by the Center for Medicare and Medicaid Services (CMS), the agency that administers the Medicare, Medicaid and Child Health Insurance Programs.

Rental Charges

The *Plan* covers a portion of the charges for the rental of medically necessary durable medical and surgical equipment and accessories needed to operate it. All rentals require pre-certification. See Schedule of Benefits for more complete information.

Purchase Charges

The *Plan* will pay a percentage of the cost of the initial purchase of durable medical equipment and accessories needed to operate it if the *utilization review manager* determines that long-term use is planned and the equipment cannot be rented, or purchase is more cost effective than rental.

Repair and Replacement

The *Plan* covers charges for repair of purchased equipment and accessories. Replacement of purchased equipment is covered only if the *utilization review manager* determines that it is warranted due to changes in an *enrollee*'s physical condition or if it is more cost effective than repair or rental of like equipment.

Specific Limitations

The *Plan* does not cover charges for more than one item of equipment for the same or similar purpose.

Prosthetics

The *Plan* provides coverage for evaluation, fabrication, and custom fitting of artificial limbs.

Therapeutic Care

Physical Therapy

The *Plan* provides coverage for Physical Therapy within certain limitations stated in the Schedule of Benefits section of this document. No referral from your MD/DO is necessary.

Registered Physical Therapist services are covered whether performed in a clinical or home setting.

Occupational Therapy

The *Plan* provides coverage for Occupational Therapy within certain limitations stated in the Schedule of Benefits section of this document. Occupational Therapy may be covered whether performed in a home or clinical setting if the provider of such services is a Registered Occupational Therapist (OTR) or a Certified Occupational Therapy Assistant (COTA). Sensorimotor therapy, cognitive therapy, and psychosocial therapy are services under the umbrella of Occupational Therapy. Services that are recreational in nature are not covered.

OTR and COTA services are covered whether performed in a clinical or home setting.

Speech and Language Pathology Therapy

The *Plan* provides coverage for Speech Therapy with certain visit limitations stated in the Schedule of Benefits contained in this document. Attempting to improve public presentation skills with the assistance of a Speech and Language Pathologist is not considered a covered expense under this Plan.

Vision Therapy

The *Plan* provides coverage for orthoptic/pleoptic training.

Hearing Care

Services for hearing care assistance include:

1. audiometricians;
2. hearing specialists;
3. hearing aids and repairs (does not require *PPO Network* utilization but is subject to separate limits, see Schedule of Benefits); and
4. surgically placed devices such as cochlear implants upon *pre-certification* by the *Plan*'s *utilization review manager*.

Mental Health Services

The *Plan* covers *physician* and other authorized *professional provider* charges for inpatient and partial hospitalization of mental health disorders, and for counseling services for marital and family conflicts, and social adjustment.

Residential care and treatment are not covered unless treatment is considered in-patient, is in-network, and approved through the *utilization review manager*.

Substance Abuse and Chemical Dependency Treatment

The *Plan* covers *physician* and other authorized *professional provider* charges for substance abuse and chemical dependency treatment.

Residential care and treatment are not covered unless treatment is considered in-patient, is in-network, and approved through the *utilization review manager*.

Infertility Treatment Benefits

This benefit is only available to *enrollees* who are legally married to a person of the opposite sex. If sterilization

and/or tubal ligation procedures have been reversed, infertility treatment and associated medication are not covered under the *Plan*. There is a lifetime maximum payable benefit for infertility benefits that is set forth in the Schedule of Benefits.

Infertility treatment benefits are provided only to *employees* and their spouses. Infertility treatment benefits are not provided for dependent *children* regardless of the marital status of that *dependent child*.

Maternity and Obstetric Benefits

Under the *Plan*, pregnancy-related and obstetric expenses are covered in the same way as medical expenses for illness or injury, except that full coverage is provided only to *employees* and their *spouses*. There is no coverage for maternity benefits or complications due to pregnancy for dependent daughters regardless of their marital status.

Preventive benefits (including those specific to maternity) are covered based on Federal guidelines of the Affordable Care Act. Preventive benefits are covered for dependent daughters the same as for *employees* and *spouses*. See Preventive Care Services section.

Inpatient maternity expenses that are incurred by the newborn child during hospitalization for delivery will be considered incurred by the child and thus subject to a separate deductible and out-of-pocket maximum at birth of the baby.

The *Plan* provides coverage for Midwives who are certified nurse midwives who have met the graduate training standards of the American College of Nurse Midwives and are licensed to practice in that state. The majority of qualified midwives practice in a hospital, or in a free standing or hospital based facility that provides a "home-like" atmosphere for childbirth; deliveries may also be in the home. A midwife often attends childbirth, or a physician may assist a midwife. The midwife must meet all state licensing requirements and provide proof of liability insurance. **The Plan will not pay for nor reimburse for midwife services if no proof of liability insurance is provided even if the state does not require liability insurance.**

Preventive Health Care

- All preventive items and services (collectively referred to as "preventive services" below) listed in 26 CFR §54.9815-2713T, or any successor regulation or statute. Such preventive services include the following:

  (i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;

  (ii) Immunizations for routine use in *children*, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

  (iii) With respect to infants, *children* and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

  (iv) With respect to women, to the extent not described in (1) above, evidence informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA").

  Preventive services do not include any items or services specified in any recommendation or guideline described in (i)-(iv) above after the recommendation or guideline is no longer

described in (i)-(iv) above.
A list of the preventive services that are covered by the *Plan* can be found at **https://www.healthcare.gov/preventive-care-benefits/** and in Appendix A. Appendix A reflects the preventive services available as of the date listed in Appendix A. If there is any conflict between the list in Appendix A and the provisions of this Preventive Health Care (Wellness) section, the provisions of this section are followed.
If received from an *in-network provider*, the preventive services covered under this section are covered with no cost-sharing required on your part (that is, no *co-payment*, no *co-insurance*, and no deductible; this is often referred to as "first-dollar coverage"). If a preventive service is provided as part of an office visit and the office visit is not itself a preventive service covered under this section, the following rules apply: (1) if the preventive service is billed separately from the office visit, then any applicable cost-sharing requirements will apply to the office visit (such as a copayment); (2) if the preventive service is not billed separately from the office visit and the primary purpose of the office visit is the delivery of such preventive service, then no cost-sharing will be imposed; and (3) if the preventive service is not billed separately from the office visit and the primary purpose of the office visit is not the delivery of such preventive service, then any applicable cost-sharing requirements will apply to the office visit.

Contraceptive management: As provided in (iv) above, the *Plan* provides first-dollar coverage for preventive care and screenings provided for in the HRSA guidelines for women's preventive care. The HRSA guidelines include annual well-woman visits and FDA-approved contraceptives. Thus, first-dollar coverage is provided for an annual well-woman visit and FDA-approved contraceptives (including insertion and removal of implantable contraceptives). Office visits for contraceptive management, generally, will not be covered as preventive services and, thus, will be subject to any applicable copayment (as set forth in the Schedule of Benefits).

- Colorectal cancer screening for adults age 50 and over at the screening intervals recommended by the US Preventive Services Task Force based on test type and individual risk level: colonoscopy or sigmoidoscopy (including bowel prep kit, anesthesia, any required specialist consultation prior to the screening procedure, and any pathology exam on a polyp biopsy); or fecal occult blood testing. **Colon cancer testing for diagnostic purposes, as opposed to general screening, is not preventive care and so cost-sharing requirements will apply.**

Benefits Description - Dental

Aetna Dental is the preferred provider organization (PPO) for all dental benefit services. To avoid a reduction in benefits and potential excess charges of *U&C* (*Usual, Reasonable, and Customary*), you must use an *in-network provider*. By utilizing *in-network providers* of the dental *PPO Network*, dental costs will be lower to both the *Plan* and to you.

By choosing not to use an *in-network provider* to which you have access, your benefits are similar to the participating provider program except for three major differences:

1. For *in-network*, preventive care is paid at 100% of charges with no deductible applied. U&C applies when using *out-of-network providers*.

2. There is a separate and additional deductible for services obtained from *out-of-network providers*. See the Schedule of Benefits for specific deductible limits for *in-network providers* and *out-of-network providers*.

3. After deductibles have been met, charges for restorative dental care will be paid at the percentage identified in the Schedule of Benefits. This percentage of payment is lower for *out-of-network providers*.

If you elect to utilize the services of an *out-of-network provider*, your covered benefits will be paid at a lower percentage rate than with participating providers. Also, you will be responsible for charges in excess of *U&C*.

The dental plan pays up to a maximum amount based on *U&C* per *Plan Year* for individual coverage and family coverage. Please refer to the Schedule of Benefits in this document for the *Plan's* percentage of coverage.

Dental Care expenses are paid in accordance with the Schedule of Benefits as follows:

Preventive Care

1. Routine oral examinations and prophylaxis (cleaning of teeth), but not more than two times in a *Plan Year*;

2. One set of bitewing x-rays per *Plan Year*;

3. Topical application of fluoride, but not more than two times per *Plan Year*; and

4. Full-mouth x-rays or panorex limited to once every three *Plan Years*.

Restorative Care

1. Amalgam, silicate, acrylic, resin, synthetic porcelain and composite filling restorations to restore diseased or fractured teeth;

2. Root canal therapy;

3. Diagnostic x-rays;

4. Pit and fissure sealant on permanent molars and bicuspids without prior restorations;

5. Space maintainers that replace prematurely lost teeth for dependent *children* under age 19;

6. Periodontal scaling and root planning;

7. Extractions;
8. Periodontal procedures (other than scaling and root planning);
9. Oral surgery;
10. General anesthesia when medically necessary;
11. Installation of crowns or fixed bridgework (including inlays and crowns as abutments);
12. Initial partial or full removable denture (to include any adjustments during the six month period following installation);
13. Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework; and
14. Dental implants.

Dental Pre-Certification Requirements

Pre-certification requirements must be confirmed with the dental *PPO Network* provider. *In-network provider* utilization and appropriate *pre-certification* protocol must be followed to minimize member responsibility for these services. The *Plan* will defer to the *PPO Network*'s benefit policies concerning *pre-certification*, supporting documentation required in claim adjudication, and *U&C* amounts. For pre-certification please contact member services.

Payment Limits

There are annual individual and family limits on the amount of dental expenses covered under the *Plan*. Please refer to the Schedule of Benefits for the maximum payable benefits and coverage percentages per *Plan Year*.

Coverage Limits and Exclusions

The Plan does not cover, or limits coverage, for the following types of dental services:

1. Any dental charges in which treatment is started before the *enrollee* was participating in this *Plan* are not covered.
2. Fees charged for infection control are not covered.
3. Temporary crowns or bridges are not covered.
4. Services or supplies that do not meet accepted standards of dental practice, including charges for services or supplies that are experimental in nature are not covered.
5. Oral hygiene instruction and oral hygiene aids are not covered.
6. Cosmetic services, including teeth whitening and veneers are not covered.

See the Limitations and Exclusions section of this document for additional information.

ORTHODONTIA TREATMENT

The *Plan* provides coverage for orthodontia expenses as a percentage rate of the provider's charges up to a maximum stated amount per *Plan Year* as outlined in the Schedule of Benefits. Payment for Orthodontia services is also subject to the limitations outlined below.

Payment and Other Limitations

1. Payment by the *Plan* will begin when the dental *PPO Network* is notified of the banding date. Subsequent payments will be made on a monthly basis as services are rendered and provider billing is received during the course of treatment.

2. *Enrollees* are not eligible for Orthodontia benefits after attaining 24 years of age.

3. The orthodontic lifetime maximum in effect at the time of banding is the orthodontic lifetime maximum benefit that will apply for these services.

4. If a person becomes ineligible for coverage under the *Plan* during the course of his or her treatment, payments will end when the person is no longer eligible for coverage regardless of whether the treatment is complete.

5. Payments by the *Plan* are on a monthly basis as services are rendered during the course of treatment subject to age and benefit limitations.

See the Limitation and Exclusions section of this document for additional information.

Benefits Description - Vision

The *Plan* provides coverage for vision related diagnoses and treatments, including routine diagnostic procedures, and the following necessary vision care services and expenses:

1. Eye examination;
2. Prescription eye glasses; and
3. Contact lenses.

Limitations

Vision care benefits are covered at the same percentage rate as other medical benefits, but there is a maximum benefit amount in each *Plan Year*. The *Plan's* percentage rate of payment and maximum amount payable for each covered *enrollee* is specified in the Schedule of Benefits. The vision care benefits do not include payment for non-prescription lenses.

Refractive Eye Surgery

Refractive eye surgery reshapes the cornea to redirect light rays so that they focus accurately on the retina, reducing or eliminating the need for corrective lenses. Refractive surgery is used to correct myopia (near sightedness), hyperopia (farsightedness), astigmatism (distorted vision). Refractive eye surgical procedures are covered up to a lifetime maximum amount set forth in the Schedule of Benefits. In order to be covered, procedures must meet federal Food and Drug Administration (FDA) approval and guidelines. Covered procedures include Radial Keratotomy (RK), Photorefractive Keratotomy (PRK), Laser In Situ Keratomileusis (LASIK), and intracorneal rings.

Medical Vision/Eye Services

Medical diagnoses and treatments of the eye(s), including diagnostic procedures and retinal exams, apply to the medical plan benefits. By using a provider participating in the medical *PPO Network*, medical costs will be lower to both the *Plan* and to you.

Benefits Description – Prescription Drugs

This benefit only covers services/supplies received directly from Express Scripts, Inc. or from a pharmacy contracted with Express Scripts, Inc.

This section describes the prescription benefits provided by your *Plan*. Please refer to the Schedule of Benefits for the specific payment percentages, maximum amounts payable, and *co-payment* requirements.

The following are covered:

- Prescription drugs, which under applicable state law, may only be dispensed by written prescription of a *physician* or dentist and are included in the formulary of your pharmacy benefit manager (see below).
- Diabetic supplies, including syringes and test strips.
- Compounds with National Drug Code (NDC) ingredients. (Compounds without NDC ingredients are not covered.)

Pharmacy Benefit Manager

The *Plan* uses Express Scripts, Inc., (ESI) as its pharmacy benefit manager (PBM) for the *Plan's* prescription drug benefit.

Formulary, Pharmacy Levels and Drug Tiers

ESI uses a national preferred formulary. The formulary encourages patients to use clinically appropriate medications while helping to manage costs. A formulary is a list of medications in different therapy classes used to categorize or group the drugs on the formulary. The classes group drugs which are considered similar by the disease they treat or by the effect they have on the body. Prescription drug coverage under the *Plan* is offered through two different pharmacy levels: 30-day Retail; and 90-day Mail Order and Walgreens Smart90 retail program. Your copayments will be lowest if you use 90-day Mail Order or the Walgreens Smart90 retail program.

If you choose to purchase long-term maintenance medication at retail pharmacies rather than via mail order, after three purchases of the medication, you will have to pay the difference in the cost between the price of the medication at the retail pharmacy and the price of the medication charged by the mail order home delivery program (and this difference will not accrue toward your *Plan Year* out-of-pocket maximums or deductibles). For a list of long-term maintenance drugs that are subject to this rule, please contact the ESI Member Services Department at 800-841-5396.

Within each category, there are three drug tiers, or levels:

Generic:	A generic drug is a safe, effective drug approved by the U.S. Food and Drug Administration (FDA) that also costs less. You pay the lowest copayment for generic drugs.
Brand:	Formulary brand (or preferred) drugs are brand name drugs. The copayment for formulary brand drugs is higher than it is for generic drugs.
Non-formulary:	Non-formulary (or non-preferred) drugs are brand name drugs that are not covered under the ESI national preferred formulary. The copayment for non-formulary drugs is higher than it is for formulary brand (preferred) or generic drugs.

The ESI formularies are developed to be clinically sound and cost effective. Clinical appropriateness is the foremost consideration; however, **the prescribing *physician* has the final decision regarding a patient's drug therapy**.

If your prescribing *physician* has allowed a generic substitution and you nevertheless choose the brand name drug, you may be required to pay the cost difference between the generic and the brand (in addition to your co-payment).

Prescription Drug Pre-Certification Requirement

Some drugs require *pre-certification*, including the following drugs:

When obtaining prescription medication through your retail pharmacist or mail order program, the following categories of medications are subject to review, *pre-certification*, and/or restrictions by the *Plan*:

1. Alzheimer's Therapy Drugs
2. Amphetamines
3. Analgesics (Stadol)
4. Androgens/Anabolic Steroids
5. Anti-Emetics
6. Anti-Narcoleptic Agents
7. Appetite Suppressants
8. Biotechnological Agents
9. Cancer Therapy
10. CNS Stimulants
11. COX 2 Inhibitors
12. Select Dermatologicals
13. Erectile Dysfunction
14. Erythroid Stimulants
15. Fertility Agents
16. Growth Hormones
17. Hypnotic Agents (Sleep Aids)
18. Immune Globulins
19. Interferons
20. Migraine Therapy Drugs
21. Multiple Sclerosis Medications
22. Myeloid Stimulants
23. Ophthalmic (select agents)
24. Pulmonary (select agents)
25. Rheumatologicals

The above list is subject to change at any time. Please call Express Scripts' Member Services, (800) 841-5396, or visit Express Scripts' website **www.express-scripts.com** for further details.

Step Therapy Drugs – Case Management

The *Plan* participates in Express Scripts' Step Therapy program under which certain high cost or brand name drugs ("Step-Therapy Drugs") are not covered by the Plan unless:

1. You first try one or more less costly drugs (which may include over-the-counter drugs) that are normally available and used to treat a particular medical condition, and your doctor certifies that these less costly drugs are not effectively treating your condition or other medical reasons why the less costly drugs cannot or should not be used to treat your medical condition; or

2. Your doctor certifies to the Plan the medical reasons for your use of the Step-Therapy Drugs in lieu of less costly drugs that are normally available and used to treat this condition.

If you are taking a Step-Therapy Drug, you or your doctor will receive a letter explaining this program. If you receive a letter, consult with your doctor immediately concerning your use of Step-Therapy Drugs. **Do not stop taking any medication prescribed by your doctor without first consulting your doctor.** Please call Express Scripts' Member Services, (800) 841-5396, or visit Express Scripts' website **www.express-scripts.com** for further details.

Preventive Prescription Drugs

Preventive prescription drugs include all prescription drugs listed in 26 CFR § 54.9815-2713T, or any successor regulation or statute. Such preventive prescription drugs include any and all prescription drugs included in the following:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;

(ii) Immunizations for routine use in *children*, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(iii) With respect to infants, *children* and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(iv) With respect to women, to the extent not described in (i) above, evidence informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive prescription drugs will not include any items or services specified in any recommendation or guideline described in (i)-(iv) above after the recommendation or guideline is no longer described in (i)-(iv) above.

Smoking cessation drugs that are prescribed by a *physician* and approved by the *plan administrator* are covered with no copay and no deductible (if received from an *in-network* pharmacy).

If prescribed by a *physician* and received directly from ESI or a pharmacy contracted with ESI, the preventive services covered under this section are covered with no cost-sharing required on your part (that is, no *co-payment*, no *co-insurance*, and no deductible; this is often referred to as "first-dollar coverage").

Benefits Description – Complementary and Alternative

The *Plan* recognizes the National Center for Complementary and Integrative Health (NCCIH) as the authority in defining complementary and alternative medicines (CAM). CAM, as defined by the NCCIH, is a group of diverse medical and healthcare systems, practices, and products that are not presently considered part of conventional medicine. Coverage for CAM is limited under the Plan. Coverage under the Accelerate Plan is limited to Therapeutic Massage Therapy, Acupuncture Treatment, and Chiropractic Treatment. Coverage under the Access Plan is limited to Chiropractic Treatment. All other CAM therapies, services, tests, laboratory tests, procedures, products, and practices are not covered under the *Plan*.

Chiropractic Treatment

The *Plan* limits chiropractic treatment coverage to manipulation (subluxation, whether performed manually or mechanically) of the spine. Certain maximums are stated in the Schedule of Benefits section of this document.

Services other than chiropractic manipulative treatment (i.e. hot or cold packs or supplies, muscle stimulation) are not covered. Patient is responsible for these charges. Covered office visit and x-ray charges during chiropractic treatment sessions are limited to one eligible charge per *Plan Year*.

Enrollees under the age of 10 are not eligible for chiropractic benefits.

Massage Therapy

Based on Benefit Plan Election, Massage Therapy may not be a covered benefit.

Massage therapy has both a maximum allowable charge and a maximum number of visits. Claims will not be considered for payment unless they include Rendering Provider name, address and phone; Tax ID; a copy of the therapist's current license if not already on file; procedure code; patient name and *enrollee*'s *Plan* ID number; length of visit (number of minutes); and date of service. CPT 97124 is the only allowable procedure recognized under the massage therapy benefit. A qualifying therapeutic massage will be a minimum of 30 minutes with services rendered in a private clinical setting. Please see the Schedule of Benefits for specific coverage and limitations.

Massage therapy must be provided by a licensed massage therapist (LMT) per regulatory requirements of the state in which services were rendered. If your massage therapist is a new provider, your submitted charges will be denied unless you provide a copy of the therapist's current license. If your massage therapist practices in a state, county, and/or city which does not have licensing requirements, the Plan may require additional or alternative information concerning the massage therapist as a condition prior to paying Plan benefits.

Enrollees under the age of 18 are not eligible for massage therapy benefits.

Acupuncture Treatment

Based on Benefit Plan Election, Acupuncture Treatment may not be a covered benefit.

The *Plan* provides coverage for acupuncture treatment within certain limitations stated in the Schedule of Benefits section of this document. Acupuncture treatment may be covered when performed in a clinical setting and by recognized providers including physicians, osteopaths, and non-physician acupuncturists who have met all state license requirements. See the Schedule of Benefits that describes the applicable visit limits and *co-insurance* amounts.

Enrollees under the age of 18 are not eligible for acupuncture benefits.

Limitations and Exclusions

In addition to the exclusions described elsewhere in this *Plan*, the following services, procedures and *conditions* are not covered by the *Plan*, even if otherwise *medically necessary*, even if they relate to a *condition* that is otherwise covered by the *Plan*, or even if they are recommended, referred, prescribed or provided by a *physician*, *professional provider*, including an *in-network provider* and/or *in-network facility*.

Coverage is not provided for the following charges or expenses:

1. Abortions. The *Plan* does not cover the expenses of an elective abortion, including medical complications that arise from an elective abortion, except in cases where continuation of the pregnancy endangers the life of the mother and in cases where pregnancy is the result of rape or incest.
2. Career or Financial Counseling Services.
3. Charges for Missed Appointments.
4. Complementary and Alternative Medicine that is not specifically and expressly covered by the Plan. The *Plan* recognizes the National Center for Complementary and Integrative Health (NCCHI as the authority in defining complementary and alternative medicines (CAM). CAM, as defined by the NCCHI, is a group of diverse medical and healthcare systems, practices, and products that are not presently considered part of conventional medicine. Coverage for CAM is limited under the *Plan*. The exceptions are limited to acupuncture therapy, massage therapy, and chiropractic treatment in the Accelerate Plan and limited to chiropractic treatment in the Access Plan. All other CAM therapies, services, tests, laboratory tests, procedures, products, and practices are not covered under the *Plan*.
5. Complications from, or expenses incidental to or incurred as a direct consequence of, a treatment, service, or supply that is excluded from coverage under this Plan.
6. Vitamins, (except for physician prescribed vitamin B12 injections, Vitamin D, and prenatal care vitamin supplements), dietary supplements and foods, herbs, minerals, nutritional supplements.
7. Custodial Care and Services. The *Plan* does not cover *custodial care* and services related to *custodial care*.
8. Elective surgeries for preventive reasons.
9. Experimental Services and Procedures. Except as permitted by participation in an approved clinical trial, the *Plan* does not cover procedures, services, drugs or other supplies that are experimental or still under clinical investigation. A procedure is considered to be experimental if it is generally deemed so by medical professionals, the Food and Drug Administration, the National Institutes of Health or by Medicare and/or Medicaid guidelines.
10. First Aid Supplies.
11. Genetic testing, except as preventive care benefits required by federal law.
12. Governmental Treatment. Except as otherwise provided by law, the *Plan* does not cover services or supplies for care or treatment provided by the United States Government or any state or local government when, without Plan coverage, the person would not be required to make payment.
13. Health Enhancement Programs, Life Style Center Programs, or any regimen designed to prevent future health problems or to influence adoption of a healthier lifestyle with a secondary objective of providing necessary medical treatment. The *Plan* would encourage you to engage in relevant and appropriate educational classes through your Health and Wellness benefit.
14. Late Claims. The *Plan* does not cover claims submitted more than one year after the date of the service.

15. Licensing Exams. The *Plan* does not cover physical examinations for the purpose of licensing or regulatory requirements.

16. Medical Necessity**.** Coverage is not provided for services and supplies that are not *medically necessary*. This rule does not apply to the Plan's benefits for preventive care. See specific preventive care services in the addendum following the Schedule of Benefits.

17. Military Injuries. The *Plan* does not provide benefits for the illnesses and injuries of *employees* returning from military leave under Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), if the Secretary of Veterans Affairs determines that the illness or injury was incurred in, or aggravated during, performance of service in the Uniformed Services (as that term is defined by USERRA).

18. Nail Debridement. The *Plan* does not cover nail debridement, except for *enrollee* with the diagnosis of diabetes.

19. Non-*emergency* services/supplies received outside of the United States.

20. Non-prescription glasses or sunglasses.

21. Nutritional counseling, except as preventive care benefits required by federal law.

22. Occupational Illness and Injury, The *Plan* does not provide coverage for charges or expenses for injuries or sicknesses which are job, employment or work related, or for which benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law; or for which coverage was available under any Worker's Compensation or Occupational Disease Act or Law, regardless of whether such coverage was actually applied for. If benefits are paid and it is determined that an *enrollee* is eligible to receive Workers' Compensation for the same incident, illness or injury, the Plan has a right to recover the benefits paid under this Plan as described in the Recovery Rights provision. As a condition of receiving benefits on a contested Workers' Compensation claim, *enrollees* must consent to reimburse the Plan when entering into any settlement and compromise agreement or at any Workers' Compensation Division Hearing. The Plan reserves its right to exercise this right to recover against a Member even though:

    a. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise or

    b. No final determination is made that the injury of illness was sustained in the course of or resulted from employment or

    c. The amount of Workers' Compensation due is not agreed upon or defined by the Member or the Workers' Compensation carrier or

    d. The medical or healthcare benefits are specifically excluded from the Workers' Compensation settlement or compromise

    An *enrollee* will not enter into a compromise or hold harmless agreement relating to any work related claims paid by the *Plan*, whether or not such claims are disputed by the workers' compensation insurer, without the express written agreement of the *Plan*.

    If satisfactory proof is furnished to the *plan administrator* that a person covered under a Workers' Compensation law (or other like law) has made claim under such law in connection with a distinct disease and no benefit, award, settlement or redemption has been or will be made under that law for such illness or injury, that illness or injury will be considered non-occupational for purposes of the *Plan*.

23. Obesity Related Treatment (except as preventive care benefits required by federal law), including Gastric Surgery, or Prescription Drug Therapy for obesity treatment. Upon review by the *Plan's utilization review manager* and/or Express Scripts, exceptions for those diagnosed with "Clinically Severe Obesity" or a significantly high weight-to-height ratio ("Body Mass Index") and certain co-morbidities may be granted. Any approved services will be limited to *in-network providers* at the PPO network's "Institutes of Quality" (IOQ).

24. Plan Limits. The *Plan* does not cover charges in excess of the *Plan* limits.

25. Plastic, Reconstructive, Cosmetic Procedures and Surgeries. The *Plan* does not cover charges for plastic, reconstructive, or cosmetic procedures, surgeries, services or supplies (whether or not for psychological or emotional reasons) for the purpose of enhancing, altering, or improving personal appearance or comfort. Limited exceptions may be obtained after first being reviewed by the *Plan's utilization review manager*, to the extent that the surgery or procedure is necessary to: improve the function of a part of the body that is malformed; or

    a. correct a condition resulting from a severe birth defect; or

    b. correct a condition that is a direct result of a disease or surgery performed to treat a disease or injury; or

    c. repair an injury, but only if the surgery is performed within twenty-four months of the accident causing the injury.

26. Pregnancies of dependent daughters are not covered, including medical complications resulting from a pregnancy, except that the *Plan* provides benefits for preventive care as required by federal law.

27. Prenatal and Parent Training Classes. (These are available to you through your Health and Wellness Benefits.)

28. Sexual Transformations and Trans Gender procedures.

29. Telephone Consultations.

30. Treatment by Household Members. The *Plan* does not cover services of a person who ordinarily resides in the home of the patient.

31. Usual, Reasonable, and Customary (U&C). The *Plan* does not cover expenses which exceed the *Usual, Reasonable, and Customary Charge* (U&C) as determined by the *plan administrator*.

32. Virtual scans and virtual physicals.

Claims Procedures

ARTICLE 1 GENERAL CLAIM FILING PROCEDURES

Section 1.01 *Introduction*

There usually will be no need for you to submit *claims* under the *Plan* because, as described below, your provider will generally do so for you. When you do need to submit a *claim*, you must do so in accordance with these Claims Procedures. This Article 1 discusses some general points regarding *claims*. The remaining sections of these Claims Procedures provide the formal Claims Procedures that must be followed in order to receive benefits under the *Plan*.

The *plan administrator* reserves the right to decide whether to pay benefits to you, to the provider of services, or to you and the provider jointly.

Failure to follow the below-stated deadlines or to exhaust these Claims Procedures will result in the forfeit of your right to sue the *Plan* in State or federal court.

Section 1.02 *Hospital Benefits*

If you or a *covered dependent* is hospitalized, you must present your benefit ID card to the facility representative. In most cases, the *hospital* will bill the *Plan* directly for the cost of the *hospital* services, the *Plan* will pay the *hospital*, and you will receive copies of the payment record. A *hospital* may require you, at the time of discharge, to pay charges that might not be covered by the *Plan*. If this happens, you must pay these amounts yourself. The *Plan* will reimburse you if any of the charges you pay are later determined to be covered by the *Plan*.

You may be billed by the *hospital* directly. In order to claim your benefits for these charges, send a copy of the itemized bill to the physical address on the front of your ID card, and be sure it includes the information listed in Section 3.03.

Outside of the United States the Plan will only reimburse for emergency care. For emergency care received outside of the United States, you should pay the *hospital*, *physician*, or *professional provider* at the time services are rendered. In order to claim your benefits for these charges, send a copy of the itemized bill to the physical address on the front of your ID card, and be sure it includes the information listed in Section 3.03.

Section 1.03 *Physician and Professional Provider Benefits*

In most cases, your *in-network provider* will bill charges directly to the *Plan* via the TPA.. You are required to pay any applicable *co-payments* at the time of service.

If you or your *covered dependents* see an *out-of-network provider for other than , emergency or urgent care you will be responsible for any charges.* **All *out-of-network* services must be *pre-certified* by the *Plan*'s *utilization review manager* except in the case of an *emergency*, in which case the *Plan* must be notified within 24 hours of the admission/treatment or on the next business day and the patient must consent to a transfer to an *in-network facility* as soon as the patient is stable.**

If the treatment is for an accidental *injury*, include a statement explaining the date, time, place and circumstances of the accident when you send us the bill.

Section 1.04 *Prescription Drug Benefits*

Certain prescription drugs require *pre-certification*. The *pre-certification* process for prescription drug benefits is administered by ESI. Your doctor or doctor's office will need to call ESI to perform a clinical review. To begin the *pre-certification* process, your doctor should call 800-841-5396. *Pre-certification* can be provided over the phone 24 hours a day, seven days a week. If your request is approved, your prescription may be filled at any participating pharmacy. Please call ESI at 800-841-5396 or visit www.express-scripts.com to determine coverage of your medication or if you have any questions.

You should use your ID card at point of service to obtain medications. If you need to submit a manual *claim* for prescription drug benefits, you should call ESI to receive a *claim* form. You should complete the *claim* form fully and submit a separate *claim* form for each separate pharmacy used and for each separate *enrollee*

who received prescription medications. The *claim* form must include receipts that contain the following information: (1) date prescription filled, (2) name and address of pharmacy, (3) prescription drug name, strength and National Drug Code, (4) prescription number, (5) quantity and days' supply, (6) price, and (7) the name of the *enrollee* receiving the medication. Send the *claim* form, including receipts, to ESI at the address instructed on the form.
If you have been an *enrollee* in the *Plan* for more than 90 days, in order to receive full prescription drug benefits, you must use your ID card at the point of service to obtain medications.
For prescription drug claims, ESI is the claims reviewer and will handle all claims for prescription drug benefits and is responsible for deciding appeals of any *adverse benefit determination*s pertaining to prescription drug benefits. However, the *plan administrator* has the final authority in deciding whether an internal *claim* or appeal will be approved or denied. External review of claims for prescription drug benefits will be performed by the *independent review organizations* with which ESI has contracted.
The provisions of this Section 1.04 supersede any inconsistent *Plan* provisions.

Section 1.05 *Ambulance Benefits*

Bills for ambulance service must show where the patient was picked up and where the patient was taken. This is in addition to the information required under Section 3.03.

Section 1.06 *Claims Inquiries*

If you have any questions about how to file a *claim*, the status of a pending *claim*, or any action taken on a *claim*, call HealthSCOPE Benefits at 888-276-4732. We will respond to your inquiry within 30 days of receipt.

Section 1.07 *Appointment of Authorized Representative*

A *claimant* may appoint an *authorized representative* in writing to act on his or her behalf with respect to *claims* and appeals under these Claims Procedures. However, no person (including a treating health care professional) will be recognized as an *authorized representative* until the *Plan* receives an Appointment of Authorized Representative form signed by the *claimant*, except that (i) for urgent pre-service *claims* the *Plan* shall, even in the absence of a signed Appointment of Authorized Representative form, recognize a health care professional with knowledge of the *claimant's medical condition* (e.g., the treating *physician*) as the *claimant's authorized representative* unless the *claimant* provides specific written direction otherwise and (ii) an *employee* is automatically deemed to be the *authorized representative* of his or her *covered dependent* who is under age 18. An Appointment of Authorized Representative form may be obtained from HealthSCOPE Benefits by calling 888-276-4732. Completed forms must be submitted to HealthSCOPE Benefits. An attempted assignment for purposes of payment (e.g., to a health care professional) does not constitute appointment of an *authorized representative* under the Claims Procedures. Once an *authorized representative* is appointed, the *Plan* shall direct all information, notification, etc. regarding the *claim* to the *authorized representative*. The *claimant* shall be copied on all notifications regarding decisions, unless the *claimant* provides specific written direction otherwise. Any reference in the Claims Procedures to "*claimant*" is intended to include the *authorized representative* of such *claimant* appointed in compliance with the above procedures.

ARTICLE 2 FOUR TYPES OF CLAIMS

Section 2.01 *Different Rules Apply*

Whether you file them directly or your provider does so for you, there are, as described below, four categories of claims that can be made under the *Plan*, each with somewhat different *claim* and appeal rules. The federal regulations set different requirements based on the type of *claim* involved. The primary difference is the timeframe within which claims and appeals must be determined.

Section 2.02 *Pre-Certification Claim*

A *claim* is a "*pre-certification claim*" (sometimes known as a pre-service *claim*) if (1) it is submitted before the underlying benefit is received and (2) the *Plan* specifically conditions receipt of the underlying benefit, in whole or in part, on receiving approval in advance of obtaining the relevant medical care.

Under the *Plan*, you or your provider must obtain *pre-certification* of *medical necessity* for all medical care (including prescription drug benefits) that (1) is not routine care provided by your *physician* and (2) does not involve an *emergency medical condition*.

To receive *medical necessity pre-certification* you must contact HealthScope Benefits at the number on the front of your ID card before you receive the medical care. For prescription drug pre-certification, call Express Scripts at 800-841-5396. For dental *pre-certification*, call the number for your dental *PPO Network* on the f of your ID card.

Such *pre-certification* does not guarantee that the *Plan* covers the requested services. *Plan* coverage decisions are made at the *post-service claim* level.

Section 2.03 *Urgent Pre-Certification Claim*

An "*urgent pre-certification claim*" is a special type of *pre-certification claim* that involves *urgent care*. A *pre-certification claim* involves *urgent care* if application of the time periods that otherwise apply to *pre-certification claims* (1) could seriously jeopardize the *claimant*'s life or health or ability to regain maximum function or (2) would—in the opinion of a *physician* with knowledge of the *claimant*'s *medical condition*—subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*.

On receipt of a *pre-certification claim*, the *Plan* will make a determination of whether it involves *urgent care*, provided that, if a *physician* with knowledge of the *claimant*'s *medical condition* determines that a *claim* involves *urgent care*, the *claim* shall be treated as an *urgent pre-certification claim*.

Throughout these Claims Procedures, when the terms "*pre-certification*" and "*pre-certification claim*" are used without the term "urgent," they are used to describe non-urgent *pre-certification claims*.

Section 2.04 *Post-Service Claim*

A "*post-service claim*" is any *claim* that (1) is submitted after the relevant medical care has been received and (2) is in regard to a determination that the *Plan* does not require be made in advance of the receipt of medical care (such as plan coverage determinations or *medical necessity* determinations for *emergency medical conditions*).

Under the *Plan*, *post-service claims* are required to determine whether the *Plan* covers medical care you receive. Generally, your *provider* will file *post-service claims*. If your *provider* does not file a *post-service claim* on your behalf, you should file such *claims* in accordance with Section 3.03.

Section 2.05 *Concurrent Care Claims*

A "*concurrent care claim*" is a *claim* that involves a request for an extension of an already approved and ongoing course of treatment that is being provided over a period of time or for a specified number of treatments.

Section 2.06 *Change in Claim Type*

The claim type is determined initially when the *claim* is filed. However, if the nature of the *claim* changes as it proceeds through these Claims Procedures, the *claim* may be re-characterized. For example, a *claim* may initially be an *urgent pre-certification claim*. If the urgency subsides, it may be re-characterized as a *pre-certification claim*.

Section 2.07 *Questions about Claim Type*

It is very important to follow the requirements that apply to your particular type of *claim*. If you have any questions regarding what type of *claim* and/or what claims procedure to follow, contact HealthSCOPE Benefits at the phone number on the front of your ID card.

ARTICLE 3 HOW TO FILE A CLAIM FOR BENEFITS

Section 3.01 *General Filing Rules*

Claims for all services must be submitted in accordance with these procedures. See Section 1.04 for instructions on filing a *claim* for prescription drug benefits. You should keep copies of all of your submitted claims.

Section 3.02 *Pre-Certification Claims (Urgent or Non-Urgent)*

To file a *pre-certification claim* or an *urgent pre-certification claim* (usually to obtain pre-certification of *medical necessity*), you, your *authorized representative*, or your *provider* must contact HealthSCOPE Benefits at the

number on the front of your ID card before you receive the medical care.

If you fail to obtain required *pre-certification* of *medical necessity*, you may request a retroactive certification of *medical necessity* from the *utilization review manager*. In order to receive retroactive certification of *medical necessity*, you must demonstrate reasonable cause (i.e., *emergency medical condition*) for your failure to receive *pre-certification*. If the *utilization review manager* determines you had reasonable cause for your failure to receive *pre-certification*, it will review your *claim* using the *Plan*'s usual *medical necessity* criteria. The decision to provide retroactive certification of *medical necessity* will be made in the sole discretion of the *utilization review manager*.

Section 3.03 *Post-Service Claims*

A *post-service claim* must be filed by you, your *authorized representative*, or your provider within one year following the date of service of the medical service, treatment or product to which the *claim* relates.

For benefits received at a *PPO facility* or through a *PPO provider*, your provider will, generally, file required *post-service claims*. For *out-of-network* services, your provider may not file *post-service claims* on your behalf. **All *out-of-network* services must be *pre-certified* by the *Plan*'s *utilization review manager* except in the case of an *emergency*, in which case the *Plan* must be notified within 24 hours of the admission/ treatment or on the next business day and the patient must consent to a transfer to an *in-network facility* as soon as the patient is stable.**

If you receive services for which your provider does not file a *post-service claim* on your behalf, you should submit a *post-service claim* to HealthSCOPE Benefits at the address on the first page of this SPD. The appropriate *claim* forms may be obtained by contacting HealthSCOPE Benefits at the number on the front of your ID card.

The following general steps should be followed in order to file a *post-service claim* for which your *provider* did not file a *claim* on your behalf:

(i) Complete the *employee* portion of the *claim* form in full. Answer all questions, even if the answer is "none" or "N/A" (not applicable).

(ii) Attach all necessary documentation of expenses to the *claim* form. Documentation must include:

- The *employee's* name and member ID number;
- The name of the covered person who was treated;
- The date(s) of service, treatment, or purchase;
- The provider's name, address, phone number and degree;
- The federal tax identification number of the provider;
- The diagnosis;
- The CPT codes related to the services or supplies provided;
- A description of services or supplies provided, detailing the charge for each supply or service (non-itemized bills are not acceptable).

(iii) Complete a separate *claim* form for each person for whom benefits are being requested.

(iv) If another plan is the primary payer, a copy of the other plan's Explanation of Benefits (EOB) must accompany the *claim* form sent to the *Plan*.

Post-service claims should be submitted in writing to HealthSCOPE Benefits.

Section 3.04 *How Incorrectly Filed Claims Are Treated*

These Claims Procedures do not apply to any request for benefits that is not made in accordance with these Claims Procedures, except that (a) in the case of an incorrectly filed *pre-certification claim*, the *claimant* shall be notified as soon as possible but no later than 5 days following receipt by the *Plan* of the *incorrectly filed claim*; and (b) in the case of an incorrectly filed *urgent pre-certification claim*, the *claimant* shall be notified as soon as possible but no later than 24 hours following receipt by the *Plan* of the incorrectly filed *claim*. The notice shall explain that the request is not a *claim* and describe the proper procedures for filing a *claim*. The notice may be oral unless written notice is specifically requested by the *claimant*.

Section 3.05 *Duplicative Requests for Benefits*

Once a *claim* has been filed, these Claims Procedures will not apply to any substantially identical request for benefits unless the passage of time, change in condition of the *enrollee*, or change of accepted medical practice might result in a different determination. Whether to accept a substantially identical request for benefits as a new *claim* is in the sole discretion of the *plan administrator*. Most such requests will not be processed as new *claims*. Rather, in the event of an *adverse benefit determination*, the appeal process described below will be the only method for pursuit of a different determination and the determination will be final upon completion of the external review described in Article 12.

ARTICLE 4 TIMEFRAME FOR DECIDING INITIAL BENEFIT CLAIMS

Section 4.01 *Pre-certification Claim*

The *Plan* shall decide an initial *pre-certification claim* within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the *claim*.

Section 4.02 *Urgent Pre-certification Claims*

The *Plan* shall decide an initial *urgent pre-certification claim* as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the *claim*.

Section 4.03 *Concurrent Care Extension Request*

If a *claim* is a request to extend a *concurrent care claim* involving *urgent care* and if the *claim* is made at least 24 hours prior to the end of the initially approved period of time or number of treatments, the *claim* shall be decided within no more than 24 hours after receipt of the *claim*. Any other *concurrent care claim* shall be decided in the otherwise applicable timeframes for *pre-certification claims*.

Section 4.04 *Concurrent Care Early Termination*

A decision by the *Plan* to reduce or terminate a previously approved course of treatment is an *adverse benefit determination* that may be appealed by the *claimant* under these Claims Procedures, as explained below. Notification to the *claimant* of a decision by the *Plan* to reduce or terminate an initially approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow the *claimant* to appeal the adverse decision and receive a decision on review under these procedures prior to the reduction or termination.

Section 4.05 *Post-Service Claim*

The *Plan* shall decide an initial *post-service claim* within a reasonable time but no later than 30 days after receipt of the *claim*.

Section 4.06 *When Extensions of Time Are Permitted*

If the *Plan* is not able to decide a *pre-certification* or *post-service claim* within the above timeframes, due to matters beyond its control, one 15-day extension of the applicable timeframe is permitted, provided that the *claimant* is notified in writing prior to the expiration of the initial timeframe applicable to the *claim*. The extension notice shall include a description of the matters beyond the *Plan*'s control that justify the extension and the date by which a decision is expected. No extension is permitted for *urgent pre-certification claims*. Despite the specified timeframes, nothing prevents the *claimant* from voluntarily agreeing to extend the above timeframes.

Section 4.07 *Incomplete Claims*

If any information needed to process a *claim* is missing, the *claim* shall be treated as an incomplete *claim*.

Section 4.08 *How Incomplete Urgent Pre-certification Claims Are Treated*

If an *urgent pre-certification claim* is incomplete, the *Plan* shall notify the *claimant* as soon as possible, but no later than 24 hours following receipt of the incomplete *claim*. The notification may be made orally to the *claimant*, unless the *claimant* requests written notice, and it shall describe the information necessary to complete the *claim* and shall specify a reasonable time, no less than 48 hours, within which the *claim* must be completed. The *Plan* shall decide the *claim* as soon as possible but not later than 48 hours after the earlier

of (a) receipt of the specified information, or (b) the end of the period of time provided to submit the specified information.

Section 4.09 *How Other Incomplete Claims Are Treated*

If a *pre-certification claim* or *post-service claim* is incomplete, the *Plan* may deny the *claim* or may take an extension of time, as described above. If the *Plan* takes an extension of time, the extension notice shall include a description of the missing information and shall specify a timeframe, no less than 45 days, in which the necessary information must be provided. The timeframe for deciding the *claim* shall be suspended from the date the extension notice is received by the *claimant* until the date the missing necessary information is provided to the *Plan*. If the requested information is provided, the *Plan* shall decide the *claim* within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the *claim* will be decided without that information.

ARTICLE 5 NOTIFICATION OF INITIAL BENEFIT DECISION BY PLAN

Section 5.01 *Pre-Certification and Urgent Pre-Certification Claims*

Written notification of the *Plan*'s decision on a *pre-certification claim* or *urgent pre-certification claim* shall be provided to the *claimant* whether or not the decision is an *adverse benefit determination*.

Section 5.02 *Notification of Adverse Benefit Determination*

Written notification shall be provided to the *claimant* of the *Plan*'s *adverse benefit determination* on a *claim* and shall include the following, in a manner calculated to be understood by the *claimant*:

- information sufficient to identify the *claim* involved, including, if applicable: (i) the date of service, (ii) the health care *provider*, (iii) the *claim* amount, and (iv) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a statement of the specific reason(s) for the decision, including (i) the *Plan*'s denial code and its corresponding meaning (ii) the *Plan*'s standard, if any, that was used in denying the appeal; and (iii), for *final internal* adverse benefit determination*s*, a discussion of the decision;
- a reference to the specific *Plan* provision(s) on which the decision is based;
- a description of any additional material or information necessary for the *claimant* to perfect the *claim/* appeal and an explanation of why such material or information is necessary;
- a description of the *Plan*'s review procedures and the time limits applicable to such procedures;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- for *adverse benefit determinations* (including *final internal adverse benefit determinations*) of appeals, a statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination;
- if the decision is based on a *medical necessity* or experimental treatment or similar exclusion or limit, disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the *Plan* to the *claimant*'s medical circumstances, or (b) a statement that such explanation will be provided at no charge on request.
- in the case of an *urgent pre-certification claim*, an explanation of the expedited review methods available for such *claims/*appeals; and
- a statement describing any remaining mandatory appeal and information regarding how to initiate any such remaining appeal;
- a statement of the right to sue in State court;
- the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act § 2793 to assist individuals with the internal claims and appeals and external review processes.

Notification of the *Plan*'s *adverse benefit determination* on an *urgent pre-certification claim* may be provided orally, but written notification shall be furnished no later than three days after the oral notice.

ARTICLE 6 HOW TO APPEAL AN ADVERSE BENEFIT DETERMINATION

Section 6.01 *Right to Appeal*

A *claimant*, or the *claimant*'s *authorized representative*, has a right to appeal an *adverse benefit determination* under these Claims Procedures.

Section 6.02 *How to File Your Appeal: Urgent Pre-Certification Appeals*

In light of the expedited timeframes for decision of *urgent pre-certification claims*, an *urgent pre-certification* appeal may be submitted to the *utilization review manager* by phone at 888-276-4732 All necessary information in connection with an urgent pre-certification appeal shall be transmitted between the *Plan* and the *claimant* by telephone, fax, or e-mail.

Section 6.03 *How to File Your Appeal: Pre-Certification Appeals*

An appeal of an *adverse benefit determination* involving a *pre-certification claim* should be submitted to the *utilization review manager*. Details on how to submit an appeal to the *utilization review manager* will be provided by the *utilization review manager* upon an *adverse benefit determination*. You may call the *utilization review manager* at 888-276-4732 for more information.

Section 6.04 *How to File Your Appeal: Post-Service Appeals*

An appeal of an *adverse benefit determination* regarding *medical necessity* should be submitted to the *utilization review manager*. Details on how to submit an appeal to the *utilization review manager* will be provided by the *utilization review manager* upon an *adverse benefit determination*. You may call the *utilization review manager* at (800) 441-2524 for more information.
Except in the case of an appeal relating to prescription drug benefits, an appeal of an *adverse benefit determination* regarding *medical necessity* is filed by submitting a written Request for Review form to the *utilization review manager*. A *claimant* has the right to submit documents, written comments, or other information in support of an appeal. Request for Review forms may be obtained by contacting the *utilization review manager*. See Section 1.04 for instructions on filing an appeal relating to prescription drug benefits.
To appeal an *adverse benefit determination* not involving *medical necessity*, or if you are unsure whether the *adverse benefit determination* involved *medical necessity*, you should contact the *plan administrator* at (888) 276-4732.

Section 6.05 *Important Appeal Deadline*

The appeal of an *adverse benefit determination* must be filed within 180 days following the *claimant*'s receipt of the notification of *adverse benefit determination*, except that the appeal of a decision by the *Plan* to reduce or terminate an initially approved course of treatment (see the definition of concurrent care decision) must be filed within 30 days of the *claimant*'s receipt of the notification of the *Plan*'s decision to reduce or terminate. Failure to comply with this important deadline will cause the *claimant* to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.

ARTICLE 7 HOW YOUR APPEAL WILL BE DECIDED

The following procedures will be followed for all appeal decisions:

Section 7.01 *Consideration of Comments, Evidence, and Testimony*

The review will take into account all information submitted by the *claimant*, whether or not presented or available at the initial benefit decision. Additionally, the *claimant* will be entitled to present evidence and testimony pertaining to the *claim*.

No deference will be given to the initial benefit decision, and the person who reviews and decides an appeal will not be the same person who made the initial benefit decision or such person's subordinate.

Section 7.02 *Consultation with Expert*

In the case of a *claim* denied on the grounds of a medical judgment, the reviewer will consult with a health care professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the same health care professional who was consulted, if any, regarding the initial benefit decision or a subordinate of that individual.

Section 7.03 *Access to Relevant Information*

A *claimant* shall have a right to review his or her *claim* file and, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the *claimant*'s *claim* for benefits. If the advice of a medical or vocational expert was obtained in connection with the initial benefit decision, the names of each such expert shall be provided on request by the *claimant*, regardless of whether the advice was relied on by the *Plan*.

Section 7.04 *Claimant's Right to New or Additional Evidence or Rationale*

The *Plan* will provide the *claimant*, free of charge, with any new or additional evidence considered, relied upon, or generated by the *Plan* in connection with the *claim*. Also, before the *Plan* issues a *final internal adverse benefit determination* that is based on a new or additional rationale, the *Plan* will provide the *claimant*, free of charge, with the rationale. Both any new evidence and any new rationale will be provided to the *claimant* sufficiently in advance of the *Plan*'s final benefit or appeal decision to allow the *claimant* a reasonable opportunity to respond to the new evidence and/or rationale.

ARTICLE 8 TIMEFRAMES FOR DECIDING BENEFITS APPEALS

Section 8.01 *Pre-Certification Claims*

The appeal of an *adverse benefit determination* relating to a *pre-certification claim* shall be decided within a reasonable time appropriate to the medical circumstances but no later than thirty (30) days after receipt of the appeal.

Section 8.02 *Urgent Pre-Certification Claims*

The appeal of an *adverse benefit determination* relating to an *urgent pre-certification claim* will be decided as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt of the appeal.

Section 8.03 *Post-Service Claims*

The appeal of an *adverse benefit determination* relating to a *post-service claim* shall be decided within a reasonable period but no later than sixty (60) days after receipt of the appeal.

Section 8.04 *Concurrent Care Claims*

The appeal of a decision by the *Plan* to reduce or terminate an initially approved course of treatment shall be decided before the proposed reduction or termination takes place. The appeal of a denied request to extend any concurrent care shall be decided in the appeal timeframe for *pre-certification claims* or *urgent pre-certification claims* described above, as appropriate to the request.

ARTICLE 9 NOTIFICATION OF DECISION ON APPEAL

Written notification of the decision on appeal shall be provided to the *claimant* whether or not the decision is an *adverse benefit determination*. If the decision is an *adverse benefit determination*, the written notification shall include the information in Section 5.02, written in a manner calculated to be understood by the *claimant*. Notification of an *adverse benefit determination* on appeal of an *urgent pre-certification claim* may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

ARTICLE 10 REVIEW OF APPEAL DECISION THAT DOES NOT INVOLVE MEDICAL NECESSITY – SECOND APPEAL

Section 10.01 *In General*

If your appeal did not involve a *medical necessity* determination (for example, the appeal involved *Plan* eligibility), then you may request a review of the appeal decision by contacting the *plan administrator*. The *plan administrator* will assign an appointee to review your second appeal. The appointee will follow the procedure described in Article 7 when reviewing your second appeal, and you have the rights described in that article.

The review will take into account all information submitted by the *claimant*, whether or not presented or available at the initial benefit decision. Additionally, the *claimant* will be entitled to present evidence and testimony pertaining to the *claim*.

No deference will be given to the initial benefit decision or the first appeal, and the person who reviews and decides the second appeal will not be the same person who made the initial benefit decision, the person who decided the first appeal, or either person's subordinate.

Section 10.02 *Deadline for Request for Second Appeal for Claim that Does Not Involve Medical Necessity*

You must submit your request for a second appeal within four months after the date of receipt of the notice of *adverse benefit determination* from your first appeal (for example, if the notice is received on March 15, then the request must be filed by July 15). If there is no corresponding date, then the deadline is the first day of the fifth month following receipt of the notice (for example, if the notice is received on October 30, since there is no February 30, the request must be filed by March 1). If the filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the nest day that is not a Saturday, Sunday, or Federal holiday.

Section 10.03 *Notification of Non-Medical Necessity Decision on Second Appeal*
The appointee of the *plan administrator* will provide written notice of the *Plan's* decision within 45 days of its receipt of your request for second appeal, unless the second appeal involves (1) a medical condition where this timeframe would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or (2) an admission, availability of care, continued stay, or health care item of service for which the claimant received emergency services, but has not been discharged, in which case the appointee will provide notice within 72 hours (and then, if the notice is not in writing, will provide written confirmation within 48 hours of the initial verbal notice).
If the decision is an *adverse benefit determination*, the written notification shall include the information in Section 5.02, written in a manner calculated to be understood by the *claimant*.

Section 10.04 *Exhaustion and Deemed Exhaustion of a Claim that Does Not Involve Medical Necessity*

The *Plan* will not consider you to have exhausted the administrative remedies available under the *Plan* until you have properly filed and received a decision on your second appeal, as described in Article 10 of this Claims Procedure.

If you fail to follow these Claims Procedures, if you miss any of the above-stated deadlines for filing a *claim* or an appeal, or if you otherwise fail to exhaust all of the administrative remedies under the *Plan*, then you will forfeit any right to pursue any remedies under State or federal law.

Section 10.05 *Reversal of Plan's Decision*

If the appointee of the *plan administrator* who reviews the second appeal reverses the first appeal's *adverse benefit determination*, the *Plan* will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the *claim*.

ARTICLE 11 EXHAUSTION AND DEEMED EXHAUSTION OF INTERNAL CLAIMS AND APPEALS PROCESSES

If you fail to follow these Claims Procedures, if you miss any of the above-stated deadlines for filing a *claim* or an appeal, or if you otherwise fail to exhaust all of the administrative remedies under the *Plan*, then you will not be eligible for external review unless you meet the requirements of both 12.02(i) and (ii) below; and you will forfeit any right to pursue any remedies under State or federal law. This means that if you do not comply with the deadlines and fully exhaust these Claims Procedures, you may not sue the *Plan*.

If the *Plan* fails to strictly adhere to these Claims Procedures when reviewing your *claim* or appeal, you will be deemed to have exhausted the *Plan*'s internal claims and appeals process, unless the violation is de minimis, non-prejudicial, is attributable to good cause or matters beyond the *Plan*'s control, occurred in the context of an ongoing, good faith exchange of information between you and the *Plan*, and is not reflective of a pattern or practice of non-compliance. If the *Plan* claims that a violation occurred that meets the above exception, you may request a written explanation of the violation; the *Plan* will reply within 10 days to such a request and will include a description of the reasons for asserting that the violation did not cause the Claims Procedures

to be deemed exhausted. If you have been deemed to have exhausted the *Plan*'s internal claims and appeals process, you may (i) initiate an external review, (ii) pursue any remedies available under State law on the basis that the *Plan* has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the *claim*.

ARTICLE 12 EXTERNAL REVIEW (FOR REVIEW OF AN APPEAL DECISION INVOLVING MEDICAL NECESSITY)

Section 12.01 *In General*

As required by the Patient Protection and Affordable Care Act, the *Plan* complies with the federal external review process. This means that you are eligible to have certain *adverse benefit determinations* reviewed by an *independent review organization* and the decision reached through the external review is binding on the *Plan*. The *Plan* will pay the cost of external reviews; however, you may be required to pay a filing fee of no more than $25. That filing fee will be refunded to you if your *adverse benefit determination* is reversed through the external review. Also, the filing fee will be waived if payment of the fee would impose an undue financial hardship. If the *Plan* imposes a filing fee for external reviews, the annual limit on filing fees will be $75.

Section 12.02 *Eligibility for External Review*

To be eligible for external review, all *final internal adverse benefit determinations* must meet requirement (i) below and all other *adverse benefit determinations* must meet both requirements (i) and (ii).

Requirements:

(i) The *adverse benefit determination* (including *final internal adverse benefit determinations*) must involve medical judgment (including, but not limited to, those based on the *Plan*'s requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or the *Plan*'s determination that a treatment is experimental or investigational), as determined by the external reviewer.

(ii) *Adverse benefit determinations* that involve a *medical condition* of the *claimant* for which the timeframe for completion of an *urgent pre-certification* appeal would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant*'s ability to regain maximum function.

The *Plan* will notify you in writing when you are eligible to file a request for an external review and will provide you with the necessary information for filing such a request.

Section 12.03 *Request for External Review*

A *claimant* who is eligible for an external review must file a request for an external review with the *Plan* within four months after the date of receipt of a notice of *adverse benefit determination* or *final internal adverse benefit determination* (for example, if the notice is received on March 15, then the request must be filed by July 15). If there is no corresponding date, then the deadline is the first day of the fifth month following receipt of the notice (for example, if the notice is received on October 30, since there is no February 30, the request must be filed by March 1). If the filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the nest day that is not a Saturday, Sunday, or Federal holiday.

Section 12.04 *Preliminary Review*

Within five business days following the date of receipt of the external review request, the *Plan* will complete a preliminary review of the request to determine whether:

(i) The *claimant* is or was covered under the *Plan* at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the *Plan* at the time the health care item or service was provided;

(ii) The *adverse benefit determination* or the final *adverse benefit determination* does not relate to the *claimant*'s failure to meet the requirements for eligibility under the terms of the *Plan* (for example, worker classification or similar determination);

(iii) The *claimant* has exhausted the *Plan*'s internal appeal process or if the *claimant* is deemed to have exhausted the internal appeals process under Article 11; and

(iv) The *claimant* has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the *Plan* will issue a notification in writing to the *claimant*. If the *Plan* determines the *claim* is not eligible for external review, the *Plan* will notify the *claimant* and will include in the notification the reasons for the *claim*'s ineligibility and contact information for the Employee Benefits Security Administration. If the *Plan* determines the request is not complete, the notification will describe the information or materials needed to make the request complete and the *Plan* will allow the *claimant* to perfect the request for external review within the filing period described above or within the 48 hour period following the receipt of the notification, whichever is later.

If the *Plan* determines the *claim* is eligible for external review, it will forward the *claim* to an *independent review organization*. The *Plan* will contract (directly or indirectly) with at least three *independent review organizations* and will rotate claims assignments among the contracted *independent review organizations*. None of the contracted *independent review organizations* will be eligible for any financial incentives based on the likelihood that they will support the denial of benefits.

Section 12.05 *Expedited External Review*

A *claimant* may request an expedited external review if the *claimant* receives:

(i) An *adverse benefit determination* that involves a *medical condition* of the *claimant* for which the timeframe for completion of an *urgent pre-certification* appeal would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant*'s ability to regain maximum function.

(ii) A *final internal adverse benefit determination*, (a) if the *claimant* has a *medical condition* where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant*'s ability to regain maximum function or (b) if the *final internal adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item of service for which the *claimant* received *emergency services*, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the *Plan* will determine whether the request meets the reviewability requirements set forth in Section 12.04 above for standard external review. The *Plan* will immediately send the notice required under Section 12.04 above for standard external review to the *claimant* of its eligibility determination.

Upon a determination that a request is eligible for external review following the preliminary review, the *Plan* will assign an *independent review organization* pursuant to Section 12.04 above for standard review. The *Plan* will provide all necessary documents and information considered in making the *adverse benefit determination* or *final internal adverse benefit determination* to the assigned *independent review organization* electronically or by telephone or facsimile or any other available expeditious method.

The assigned *independent review organization*, to the extent the information or documents are available and the *independent review organization* considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned *independent review organization* will review the *claim* de novo and is not bound by any decisions or conclusions reached during the *Plan*'s internal claims and appeals process.

Section 12.06 *Notification of Final External Review Decision*

The assigned *independent review organization* will provide written notice of the final external review decision to the *Plan* and the *claimant* within 45 days of the *independent review organization's* receipt of the request for external review. In the case of expedited external review, the *independent review organization* will provide notice of the final external review decision as expeditiously as the *claimant's medical condition* or circumstances require, but in no event more than 72 hours after the *independent review organization* receives the request for an expedited external review; if the initial notice is not in writing, the *independent review organization* will provide written confirmation of the decision to the *claimant* and *Plan* within 48 hours of providing the initial notice.

The notification of a final external review decision will contain all information required by DOL guidance, including the following:

(i) A general description of the reason for the request for external review, including information sufficient to identify the *claim* (including the date or dates of service, the health care provider, the *claim* amount (if applicable), the diagnosis code and its corresponding meaning, the treatment

code and its corresponding meaning, and the reason for the previous denial);

(ii) The date the *independent review organization* received the assignment to conduct the external review and the date of the *independent review organization* decision;

(iii) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(iv) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(v) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the *Plan* or to the *claimant*;

(vi) A statement that judicial review may be available to the *claimant*; and

(vii) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act Section 2793.

Section 12.07 *Reversal of Plan's Decision*

Upon receipt of a final external review decision reversing the *adverse benefit determination* or *final internal adverse benefit determination*, the *Plan* will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the *claim*.

ARTICLE 13 AVOIDING CONFLICTS OF INTEREST

The *Plan* will ensure that all *claims* and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support the denial of *Plan* benefits.

If you have questions about these Claims Procedures, contact the *plan administrator*.

Benefits Available from Other Sources

Situations may arise in which your healthcare expenses may be the responsibility of someone other than this *Plan*. Here are descriptions of the situations that may arise.

A. Coordination of Benefits (COB)

- This provision applies to this *Plan* when you or your *covered dependent* has healthcare coverage under more than one plan. For a complete explanation of COB see the chapter titled **Coordination of Benefits**.

B. Third-Party Liability

- An individual covered by us may have a legal right to recover benefits or healthcare costs from another person, organization or entity, or an insurer as a result of an *illness* or *injury* for which benefits or healthcare costs were paid by us. For example, an individual who is injured may be able to recover the benefits or healthcare costs from an individual or entity responsible for the injury or from an insurer, including different forms of liability insurance, uninsured motorist coverage or under-insured motorist coverage. As another example, an individual may become sick or be injured in the course of employment, in which case the employer or a workers' compensation insurer may be responsible for healthcare expenses connected with the *illness* or *injury*.
- If a covered individual, as defined below, has a right to recover benefits or healthcare costs from a third party, we will pay the covered individuals' expenses subject to an automatic lien in the *Plan*'s favor to the extent of benefits paid, upon any compensation received from the other party, up to the sum of the amount paid by the *Plan* to perfect the lien and the amount paid by the *Plan* for your benefits. The total lien amount will not exceed one-third of the money awarded to you under any final judgment, compromise, or settlement agreement if you retained an attorney, or one-half of the money awarded to you under any final judgment, compromise, or settlement agreement if you did not retain an attorney. If you are found by a judge, jury or arbitrator to be partially at fault then the lien shall be reduced by the same comparative fault percentage by which your recovery was reduced. The lien amount is also subject to pro rata reduction, commensurate with your reasonable attorney's fees and costs, in accordance with common fund doctrine. The above-described limitations on the total amount of the lien do not apply to liens made against workers' compensation claims, liens for Medicaid benefits, or liens for *hospital* services and *hospital*-affiliated health facility services.
- If benefits have been paid, or payment of benefits is pending, we are entitled to recover the amount paid or the amount pending payment from the proceeds of any recovery made by a covered individual against a third party.
- This Section applies to any covered individual for whom payment of benefits is made by us whether or not the event giving rise to the covered individual's injuries occurred before the individual became covered by us.
- **Definitions**:
- For purposes of this Section relating to third party recoveries, the following definitions apply:

- **Covered Individual** means an individual covered by us, including a dependent of a member. "Covered individual" also includes the estate, heirs, guardian or conservator of the individual for whom benefits have been paid or may be paid by us, and includes any trust established for the purpose of receiving "Recovery Funds" and paying for the future income, care or medical expenses of such individual.
- **Benefits** means any amount paid by us, or submitted to us for payment to or on behalf of the covered individual. Bills, statements or invoices submitted to us by a provider of services,

supplies or facilities to or on behalf of a covered individual are considered requests for payment of "benefits" by the covered individual.

- **Third Party Claim** means any claim, settlement, award, lawsuit, verdict, judgment, arbitration decision or other action against a third party (or any right to assert the foregoing) by or on behalf of a covered individual, regardless of the characterization of the claims or damages of the covered individual, and regardless of the characterization of the recovery funds. (For example, a covered individual who has received payment of medical expenses from us, may file a third party claim against the party responsible for the covered individual's injuries, but only seek the recovery of non-economic damages. In that case, we are still entitled to recover benefits as described herein.)
- **Third Party** means any individual or entity responsible for the *injury* or *illness*, or the aggravation of an *injury* or *illness*, of the covered individual. Third party includes any insurer of such individual or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the covered individual including uninsured motorist coverage, under-insured motorist coverage, and workers' compensation insurance.
- **Recovery Funds** means any amount recovered from a third party.
    - Under this Section relating to third party recoveries, if we have paid any benefits, we will be entitled to recover the amount we have paid from the proceeds of any recovery made by a covered individual against a third party. Upon claiming benefits, or accepting payment of benefits, or claiming or accepting the provision of benefits from us, the covered individual agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, our right of reimbursement or subrogation as discussed in this Section. In connection with our rights to obtain reimbursement or exercise our rights as described below, the covered individual shall do one or more of the following things and agrees that we may do one or more of the following things, at our discretion:

(i) If the covered individual seeks payment by us of any benefits for which there may be a third party claim, the covered individual shall notify us of the potential third party claim. The covered individual has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to us by a provider to the covered individual.

(vi) Upon request from us, the covered individual shall provide to us all information available to the covered individual, or any representative, or attorney representing the covered individual, relating to the potential third party claim. The covered individual and his or her representatives shall have the obligation to notify us in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any damages from the third party, whether or not the covered individual is seeking recovery of benefits paid by us from the third party.

(vii) In order to receive payment of benefits pursuant to this Section, we require that any covered individual seeking payment of benefits by us, and if the covered individual is a minor or legally incapable of contracting, then the covered person's parent or guardian, must fill out, sign and return to our office a third party recovery Agreement that includes a questionnaire about the accident and the potential third party recovery. This Agreement will include provisions consistent with the provisions of this Section, including an agreement to repay us for any benefits that we have paid relating to the injuries for which the covered individual is seeking recovery from a third party. If the covered individual has retained an attorney to represent the covered individual with respect to a third party claim, then the attorney must sign the third party recovery Agreement, acknowledging the obligations described in the Agreement.

(viii) If the covered individual makes a demand upon a third party, enters into settlement negotiations or commences litigation, the covered individual must not prejudice, in any way, our recovery rights under this Section. If a suit is filed by the covered individual, the covered individual agrees that we may cause to be recorded a notice of payment of benefits, and such notice will constitute a lien on any judgment or settlement. We may provide notice to the third party or its insurer. In the event of settlement, the covered individual must obtain our consent

prior to releasing any third party from liability for payment of any expenses covered, paid or pending for payment by us. The covered individual will hold the rights of and to recovery funds in trust for our benefit, up to the amount of benefits we have paid or which are pending payment at the time of resolution of the third party claim.

(ix) For any benefits provided, pending payment, or paid by the *Plan*, the covered individual shall promptly reimburse the *Plan* from any recovery funds, the full value of any such benefits.

(x) To secure our rights to reimbursement for any benefits paid or provided, the covered individual, by claiming or accepting payment or the provision of benefits by us hereby grants to us a first priority lien against the proceeds of any third party claim and assigns to us any benefits the covered individual may have under any insurance coverage's, such lien and assignment to apply only to the extent of benefits paid, provided, or pending for payment. This subparagraph (vi) is subject to the limitation in the second paragraph of subsection B above.

(xi) The covered individual shall cooperate with us to protect our recovery rights under this Section, and in addition, but not by way of limitation, shall:

a. Sign and deliver such documents as we reasonably require to protect our rights.

a. Provide any information to us relevant to the application of the provisions of this Section, including medical information (including doctors' reports, chart notes, diagnostic test results, etc.), settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments.

b. Take such actions as we may reasonably request to assist us in enforcing our rights to be reimbursed from third party recoveries.

(xii) By accepting the payment of benefits by us, the covered individual agrees that we have the right to intervene in any lawsuit or arbitration filed by or on behalf of a covered individual seeking damages from a third party. If we choose to intervene in the third party claim, we shall not be liable for any attorney fees or costs incurred by the covered individual in connection with the third party claim, and we shall have no obligation to reimburse the covered individual for such attorney's fees or costs.

(xiii) The covered individual agrees that we may notify any third party, or third party's representatives or insurers of our recovery rights set forth herein.

(xiv) Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out reimbursement from third party recoveries and the provisions of this Section.

(xv) If it is reasonable to expect that the covered individual will incur future expenses for which benefits might be paid by us, the covered individual shall seek recovery of such future expenses in any third party claim

(xvi) If the covered individual continues to receive medical treatment for an *illness* or *injury* after obtaining a settlement or recovery from a third party, we will provide benefits for the continuing treatment of that *illness* or *injury* pursuant to the terms of this third party claims Section and only to the extent that the covered individual can establish that any sums that may have been recovered from the third party for the continuing medical treatment have been exhausted for that purpose.

(xvii) By accepting benefits, paid to or on behalf of the covered individual, the covered individual agrees with the provisions of this Section and instructs his/her legal representatives to comply with the provisions of this Section.

(xviii) If the covered individual or the covered individual's representatives fail to do any of the foregoing acts at our request, then we have the right to suspend payment of any benefits for or on behalf of the covered individual related to any sickness, *illness*, *injury* or *medical condition* arising out of the event giving rise to, or the allegations in, the third party claim. In exercising this right, we may notify medical providers seeking authorization or pre-certification of payment of benefits that all payments have been suspended, and may not be paid.

(xix) We have the sole discretion to interpret and construe these reimbursement and subrogation provisions.

(xx) Coordination of benefits (where the covered individual has healthcare coverage under more than one plan or health insurance policy) is not considered a third party claim.

(xxi) If any term, provision, agreement or condition of this Section is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

C. **Motor Vehicle Insurance**

- We will not pay benefits for healthcare costs to the extent that a covered individual including a *covered dependent* is covered by motor vehicle insurance. But we will advance payment of benefits over the amount covered by the motor vehicle insurance, subject to the third party recovery Section above. If we have paid benefits first, we are entitled to any reimbursement from the motor vehicle insurer, under the third party recovery Section above.
- You must give us information about any medical insurance payments available to the covered individual or the covered individual's *covered dependents*.

Coverage for injuries sustained in an automobile accident in which you are (or your *covered dependent* is) the driver of a vehicle involved in the accident is only provided if you (or your *covered dependent*) had automobile insurance, at the time of the accident, that met (or exceeded) your state's minimum automobile insurance requirements.

MEDICARE

Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare is to be the primary payer, this *Plan* will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The *plan administrator* will make this determination based on the information available through CMS.

Coordination of Benefits

Coordination Of This Plan's Benefits With Other Benefits

The Coordination of Benefits (COB) provision applies when you or your dependents have health care coverage under more than one Plan. Plan, for purposes of this COB section, is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. When this plan is the Secondary plan it will reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

Definitions

A. A Plan, for purposes of this COB section, is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes self-funded employee health plans, group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans unless permitted by law.

Each arrangement for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. Plan means, in a COB provision, the part of the arrangement providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the arrangement providing health care benefits is separate from this Plan. An arrangement may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this Plan is a Primary plan or Secondary plan when you and/or your dependent has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and will reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, *co-insurance* and *co-payments*, that is covered at least in part by any Plan 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 that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different from the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, pre-certification or prior authorization of admissions, and preferred provider arrangements.

E. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you or your dependent are covered by two or more Plans the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B.

(1) Except as provided in Paragraph (2) a Plan that does not contain a coordination of benefits provision that is consistent with this section is always primary unless the provisions of both Plans state the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the

person is a Medicare beneficiary, and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan, the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to *plan years* commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of the benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial parent;
- The Plan covering the spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child (nor the stepparents of the child), the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-Off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid-off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law, or otherwise is covered under another Plan, the Plan covering the person as an employee, member,

subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a *plan year* are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provisions of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and the other Closed panel plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other Plans. The *plan administrator* may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. The *plan administrator* need not tell, or get the consent of any person to do this. Each person claiming benefits under this plan must give any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

If the amount of the payments made by this plan is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

General Plan Information

The following describes other procedures and policies in effect when processing your *claims*.

Right to Receive and Release Necessary Information

The *Plan* may, without the consent of or notice to any person, release to or obtain from any organization or person, information needed to implement *Plan* provisions. When you request benefits, you must furnish all the information required to implement *Plan* provisions. When necessary to process *claims*, we may require that you submit information concerning benefits to which you or your *covered dependents* are entitled. Such information may include, but is not limited to, medical records pertaining to requested benefits. We may also require that you authorize any *physician* or provider to provide us with information about a *condition* for which you claim benefits.

Transfer of Benefits

Only you and your *covered dependents* are entitled to benefits under this *Plan*. You may not assign or transfer your benefits to anyone else, and any attempted assignment or transfer will not be binding on the *Plan*.

However, under normal conditions, the *Plan* automatically pays your and your *covered dependents*' benefits to any *PPO provider* or *PPO facility* used by you or your *covered dependents*. Furthermore, the *Plan* may, in its own discretion, make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment. Also, the *Plan* will make payments to your separated/*divorced spouse*, state child support agencies or Medicaid agencies if required by a qualified medical child support order (QMCSO) or state Medicaid law. The *Plan* may, in its discretion, honor requests made prior to your death in relation to remaining benefits payable by the *Plan*.

Any payment made by the *Plan* in accordance with these provisions will fully release the *Plan* of its liability to you.

Recovery of Excess or Mistaken Payments

Whenever payments for services rendered to you or any of your *covered dependents* have been made in excess of the amount necessary to satisfy the provisions of this Plan (including payments made by mistake or due to fraud), the *Plan* has the right to (i) recover these payments from any individual (including yourself), insurance company, provider, payer, or other organization to whom the excess payments were made or (ii) withhold payment on your or your *covered dependent*'s future benefits until the amount withheld equals the amount of the overpayment.

Responsibility for Quality of Medical Care

In all cases, you or your *covered dependents* have the exclusive right to choose your *physicians* and other providers. The *Plan* is not responsible for the quality of medical care you receive, since all those who provide care do so as independent contractors. The *Plan* cannot be held liable for any claim or damages connected with injuries you or your *covered dependent* suffer while receiving medical services or supplies.

Governing Law

This *Plan* is governed by applicable state and federal laws.

Where Legal Action Must be Filed

Any legal action arising out of this *Plan* must be served on the *plan administrator* and must be filed in the Sixth Judicial Circuit of the State of Maryland.

Time Limits for Filing A Lawsuit

Any legal action arising out of, or related to, this *Plan* and filed against the *Plan* by you, any of your dependents, any *enrollee*, or any third party, must be filed in court within one year of the time the claim arose. For example, a claim that benefits were not *pre-certified* for *medical necessity*, and any and all damages relating thereto, would arise when the external review process described in Article 12 of the Claims Procedures section has ended.

Plan Amendment and Termination

The *Plan* may be amended or terminated at any time without prior notice by a resolution of the North American Division Committee of the General Conference of Seventh-day Adventists or by the North American Division Risk Management Committee. The right to amend includes the right to curtail or eliminate coverage for any treatment, procedure, or service, regardless of whether any covered employee is receiving such treatment for an injury, defect, illness, or disease contracted prior to the effective date of the amendment.

Effective Date of Amendment or Termination

All changes to this *Plan* shall become effective as of a date established by the amendment. Upon termination or discontinuance, contributions and benefits elections relating to the *Plan* shall terminate.

Special Election for Employees and Spouses Age 65 and Over

If you remain actively employed after reaching age 65, you or your spouse will remain covered under this *Plan* without reduction for Medicare benefits or designate Medicare as the primary payer of benefits. If you choose to remain covered under this *Plan*, this *Plan* will be the primary payer of benefits and Medicare will be secondary.

If you are under age 65 and your *spouse* is over age 65, this *Plan* will be the primary payer of benefits and Medicare will be secondary.

Claim Review

The *Plan* conducts appropriate claim editing procedures to examine all charges for proper billing practices, including such things as unbundling of procedures for increased charges or wrong sex billing codes.

Health Care Fraud and Abuse

The *Plan* screens and audits claims for health care fraud. Under HIPAA, fraud is defined as knowingly, and willfully executing or attempting to execute a scheme or artifice (i) to defraud any healthcare benefit program or (ii) to obtain by means of false or fraudulent pretenses, representations, or promises any of the money or property owned by any healthcare benefit program. Abuse is more generally considered acts that are inconsistent with sound medical or business practice where abuse activities cannot be clearly established as willful or intentional misrepresentation.

The most common types of fraud, waste or abuse are misrepresentation of services with incorrect Current Procedural Terminology (CPT) codes; billing for services not rendered; altering claim forms for higher payments; falsification of information in medical record documents, such as International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes and treatment histories; billing for services that were not performed or misrepresenting the types of services that were provided; billing for supplies not provided; and providing medical services that are unnecessary based on the patient's condition.

Any individual who willfully and knowingly engages in activities intended to defraud the health plan may face consequences up to and including prosecution to the fullest extent of the law.

Health Care Claims Audits

As part of an ongoing program to provide outstanding customer service and cost-effective medical care and as a supplement to other associated *Plan* initiatives, such as utilization management, the *Plan* shall exercise the right to analyze claims data and carry out audit procedures. The objective of the audit process is to ensure that the *Plan* fulfills its responsibility to its partners, enrollees, and sponsors by identifying, correcting and recovering inaccurate claims payments. The audit process shall confirm that claim submissions accurately represent the services provided to *Plan enrollees*, and ensure that billing is conducted in accordance with official guidelines and other applicable standards, rules, laws, regulations, contract provisions, policies and procedures. Items that may be addressed during the audit may include but are not limited to the following:

1. Coding and Billing Audits which may encompass accurate application of many different items such as the following:
    A. Diagnosis coding,
    B. Procedure coding,
    C. Units or keystroke errors,
    D. Diagnosis Related Grouping (DRG),
    E. Ambulatory Payment Classification (APC),
    F. Ambulatory surgery payment groupings (ASC),
    G. Discharge disposition,
    H. Present on Admission (POA) indicators,
    I. HAC, Medical/Surgical Misadventure or Medical Never Event,
    J. National Correct Coding Initiative (NCCI) edits,
    K. Outpatient Code Editor (OCE) edits,
    L. Modifiers, etc.
2. Charge Audits may encompass not only accuracy of the charges but appropriateness of the charges when items may not be consistent with uniform billing practices (for example, unbundling of items from the room rate such as venipuncture, pulse oximetry, oxygen, floor stock supplies, etc.).
3. Assessing if services provided were reasonable and necessary (for example, level of care or setting, experimental and investigational usage of drugs or devices).
4. Covered Services.
5. Readmissions up to 30 days.

No Waiver

Failure of the *plan administrator* or your *employer* to insist upon compliance with any provision of this *Plan* at any given time or times or under any given set or sets of circumstances shall not operate to waive or modify such provision or in any manner whatsoever to render it unenforceable, as to any other time or times or as to any other occurrence or occurrences, whether the circumstances are, or are not, the same.

Rights Under Newborns' and Mothers' Health Protection Act

Under federal law, group health plans such as this *Plan* generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the *plans* may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan may not, under federal law, require that a physician or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Rights Under the Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires that health plans cover post-mastectomy reconstructive breast surgery if they provide medical and surgical coverage for mastectomies. Specifically, health plans must cover:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of all stages of mastectomy, including lymph edemas.

Benefits required under the Women's Health and Cancer Rights Act will be provided in consultation between the patient and attending physician. These benefits are subject to the *Plan's* regular co-payments and deductibles. These types of benefits are provided under this *Plan*.

Section 125 Cafeteria Plan

Your *employer* may participate in and offer a Section 125 Cafeteria Plan program at your workplace. (Section 125 refers to the section of the Internal Revenue Code authorizing cafeteria plans.) Section 125 programs allow employees to elect to contribute part of their salary to be used to pay, on a pre-tax basis:

1. qualifying out-of-pocket medical expenses not reimbursed by this *Plan* or any other health plan or insurance, such as *co-payments*, deductibles and *co-insurance*; and
2. contributions or premiums, if any, required to be paid for *Plan* coverage.

If your employer has a Section 125 program, there are restrictions on when you are allowed to enroll in the program and when you can change your elections and coverage under the program. Please contact your employer for more information about these restrictions and other requirements and features of the Section 125 program.

Health Insurance Portability and Accountability Act Provisions (HIPAA Privacy Policy)

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") protects the privacy of certain types of individual health information, regulates the use of such information by the Plan and imposes certain security protection measures concerning electronic health information. The Department of Health and Human Services has issued regulations on this subject that can be found at 45 CFR parts 160 and 164 ("HIPAA Regulations"). The individual health information that is protected ("Protected Health Information" or "PHI") is any information created or received by the Plan that relates to:

1. Your past, present or future physical or mental health or your past, present or future physical or mental condition
2. the provision of healthcare to you or
3. past, present, or future payment for healthcare.

However, HIPAA allows medical information, including PHI, to be disclosed by the Plan to the Plan Sponsor and to be used by the Plan Sponsor. The permitted disclosures to and uses by the Plan Sponsor of medical information are as follows:

1. The Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary information for the purpose of
    a. obtaining premium bids for providing insurance coverage; or
    b. modifying, amending, or terminating the Plan ("Summary Information"). The Plan Sponsor may use Summary Information so received from the Plan only for these two listed purposes.
2. The Plan may disclose to the Plan Sponsor, and the Plan Sponsor may use, information on whether an individual is participating in the Plan or is enrolling or dis-enrolling in the Plan.
3. The Plan may disclose PHI to the Plan Sponsor and/or the Plan Sponsor may use such PHI if you have specifically authorized in writing such disclosure and/or use.
4. The Plan may disclose PHI to the Plan Sponsor, and the Plan Sponsor may use PHI, to carry out plan administration functions, such as activities relating to:
    a. obtaining premiums or to determining or fulfilling responsibility for coverage and provision of benefits under the Plan
    b. payment for or obtaining or providing reimbursement for healthcare services - Payments under this Plan generally are made either to the healthcare provider or to the employee. All Members should be aware that the Plan and the Plan Sponsor will be providing PHI concerning all dependents of an employee to the employee as part of the Explanation of Benefits and when reimbursing the employee for covered services under the Plan. If there is some reason why a dependent (spouse or child) of an employee does not want the employee to receive PHI, the dependent should so inform his or her healthcare provider and should also contact the Plan Administrator
    c. determining eligibility for the Plan or eligibility for one or more types of coverage or benefits provided under the Plan
    d. coordination of benefits or determinations of *co-payments* or other cost sharing mechanisms
    e. adjudication and subrogation of claims, billing, claims management, collection activities and related healthcare data processing
    f. payment under a contract for reinsurance

g. review of healthcare services with respect to medical necessity, coverage under the health plan, appropriateness of care, or justification of charges

h. utilization review activities, including pre-certification and preauthorization of services and concurrent and retrospective review of services

i. disclosure to consumer reporting agencies of any of the following PHI regarding collection of premiums or reimbursement: name and address, date of birth, Social Security Number, payment history, account number and name and address of the health plan

j. medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs

k. business planning and development, such as conducting cost-management and planning-related analyses relating to managing and operating the Plan, including formulary development and administration and/or the development or improvement of methods of payment

l. resolution of internal grievances

m. prosecution or defense of administrative claims or lawsuits involving the Plan or Plan Sponsor

n. conducting quality assurance and improvement activities, case management and care coordination

o. evaluating healthcare provider performance or Plan performance

p. securing or placing a contract for reinsurance of risk relating to healthcare claims, other activities relating to the renewal or replacement of stop-loss or excess of loss insurance

q. contacting healthcare providers and patients with information about treatment alternatives These uses and disclosures are consistent with HIPAA Regulations.

The Plan Sponsor has agreed to (and the Plan has received a certification from the Plan Sponsor evidencing such agreement) the following restrictions:

1. The Plan Sponsor will not use or further disclose the PHI except as described above or as otherwise required by law.
2. Any agents or subcontractors of the Plan Sponsor to whom the Plan Sponsor provides PHI will agree to the same restrictions and conditions on the use and disclosure of PHI that apply to the Plan Sponsor. Any agents or subcontractors of the Plan Sponsor to whom the Plan Sponsor provides electronic PHI must agree to implement reasonable and appropriate security measures to protect the information.
3. The Plan Sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
4. The Plan Sponsor will report to the Plan any use or disclosure of the PHI that is inconsistent with the permitted uses and disclosures of which the Plan Sponsor becomes aware. The Plan Sponsor will report to the Plan any security incident of which the Plan Sponsor becomes aware.
5. The Plan Sponsor will give you access and provide copies to you of your PHI in accordance with the HIPAA Regulations.
6. The Plan Sponsor will allow you to amend your PHI in accordance with the HIPAA Regulations.
7. The Plan Sponsor will make available PHI to you in order to make an accounting of PHI in accordance with the HIPAA Regulations.
8. The Plan Sponsor will make available its internal practices, books and records relating to the use and disclosure of PHI received from the Plan to the Secretary of Health and Human

Services (or the Secretary's designee) for determining compliance by the Plan with the HIPAA Regulations.

9. The Plan Sponsor will, if feasible, return or destroy all protected PHI received from the Plan and retain no copies of the PHI when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

10. The Plan Sponsor will ensure that adequate separation between the Plan and Plan Sponsor is established. Only the following employees or classes of employees or other persons under the control of the Plan Sponsor will be given access to the PHI to be disclosed:

    a. Officers of the Plan Administrator

    b. Employees of the Plan Administrator

    c. Plan Sponsor's designated Benefit Coordinator and Controlling Committee

11. The Plan Sponsor will ensure that this adequate separation is supported by reasonable and appropriate security measures to the extent that these individuals have access to electronic PHI.

12. The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan, except enrollment/disenrollment information and Summary Information, which are not subject to these restrictions.

The access to and use by the employees described above is limited to the plan administration functions that the Plan Sponsor performs for the Plan. Employees who violate this section are subject to disciplinary action by the Plan Sponsor, including, but not limited to, reprimands and termination.

The Plan has issued a Privacy Notice which explains the Plan's privacy practices and your rights under HIPAA. This Notice is available by contacting the Plan's Privacy/Security Officer at the following address: **Adventist Risk Management, P.O. Box 4288, Silver Spring, MD 20914-4288 or email, privacyofficer@adventistrisk.org. The Privacy Notice is also available at www.AscendtoWholeness.org.**

Release of Medical Information

Any *employee* covered by the *Plan*, on behalf of himself or herself and the *employee's covered dependents*, shall be deemed to have authorized any attending physician, nurse, hospital, or other provider of services or supplier to furnish the *plan administrator* with all information and records or copies of records relating to the diagnosis, treatment, or care of any person covered by the *Plan*. Members shall, by asserting a claim for *Plan* benefits, be deemed to have waived all provisions of law forbidding the disclosure of such information and records. If so requested or required by law, each Member shall sign any release or authorization form in order to facilitate the release of such medical records.

Furnishing Information

A person covered by the *Plan* must furnish all information needed to effect coverage under the *Plan* and termination or changes in such coverage. The *plan administrator* may require that a Member provide certain personal data (including reasonable proof of the accuracy of the data) necessary for the determination of the person's benefits. Failure to furnish the data (or proof of its accuracy) may delay the payment of benefits. Benefit payments may be adjusted to reflect correction of inaccurate or incomplete information, and an employee, other Member and/or medical provider may be required to make up any overpayments, and the Plan may make up any underpayments.

Medicare Part D Notice

Important Notice from the plan About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **The Plan has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you elect Medicare Part D coverage and maintain your Plan coverage, your Plan coverage will coordinate with Part D coverage. In most instances, the Plan will pay prescription drug benefits as the primary payer and Medicare will pay secondary, and therefore the value of your Medicare Part D coverage will be greatly reduced.

If you decide to join a Medicare drug plan and drop your current Plan coverage, be aware that if you are no longer an active employee with a participating employer, you and your dependents may not be able to get this coverage back. If you are an active employee with a participating employer, you can get this coverage back, but not until the next open enrollment period (unless you have qualifying change in status and your requested change is on account of and corresponds with the event you experience).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium

may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact Adventist Risk Management at 1-888-276-4732. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	December 1, 2017
Name of Entity/Sender:	Healthcare Assistance Plan for Employees of the Seventh-day Adventist Organizations of the North American Division (USA) of the General Conference of Seventh-day Adventist ("Plan"), by its Plan Administrator, Adventist Risk Management, Inc.
Contact--Position/Office:	Plan Administrator
Address:	12501 Old Columbia Pike, Silver Spring, MD 20904
Phone Number:	888-ARM-4SDA or 888-276-4732

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your *children* are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your *children* aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

NEVADA – Medicaid

Medicaid Website: https://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

NEW HAMPSHIRE – Medicaid

Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: http://www.eohhs.ri.gov/
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

WASHINGTON – Medicaid

Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p100905.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/agencies/ebsa 1-866-444-EBSA (3272)	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565

APPENDIX A – LIST OF COVERED PREVENTIVE SERVICES

Preventive care benefits for adults –
See below or go to https://www.healthcare.gov/preventive-care-adults/

Preventive care benefits for women –
See below or go to https://www.healthcare.gov/preventive-care-women/

Preventive care benefits for children –
See below or go to https://www.healthcare.gov/preventive-care-children/

Preventive care benefits for adults

IMPORTANT
These services are free only when delivered by a doctor or other provider in your plan's network.

1. Abdominal aortic aneurysm one-time screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/talk-to-your-doctor-about-abdominalaortic-aneurysm) for men of specified ages who have ever smoked.

2. Alcohol misuse screening and counseling (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/heart-health/drink-alcohol-only-in-moderation),

3. Aspirin use (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/heart-health/talkwith-your-doctor-about-taking-aspirin-every-day) to prevent cardiovascular disease for men and women of certain ages.

4. Blood pressure screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screeningtests/get-your-blood-pressure-checked).

5. Cholesterol screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/getyour-cholesterol-checked) for adults of certain ages or at higher risk.

6. Colorectal cancer screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-tested-for-colorectal-cancer) for adults over 50.

7. Depression screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/talkwith-your-doctor-about-depression).

8. Diabetes (Type 2) screening (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/take-steps-to-prevent-type-2-diabetes) for adults with high bload pressure.

9. Diet Counseling (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/eathealthy) for adults at higher risk for chronic disease.

10. Hepatitis B screening (http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/hepatitis-b-virus-infection-screening-2014?ds=1 &s=hepatitis%20b) (https://www.healthcare.gov/links-to-other-sites/) for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.

11. Hepat it is C screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/talking-with-the-doctor/hepatitis-c-screening) for adults at increased risk, and one time for everyone born 1945 - 1965.

12. HIV screening (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-otherstds/get-tested-for-hiv) for everyone ages 15 to 65, and other ages at increased risk.

13. Immunization vaccines (http://healthfinder.gov/HealthTopics/Category/doctor-visits/shotsvaccines/get-important-shots) for adults - doses, recommended ages, and recommended populations vary:
    - Diphtheria (http://www.vaccines.gov/diseases/diphtheria/index.html)
    - Hepatitis A (http://www.vaccines.gov/diseases/hepatitis_a/index.html)
    - Hepatitis B (http://www.vaccines.gov/diseases/hepatitis_b/index.html)
    - Herpes Zoster (http://www.vaccines.gov/diseases/shingles/index.html)
    - Human Papillomavirus (HPV) (http://www.vaccines.gov/diseases/hpv/index.html) Influenza (flu shot) (http://www.vaccines.gov/diseases/flu/index.html)

- Measies (http://www.vaccines.gov/diseases/measles/index.html)
- Meningococcal (http://www.vaccines.gov/diseases/meningitis/index.html)
- Mumps (http://www.vaccines.gov/diseases/mumps/index.html)
- Pertussis (http://www.vaccines.gov/diseases/pertussis/index.html)
- Pneumococcal (http://www.vaccines.gov/diseases/pneumonia/index.html)
- Rubella (http://www.vaccines.gov/diseases/rubella/index.html)
- Tetanus (http://www.vaccines.gov/diseases/tetanus/index.html)
- Varicella (Chicken pox) (http://www.vaccines.gov/diseases/chickenpox/index.html)

14. Lung cancer screening (http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/lung-cancer-screening). (https://www.healthcare.gov/links-to-other-sites/) for adults 55 - 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years.

15. Obesity screening and Counseling (http://healthftnder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/watch-your-weight).

16. Sexually transmitted infection (STI) prevention counseling (http://healthfinder.gov/healthtopics/category/health-conditions-and-diseases/hiv-and-other-stds) for adults at higher risk.

17. Syphilis screening (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/syphilis-testing-questions-for-the-doctor) for adults at higher risk.

18. Tobacco Use screening (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/quit-smoking) for all adults and cessation interventions for tobacco users.

MORE ON PREVENTION

- Learn more about preventive care from the CDC (http://www.cdc.gov/prevention/).
- See preventive services covered for children (/preventive-care-children/) and women (/preventive-care-women/).
- Learn more about what else Marketplace health insurance plans cover (/coverage/what-marketplace-plans-cover/).

Preventive care benefits for women

IMPORTANT
These services are free only when delivered by a doctor or other provider in your plan's network.

Services for pregnant women or women who may become pregnant:

1. Anemia screening (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/have-a-healthy-pregnancy) on a routine basis.

2. Breastfeeding comprehensive support and counseling (http://healthfinder.gov/HealthTopics/Category/pregnancy/getting-ready-for-your-baby/breastfeed-your-baby) from trained providers, and access to breastfeeding supplies, for pregnant and nursing women.

3. Contraception (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-otherstds/choose-the-right-birth-control): Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."

4. Folic acid (http://healthfinder.gov/HealthTopics/Category/nutrition-and-physical-activity/nutrition/get-enough-folic-acid) supplements for women who may become pregnant.

5. Gestational diabetes screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/talking-with-the-doctor/gestational-diabetes-screening-questions-for-the-doctor) for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.

6. Gonorrhea screening (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hivand-other-stds/get-tested-for-chlamydia-and-gonorrhea) for all women at higher risk.

7. Hepatitis B screening (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/have-a-healthy-pregnancy) for pregnant women at their first prenatal visit.

8. Rh Incompatibility screening (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/have-a-healthy-pregnancy) for all pregnant women and follow-up testing for women at higher risk.

9. Syphilis screening (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-andother-stds/syphilis-testing-questions-for-the-doctor).

10. Expanded tobacco intervention and counseling (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/quit-smoking) for pregnant tobacco users.

11. Urinary tract or other infection screening (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/have-a-healthy-pregnancy)

Get more information about services for pregnant women from HealthFinder.gov
(http://healthflnder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/have-a-healthy-pregnancy)

Other covered preventive services for women:

1. Breast cancer genetic test counseling (BRCA) (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/cancer/talk-with-a-doctor-if-breast-orovarian-cancer-runs-in-your-family) for women at higher risk.

2. Breast cancer mammography screenings (http://healthfinder.gov/HealthTopics/Category/doctorvisits/screening-tests/get-tested-for-breast-cancer) every 1 to 2 years for women over 40.

3. Breast cancer chemoprevention counseling (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/cancer/talk-with-a-doctor-if-breast-or-ovarian-cancer-runs-in-your-family) for women at higher risk.

4. Cervical cancer screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-tested-for-cervical-cancer) for sexually active women.

5. Chlamydia infection screening (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/get-tested-for-chlamydia-and-gonorrhea) for younger women and other women at higher risk.

6. Domestic and interpersonal violence screening and counseling (http://healthfinder.gov/HealthTopics/Category/everyday-healthy-living/mental-health-and-relationship/take-steps-toprotect-yourself-from-relationship-violence) for all women.

7. Gonorrhea screening (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hivand-other-stds/get-tested-for-chlamydia-and-gonorrhea) for all women at higher risk.

8. HIV screening and counseling (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/get-tested-for-hiv) for sexually active women.

9. Human Papillomavirus (HPV) DNA test (http://healthfinder.gov/HealthTopics/Category/doctorvisits/screening-tests/get-tested-for-cervical-cancer) every 3 years for women with normal cytology results who are 30 or older.

10. Osteoporosis screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-abone-density-test) for women over age 60 depending on risk factors.

11. Rh incompatibility screening (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/have-a-healthy-pregnancy) follow-up testing for women at higher risk.

12. Sexually transmitted infections counseling (http://healthfinder.gov/healthtopics/category/health-conditions-and-diseases/hiv-and-other-stds) for sexually active women.

13. Syphilis screening (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-andother-stds/syphilis-testing-questions-for-the-doctor) for women at increased risk.

14. Tobacco use screening and interventions (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/quit-smoking).

15. Well-woman visits (http://healthfinder.gov/HealthTopics/Category/everyday-healthy-living/sexual-health/get-your-well-woman-visit-every-year) to get recommended services for women under 65.

MORE ON PREVENTION

- Learn more about preventive care from the CDC (http://www.cdc.gov/prevention/).
- See preventive services covered for all adults (/preventive-care-adults/) and children (/preventive-care-children/).
- Learn more about what else Marketplace health insurance plans cover (/coverage/what-marketplace-plans-cover/).

Preventive care benefits for adults

IMPORTANT
These services are free only when delivered by a doctor or other provider in your plan's network.

1. Abdominal aortic aneurysm one-time screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/talk-to-your-doctor-about-abdominalaortic-aneurysm) for men of specified ages who have ever smoked.

2. Alcohol misuse screening and counseling (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/heart-health/drink-alcohol-only-in-moderation),

3. Aspirin use (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/heart-health/talkwith-your-doctor-about-taking-aspirin-every-day) to prevent cardiovascular disease for men and women of certain ages.

4. Blood pressure screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screeningtests/get-your-blood-pressure-checked).

5. Cholesterol screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/getyour-cholesterol-checked) for adults of certain ages or at higher risk.

6. Colorectal cancer screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-tested-for-colorectal-cancer) for adults over 50.

7. Depression screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/talkwith-your-doctor-about-depression).

8. Diabetes (Type 2) screening (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/take-steps-to-prevent-type-2-diabetes) for adults with high bload pressure.

9. Diet Counseling (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/eathealthy) for adults at higher risk for chronic disease.

10. Hepatitis B screening (http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/hepatitis-b-virus-infection-screening-2014?ds=1 &s=hepatitis%20b) (https://www.healthcare.gov/links-to-other-sites/) for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.

11. Hepat it is C screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/talking-with-the-doctor/hepatitis-c-screening) for adults at increased risk, and one time for everyone born 1945 - 1965.

12. HIV screening (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-otherstds/get-tested-for-hiv) for everyone ages 15 to 65, and other ages at increased risk.

13. Immunization vaccines (http://healthfinder.gov/HealthTopics/Category/doctor-visits/shotsvaccines/getimportant-shots) for adults - doses, recommended ages, and recommended populations vary:
    - Diphtheria (http://www.vaccines.gov/diseases/diphtheria/index.html)
    - Hepatitis A (http://www.vaccines.gov/diseases/hepatitis_a/index.html)
    - Hepatitis B (http://www.vaccines.gov/diseases/hepatitis_b/index.html)
    - Herpes Zoster (http://www.vaccines.gov/diseases/shingles/index.html)
    - Human Papillomavirus (HPV) (http://www.vaccines.gov/diseases/hpv/index.html) Influenza (flu shot) (http://www.vaccines.gov/diseases/flu/index.html)
    - Measies (http://www.vaccines.gov/diseases/measles/index.html)

- Meningococcal (http://www.vaccines.gov/diseases/meningitis/index.html)
- Mumps (http://www.vaccines.gov/diseases/mumps/index.html)
- Pertussis (http://www.vaccines.gov/diseases/pertussis/index.html)
- Pneumococcal (http://www.vaccines.gov/diseases/pneumonia/index.html)
- Rubella (http://www.vaccines.gov/diseases/rubella/index.html)
- Tetanus (http://www.vaccines.gov/diseases/tetanus/index.html)
- Varicella (Chicken pox) (http://www.vaccines.gov/diseases/chickenpox/index.html)

14. Lung cancer screening (http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/lung-cancer-screening). (https://www.healthcare.gov/links-to-other-sites/) for adults 55 - 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years.

15. Obesity screening and Counseling (http://healthftnder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/watch-your-weight).

16. Sexually transmitted infection (STI) prevention counseling (http://healthfinder.gov/healthtopics/category/health-conditions-and-diseases/hiv-and-other-stds) for adults at higher risk.

17. Syphilis screening (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/syphilis-testing-questions-for-the-doctor) for adults at higher risk.

18. Tobacco Use screening (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/quit-smoking) for all adults and cessation interventions for tobacco users.

MORE ON PREVENTION

- Learn more about preventive care from the CDC (http://www.cdc.gov/prevention/).
- See preventive services covered for children (/preventive-care-children/) and women (/preventive-care-women/).
- Learn more about what else Marketplace health insurance plans cover (/coverage/what-marketplace-plans-cover/).

Preventive care benefits for children

IMPORTANT

These services are free only when delivered by a doctor or other provider in your plan's network.

Coverage for children's preventive health services

All Marketplace health plans and many other plans must cover the following list of preventive services for children without charging you a co-payment (/glossary/co-payment) or co-insurance (/glossary/co-insurance). This is true even if you haven't met your yearly deductible (/glossary/deductible).

1. Alcohol and drug use assessments (http://www.healthfinder.gov/HealthTopics/Category/parenting/healthy-communication-and-relationships/talk-toyour-kids-about-tobacco-alcohol-and-drugs) for adolescents.

2. Autism screening (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4) for children at 18 and 24 months.

3. Behavioral assessments for children ages: **0 to 11 months** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-babys-visit-to-thedoctor-ages-0-to-11-months), **1 to 4 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctorvisits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4), **5 to 10 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-5-to-10), **11 to 14 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctorvisits/make-the-most-of-your-childs-visit-to-the-doctor-ages-11-to-14), **15 to 17 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-teens-visit-to-thedoctor-ages-15-to-17).

4. Blood pressure screening for children ages: **0 to 11 months** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-babys-visit-to-thedoctor-ages-0-to-11-months), **1 to 4 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4), **5 to 10 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-5-to-10), 11 to 14 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-11-to-14), **15 to 17 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-teens-visit-to-thedoctor-ages-15-to-17).

5. Cervical dysplasia screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-tested-for-cervical-cancer) for sexually active females.

6. Depression screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-your-teen-screened-for-depression) for adolescents.

7. Developmental screening (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/watch-for-signs-of-speech-or-language-delay) for children under age 3.

8. Dyslipidemia screening for children at higher risk of lipid disorders ages: **1 to 4 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4), **5 to 10 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-5-to-10), **11 to 14 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-11-to-14), **15 to 17 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctorvisits/make-the-most-of-your-teens-visit-to-the-doctor-ages-15-to-17).

9. Fluoride chemoprevention supplements (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/take-care-of-your-childs-teeth) for children without fluoride in their water source.

10. Gonorrhea preventive medication (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/talk-with-your-doctor-about-newborn-screening) for the eyes of all newborns.

11. Hearing screening (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/talk-with-your-doctor-about-newborn-screening) for all newborns.

12. Height, weight and body mass index (BMI) measurements for children ages: **0 to 11 months** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-babys-visit-to-the-doctor-ages-0-to-11-months), **1 to 4 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4), **5 to 10 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-5-to-10), **11 to 14 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-11-to-14), **15 to 17 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-teens-visit-to-the-doctor-ages-15-to-17).

13. Hematocrit or hemoglobin screening (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4) for all children.

14. Hemoglobinopathies or sickle cell screening (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/talk-with-your-doctor-about-newborn-screening) for newborns.

15. Hepatitis B screening (http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/hepatitis-b-virus-infection-screening-2014?ds=1&s=adolescent) - (https://www.healthcare.gov/links-to-other-sites/) for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and U.S.-born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11 - 17 years.

16. HIV screening (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-otherstds/get-tested-for-hiv) for adolescents at higher risk.

17. Hypothyroidism screening (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/talk-with-your-doctor-about-newborn-screening) for newborns.

18. Immunization vaccines (http://healthfinder.gov/HealthTopics/Category/doctor-visits/shotsvaccines/getyour-childs-shots-on-schedule) for children from birth to age 18 - doses, recommended ages, and recommended populations vary:
    - Diphtheria (http://www.vaccines.gov/diseases/diphtheria/index.html), Tetanus (http://www.vaccines.gov/diseases/tetanus/index.html), Pertussis (Whooping Cough) (http://www.vaccines.gov/diseases/pertussis/index.html).
    - Haemophilus influenza type b (http://www.vaccines.gov/diseases/hib/index.html)
    - Hepatitis A (http://www.vaccines.gov/diseases/hepatitis_a/index.html)
    - Hepatitis B (http://www.vaccines.gov/diseases/hepatitis_b/index.html)
    - Human Papillomavirus (PVU) (http://www.vaccines.gov/diseases/hpv/index.html)
    - Inactivated Poliovirus (http://www.vaccines.gov/diseases/polio/index.html)
    - Influenza (flu shot) (http://www.vaccines.gov/diseases/tlu/index.html)
    - Measles (http://www.vaccines.gov/diseases/measles/index.html)
    - Meningococcal (http://www.vaccines.gov/diseases/meningitis/index.html)
    - Pneumococcal (http://www.vaccines.gov/diseases/pneumonia/index.html)
    - Rotavirus (http://www.vaccines.gov/diseases/rotavirus/index.html)
    - Varicella (Chickenpox) (http://www.vaccines.gov/diseases/chickenpox/index.html)

19. Iron supplements (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-babys-visit-to-the-doctor-ages-0-to-11-months) for children ages 6 to 12 months at risk for anemia.

20. Lead screening (http://healthfinder.gov/HealthTopics/Category/pregnancy/getting-ready-for-your-baby/protect-your-family-from-lead-poisoning) for children at risk of exposure.

21. Medical history for all children throughout development ages: **0 to 11 months** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-babys-visit-to-the-doctor-ages-0-to-11-months), **1 to 4 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4), **5 to 10 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-5-to-10), **11 to 14 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctorvisits/make-the-most-of-your-childs-visit-to-the-doctor-ages-11-to-14), **15 to 17 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-teens-visit-to-the-doctor-ages-15-to-17).

22. Obesity screening and counseling (http://healthfinder.gov/HealthTopics/Category/parenting/nutrition-and-physical-activity/help-your-child-stay-at-a-healthy-weight).

23. Oral health risk assessment for young children ages: **0 to 11 months** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-babys-visit-to-the-doctor-ages-0-to-11-months), **1 to 4 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4), **5 to 10 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-5-to-10).

24. Phenylketonuria (PKU) screening (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/talk-with-your-doctor-about-newborn-screening) for newborns.

25. Sexually transmitted infection (STI) prevention counseling and screening (http://healthfinder.gov/healthtopics/category/health-conditions-and-diseases/hiv-and-other-stds) for adolescents at higher risk.

26. Tuberculin testing for children at higher risk of tuberculosis ages: **0 to 11 months** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-babys-visit-to-the-doctor-ages-0-to-11-months), **1 to 4 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4), **5 to 10 years** (http://health finder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-5-to-10), **11 to 14 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-11-to-14), **15 to 17 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-teens-visit-to-the-doctor-ages-15-to-17).

27. Vision screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-your-childs-vision-checked) for all children.

More information about preventive services for children

- Preventive services for children age **0 to 11 months** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-babys-visit-to-thedoctor-ages-0-to-11-months).
- Preventive services for children age **1 to 4 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4).
- Preventive services for children age **5 to 10 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-5-to-10).
- Preventive services for children age **11 to 14 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-11-to-14).
- Preventive services for children age **15 to 17 years** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-teens-visit-to-the-doctor-ages-15-to-17).

MORE ON PREVENTION

- Learn more about preventive care from the CDC (http://www.cdc.gov/prevention/).
- See preventive services covered for adults (/preventive-care-adults/) and women (/preventive-care-women/).
- Learn more about what else Marketplace health insurance plans cover (/coverage/what-marketplace-plans-cover/).