ASCEND TO WHOLENESS
HEALTHCARE PLAN

NORTH AMERICAN DIVISION
Healthcare Assistance Plan

Ascend to Wholeness Plan

SUMMARY PLAN DOCUMENT (SPD)

JANUARY 01, 2025

PLAN ADMINISTRATOR
North American Division of Seventh-day Adventists with duties delegated to:
Adventist Risk Management, Inc.
12501 Old Columbia Pike
Silver Spring, MD 20904
www.adventistrisk.org

MEMBER AND PROVIDER SERVICES
1-888-276-4732
benefits@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
WebTPA
P.O. Box 99906
Grapevine, TX 76099-9706
EDI: 75261
1-888-276-4732

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

UTILIZATION REVIEW MANAGER
(MEDICAL NECESSITY, PRE-CERTIFICATION, AND APPEALS)
Adventist Health Benefits Administration
PO Box 92101
Portland, OR 97292
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 113 for more details.

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 North American Division of Seventh-day Adventists established this *Plan* for its *participating employers*, which are Seventh-day Adventist Organizations, inclusive of the General Conference of Seventh-day Adventists and its subsidiaries and affiliates, that participate in the *Plan* for their eligible *employees* based in the United States and certain *included territories* (Guam and the Northern Mariana Islands), and the *employees*' *eligible dependents*, in order 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 (and, if you are *stationed* in an *included territory*, also provides benefits for *covered services* received in an *included territory*). The *Plan* also pays a portion of the cost of emergency medical expenses incurred anywhere in the world for outpatient care, hospital care, surgery, preadmission services, and prescription drugs. Non-*emergency services* received outside of the United States are excluded from coverage (except if received in an *included territory* if you are *stationed* in an *included territory*).

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 North American Division of Seventh-day Adventists to administer the *Plan*, which it does via its delegate Adventist Risk Management, Inc. (which is part of the Church). The North American Division of Seventh-day Adventists (the *plan administrator* of this *Plan*), its delegate Adventist Risk Management, Inc. ("ARM"), and ARM's representatives and delegates administer the *Plan*. When the term "*plan administrator*" is used in this *Plan*, it generally refers to ARM as the delegate of the North American Division of Seventh-day Adventists.

This Summary Plan Document (**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, 2025. This SPD is also the *Plan* document. This SPD describes the benefits available to all *enrollees* of the *Plan*; however, depending on your state or *territory* of residence, you may be entitled to additional benefits by state or *territory* 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 Member Services at 888-276-4732 or to your *plan administrator* by email at benefits@adventistrisk.org. 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 Plan (the "*Plan*")

Plan Sponsor/Plan Administrator:

The *Plan* is sponsored by the North American Division of Seventh-day Adventists. For the purposes of *Plan* financial liability, your *participating employer* is the *plan sponsor* for its piece of the *Plan*. As such, any obligation to you as an *enrollee* arising from this *Plan* is a general asset obligation of your *participating employer*.

The *Plan* is administered by the North American Division of Seventh-day Adventists, which has delegated its plan administrative duties to Adventist Risk Management:

Adventist Risk Management, Inc.
12501 Old Columbia Pike
Silver Spring, MD 20904
www.adventistrisk.org
benefits@adventistrisk.org
(888) 276-4732

When the term "plan administrator" is used in this *Plan*, it generally refers to Adventist Risk Management as the delegate of the North American Division of Seventh-day Adventists.

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.

The *plan administrator* has the discretionary authority to administer the *Plan* in all of its details, including determining eligibility for benefits and construing all terms of the *Plan*. The *plan administrator* has the discretion to determine all questions of fact and/or law that may arise in connection with the administration of the *Plan*. The *plan administrator* may assign its duties to others, and the *plan administrator* has assigned its duties to Adventist Risk Management and has granted Adventist Risk Management the authority to delegate its plan administrative duties to other entities on its behalf.

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*. The *plan administrator* may delegate its duties to third parties. This is not an insured plan.

Plan Year: January 1 through December 31

Medical, Dental, and Vision Claims Processing:

WebTPA
P.O. Box 99906
Grapevine, TX 76099-9706
EDI: 75261 (888) 276-4732
www.ascendtowholeness.org

Medical Necessity Pre-Certification/Utilization Review/Care Management:

Adventist Health Benefits Administration
PO Box 92010
Portland, OR 97292
(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, by the North American Division Risk Management Committee, or by the delegate of North American Division of Seventh-day Adventists, which is Adventist Risk Management, or any authorized representative of the North American Division of Seventh-day Adventists or its delegate, Adventist Risk Management. 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 option or Access option), applicable deductibles, the annual out-of-pocket maximums, and the *copayments and coinsurance* 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 (unless specifically required by the *No Surprises Act*). 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 (unless specifically required by the *No Surprises Act*). (*Pre-certification* is not required for routine *in-network* health care performed in a provider's office, *urgent care*, emergency room, or via *telehealth*.)

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 and in the Surprise Medical Bills Notice.

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 listed in the Ancillary Medical Benefits chart, office/telehealth visits, *urgent care* center visits, emergency room visits that do not result in hospital admission, preventive care services, hospice, vision, and prescription drug expenses.

Please note that fixed dollar copayments do not apply toward your annual deductible.

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 *copayments*, *coinsurance* 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, & customary charge* billed by an *out-of-network provider* directly to an *enrollee*)
- Amounts paid or credited for SaveOnSP specialty drugs, listed at www.saveonsp.com/adventistrisk (unless you are *stationed* in an *included territory*), and any other amounts paid or credited for any drug under a drug manufacturer patient assistance program; for example, copay coupons (these are not true out-of-pocket costs)
- Amounts you pay for services listed in the Schedule of Benefits under "Ancillary Medical Benefits," such as alternative therapies, refractive eye surgery, hearing aids, and infertility treatment
- Amounts you pay for dental and vision benefits (except that amounts you pay for an under age 19 pediatric annual eye examination and one pair of standard, clear-lens, prescription glasses per child will apply toward your *out-of-pocket maximum*)
- Benefit reductions due to non-compliance with policy guidelines and expenses incurred due to non-compliance with *pre-certification*.

You will be required to continue paying your employee-share contributions even after the *Plan*'s annual out-of-pocket maximums are 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*.

Coinsurance and Copayments

For *PPO providers* and *PPO facilities*, the *usual, reasonable, & 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, & customary charge*) and therefore could owe more than your *copayment* plus your *coinsurance*. (See the Surprise Medical Bills Notice for details of when you should not receive a balance bill.)

After you pay your deductible, the *Plan* will pay 100% of the *usual, reasonable, & customary charge* for *covered services* less your required coinsurances and copayments.

The percentages the *Plan* pays apply only to *covered service* expenses that do not exceed *usual, reasonable & customary charges*. You are responsible for all *non-covered service* expenses. You are also responsible for any amount that exceeds the *usual, reasonable & customary charge for covered service* expenses (except for services subject to the *No Surprises Act*).

The Schedule of Benefits lists your *coinsurance* percentage of the cost of *covered services* (up to the *usual, reasonable, & customary charge*). *Coinsurance* 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 below chart is 20%, then for *in-network providers* your *coinsurance* would be 20% of the *network rate*.

Copayments are fixed dollar amounts of *covered service* expenses to be paid by the *enrollee*. *Copayments* apply per visit/admission/occurrence. If the *usual*, *reasonable*, & *customary charge* is less than the copayment, then the copayment is *usual*, *reasonable*, & *customary charge*. **Please note that fixed dollar copayments do not apply toward your annual deductible. Copayments accumulate towards annual member out-of-pocket annual maximums**.

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 certain 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:

- *Copayments* do not accrue toward deductible and apply only to the office visit charge.
- All other *Usual*, *Reasonable*, & *Customary (U&C)* charges for *covered services* 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 coinsurances and *copayments* until you reach the *Plan* 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"). See the Continuity of Care section of the Providers and Facilities Available Under the *Plan* chapter for short-term transition services available in limited circumstances when an *in-network provider/facility* leaves the *network*. The services listed in the "Ancillary Medical Benefits" chart are covered both *in-network* and *out-of-network*.
- Charges in excess of the *Usual*, *Reasonable*, & *Customary Charge* are member responsibility. **This means if you get care from an *out-of-network* provider, you may owe amounts in excess of your *copayment* and *coinsurance*.** (There are protections from balance billing in limited situations to the extent provided by the *No Surprises Act* for emergencies, air ambulances, and certain *out-of-network provider* services rendered in *in-network facilities*.)
- 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*.

For *employees stationed* in the *included U.S. territories* and their *eligible dependents* only, *out-of-network* services rendered in the *included territories* will be covered at the *in-network* cost sharing level. However, using an *out-of-network provider/facility* may expose *enrollees* to balance billing, so using a provider/facility contracted with the *Plan* is still advised, if available. (Please call Member Services at 888-276-4732 for assistance.)

MEDICAL BENEFITS

Benefits	Accelerate Option	Access Option	Out-of-Network *Usually Not Covered. Even If Covered, You May Be Subject To Balance Billing.*
	MEMBER RESPONSIBILITY *(If stationed in an included U.S. territory, see special rule above.)*		
DEDUCTIBLE • Individual/Family • Services subject to deductible are marked with (D) • Out-of-network services are usually not covered. When covered, deductible is same as plan option selected (Accelerate or Access). Amounts paid in excess of the *Usual, Reasonable, & Customary Charge* and/or amounts paid for services that are not covered out-of-network will not apply toward your deductible.	$375 / $750	$750 / $1,500	Accelerate: $375 / $750 Access: $750 / 1,500

Benefits	Accelerate Option	Access Option	Out-of-Network *Usually Not Covered. Even If Covered, You May Be Subject To Balance Billing.*
	MEMBER RESPONSIBILITY *(If stationed in an included U.S. territory, see special rule above.)*		
COINSURANCE (AFTER DEDUCTIBLE) PAID BY MEMBER	20%, unless otherwise noted	20%, unless otherwise noted	Out-of-network services usually not covered. When covered for the select items listed below, coinsurance will be 20% unless otherwise noted (and you may be subject to balance billing).
OUT-OF-POCKET MAXIMUMS • Individual/Family • Out-of-pocket maximum is same as plan option selected (Accelerate or Access), but applies only when services are covered out-of-network. Amounts paid in excess of the *Usual, Reasonable, & Customary Charge* and/or amounts paid for services that are not covered out-of-network will not apply toward your out-of-pocket maximum.	$2,950 / $5,900	$5,900 / $11,800	Accelerate: $2,950 / $5,900 Access $5,900 / $11,800 (applies only for services that are covered out-of-network)
PREVENTIVE SERVICES	0%	0%	Not covered
FACILITY / AMBULATORY SERVICES			
OUTPATIENT SERVICES (INCLUDES SERVICES/SUPPLIES RECEIVED AT OFFICE VISITS BEYOND OFFICE VISIT CHARGE) • *Pre-certification* required for some outpatient services (see the "Services Requiring Pre-Certification" section)	20% (D)	20% (D)	Not covered
INPATIENT / OUTPATIENT HOSPITAL STAYS / MATERNITY DELIVERY **OFFICE / AMBULATORY SURGICAL PROCEDURES** • *Pre-certification* required for all inpatient surgeries/stays (except for observation only and normal delivery in *a PPO facility* by a *PPO provider*) • *Pre-certification* required for most outpatient/ambulatory procedures (see the "Services Requiring Pre-Certification" section)	20% (D)	20% (D)	Not covered
ORGAN/TISSUE TRANSPLANTS • *Pre-certification* required • Approved services are limited to *in-network* Institutes of Excellence (see the "Organ/Tissue Transplant" section)	20% (D)	20% (D)	Not covered
PHYSICIAN/PROVIDER SERVICES			
OFFICE VISIT (APPLIES ONLY TO OFFICE VISIT CHARGE)	$25 copay	$50 copay	Not covered
SURGEON FEES AND PHYSICIAN FEES BEYOND OFFICE VISIT CHARGE • *Pre-certification* required for all inpatient *surgeries* • *Pre-certification* required for most outpatient/ambulatory procedures (see the "Services Requiring Pre-Certification" section)	20% (D)	20% (D)	Not covered

Benefits	Accelerate Option	Access Option	Out-of-Network *Usually Not Covered. Even If Covered, You May Be Subject To Balance Billing.*
	MEMBER RESPONSIBILITY *(If stationed in an included U.S. territory, see special rule above.)*		
THERAPEUTIC SERVICES – Rehabilitative & Habilitative **Physical Therapy** **Occupational Therapy** **Speech Therapy** • Maximum of 60 visits for any therapeutic category per plan year (unless extra visits are prior approved via additional medical *necessity review*)	20% (D)	20% (D)	Not covered
ABA Therapy •*Pre-certification* required	20% (D)	20% (D)	Not covered
VISION THERAPY • Maximum of 30 visits per plan year • *Pre*-certification required	20% (D)	20% (D)	Not covered
TELEHEALTH • Telehealth for medical services may be accessed through the *Plan*'s telehealth vendor (Amwell) or from a *PPO provider* appropriately licensed for these services • Telehealth counseling sessions for mental health and substance abuse/chemical dependency may be accessed through the *Plan*'s telehealth vendor (Amwell) or from a *PPO provider* appropriately licensed to provide and bill for the covered services or from an out-of-network provider. Member may be balance billed by the out-of-network provider.	$0 copay	$0 copay	$0 copay for counseling sessions for mental health and substance abuse/chemical dependency. **Any provider who is neither an Amwell provider nor a *PPO provider* is not covered, except for counseling sessions for mental health and substance abuse/chemical dependency.**
MATERNITY & OBSTETRICS	20% (D)	20% (D)	Not covered
EMERGENCY CARE			
EMERGENCY ROOM • Deductible does not apply if not admitted to the hospital* • If admitted, deductible applies, but *copayment* is waived • Emergency room visits are only covered when there is an *emergency medical condition*	20% after $100 copay (D)*	20% after $100 copay (D)*	20% after $100 copay (D)*
EMERGENT IN-PATIENT HOSPITAL ADMISSION • *Out-of-network* services are only covered for *emergency services* (and post-stabilization services to the extent coverage is required by the *No Surprises Act*), after which point *out-of-network* services will not be covered if the patient refuses transfer to an *in-network* facility	20% (D)	20% (D)	20% for *emergency services* (including post-stabilization services to the extent coverage is required by the *No Surprises Act*); then not covered (D)
AMBULANCE SERVICES • *Pre-certification* required for nonemergency ground transportation and for any air transportation (unless the *utilization review manager* determines that ground transportation would have endangered the life of the enrollee)	20% (D)	20% (D)	20% (D)

Benefits	Accelerate Option	Access Option	Out-of-Network *Usually Not Covered. Even If Covered, You May Be Subject To Balance Billing.*
	MEMBER RESPONSIBILITY *(If stationed in an included U.S. territory, see special rule above.)*		
URGENT CARE CENTERS • May be paid as either an office visit or as afacility visit according to provider contract • Deductible does not apply regardless of how billed • Facility fees for office visits are not paid	$25 – when billed as a physician office visit **Or** $100 + 20% – when billed as a facility visit	$50 – when billed as a physician office visit **Or** $100 + 20% – when billed as a facility visit	$25 or $50 copay (depends on selected Plan option) when billed as a physician office visit **Or** $100 + 20% – when billed as a facility visit
EQUIPMENT / SUPPLIES			
DURABLE MEDICAL EQUIPMENT (DME) • Benefits include purchase or rental, not to exceed the purchase price of the equipment • *Pre-certification* required for some DME items (see the "Services Requiring Pre-Certification" section) • Out-of-network DME benefits available • Requires physician/provider prescription • Applies to plan year deductible and out-of-pocket maximum	20% (D)	20% (D)	20% (D)
BREAST PUMP • *Pre-certification* required for breast pump expenses of $2,000 or more	0%	0%	0%
WIG AS A RESULT OF RADIATION, CHEMOTHERAPY, OR PATHOLOGICAL CHANGE IN THE BODY • Plan year maximum benefit $1,000	20%	20%	20%
MENTAL HEALTH / SUBSTANCE ABUSE			
MENTAL HEALTH COUNSELING SESSIONS Out-of-network behavioral practitioner care covered at usual and customary rates, member may be balance billed	$25	$50	$25 or $50, copay depends on selected Plan option
MENTAL HEALTH OUTPATIENT SERVICES / PARTIAL HOSPITALIZATION • *Pre-certification* required for intensive outpatient programs and some other outpatient services (see the "Services Requiring Pre-Certification" section). • *Pre-certification* required for partial hospitalization.	20% (D)	20% (D)	Not covered
MENTAL HEALTH INPATIENT SERVICES • *Pre-certification* required	20% (D)	20% (D)	Not covered
RESIDENTIAL CARE AND TREATMENT • *Pre-certification* required	20% (D)	20% (D)	Not covered
SUBSTANCE ABUSE/CHEMICAL DEPENDENCY COUNSELING SESSIONS Out-of-network behavioral practitioner care covered at usual and customary rates, member may be balance billed	$25	$50	$25 or $50, copay, depends on selected Plan option
SUBSTANCE ABUSE/CHEMICAL DEPENDENCY OUTPATIENT SERVICES • *Pre-certification* required for intensive outpatient programs and some other outpatient services (see the "Services Requiring Pre-Certification" section)	20% (D)	20% (D)	Not covered

Benefits	Accelerate Option	Access Option	Out-of-Network *Usually Not Covered. Even If Covered, You May Be Subject To Balance Billing.*
	MEMBER RESPONSIBILITY *(If stationed in an included U.S. territory, see special rule above.)*		
SUBSTANCE ABUSE/CHEMICAL DEPENDENCY INPATIENT TREATMENT • *Pre-certification* required	20% (D)	20% (D)	Not covered
TELEHEALTH • Telehealth counseling sessions for mental health and substance abuse/chemical dependency may be accessed through the *Plan*'s telehealth vendor (Amwell) or from a PPO provider or an out-of-network (OON) provider if available • OON telehealth counseling sessions are covered at usual and customary rates • Member may be balance billed by OON providers	$0 copay	$0 copay	$0 copay
OTHER SERVICES			
HEARING CARE PROFESSIONAL TESTING/SCREENING	20% (D)	20% (D)	Not covered
HOME HEALTH CARE • Maximum of 120 visits per plan year	20% (D)	20% (D)	Not covered
SKILLED NURSING FACILITY • *Pre-certification* required	20% (D)	20% (D)	Not covered
HOSPICE CARE • Deductible does not apply • Pre-certification required for in-patient hospice	0%	0%	0% Member may be balanced billed by out-of-network providers
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%	0%
NUTRITIONAL COUNSELING • Five visit annual limit (additional visits may be authorized by the *utilization review manager*) • *PPO provider* and *out-of-network* telehealth nutritional counseling available, copay applies for Access option	$0 copay	$10 copay	In-person and telehealth available – $0 or $10 copay, depends on selected Plan option
UNAVAILABLE SERVICES			
UNAVAILABLE SERVICES (When in-network medical services are not available) • Only covered with approved Unavailable Service Request Form • Deductible applies if it would apply to the same service if rendered *in-network**	N/A	N/A	20% if approved; otherwise not covered (D)*

ANCILLARY MEDICAL BENEFITS

Benefits	Accelerate Option	Access Option
	MEMBER RESPONSIBILITY (Deductible does not apply)	
ALTERNATIVE THERAPIES CHIROPRACTIC SERVICES •Limited to spinal manipulation after annual office visit and X-ray •Maximum visit limit per plan year = 15 •Must be age 10 or older • Does not apply to plan year deductible or out-of-pocket maximum Pre-certification required for additional visits over 15	20%	50%
ALTERNATIVE THERAPIES MASSAGE THERAPY •Maximum allowable charge is $90 per visit •Minimum of a 30-minute visit •Maximum visit limit per plan year = 15 •Must be age 18 or older • 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%
LIFESTYLE PROGRAMS Pivio (Previously CHIP) WW (Weight Watchers) • 1 completed session/program per plan year, online or in-person • Physician prescription required with claim submission • Member will be reimbursed upon producing a receipt for covered service • Does not apply to plan year deductible or out-of-pocket maximum • Proof of 80% completion required as a condition of coverage	0% with proof of 80% completion	Only Pivio is covered (with 0% member cost-sharing with proof of 80% completion) WW is not covered

DENTAL BENEFITS – ACCELERATE OPTION

Benefits	In-Network*	Out-of-Network
	MEMBER RESPONSIBILITY	
PLAN YEAR DEDUCTIBLE • Individual/Family • Deductibles accumulate separately for in-network and out-of-network services.	$100 / $300	$150 / $450
COINSURANCE (AFTER DEDUCTIBLE)	20%	25%
ANNUAL MAXIMUM PAYABLE BENEFIT PER PLAN YEAR • Individual	$2,500	
DENTAL CARE PREVENTIVE CARE • Deductible does not apply • Does apply to plan year annual maximum payable benefit, except for pediatric (under age 19) preventive dental care	0%	0%
DENTAL CARE RESTORATIVE CARE • Applies to correlating plan year deductible	20%	25%
ORTHODONTIC CARE • $2,300 maximum lifetime payable • Eligible up to age 26 (through age 25)	50%	

*For *employees* (and their dependents) *stationed* in the *included U.S. territories*, “in-network” includes all dental *professional providers* rendering services within the scope of their license within the *included territories*.

VISION BENEFITS – ACCELERATE OPTION

Benefits	NO NETWORK REQUIRED
	MEMBER RESPONSIBILITY
VISION CARE • No deductible • Plan year annual maximum payable benefit $450 per member • Annual maximum payable does not apply to pediatric annual eye examination and one pair of standard, clear-lens, prescription glasses per plan year for those under age 19	20%

PRESCRIPTION BENEFITS – ACCELERATE OPTION

Prescription Drug	
Out-of-Pocket Maximums Individual/Family	$1,250 / $2,500
Prescription copayment responsibility*	
30 DAY SUPPLY – short term drugs **Tier 1 - Chronic Preventive Generics** $2 **Tier 1 – Other Generics** $10 **Tier 2 - Preferred Brand** $25 **Tier 3 - Non-Preferred Brand** $45	**90 DAY SUPPLY – long term maintenance drugs (via Walgreen's Smart90, Express Scripts Home Delivery, or Accredo Specialty Pharmacy)** **Tier 1 - Chronic Preventive Generics** $4 **Tier 1 – Other Generics** $20 **Tier 2 - Preferred Brand** $50 **Tier 3 - Non-Preferred Brand** $90

- This benefit only covers formulary supplies/services received from Express Scripts (ESI) or from a pharmacy contracted with ESI
- Copayments apply to the prescription benefit out-of-pocket maximum, except as noted for the SaveOn Specialty Program
- Penalties for non-compliance do not apply toward *plan year* out-of-pocket maximum
- The *Plan* pays 100% (and Members pay $0) for some chronic 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**)
- Plan members pay a lower copay ($2 copay per 30-days' supply or $4 per 90-days' supply) for certain chronic preventive generics used to treat osteoporosis, depression, diabetes, high blood pressure, and high cholesterol, etc
- See below for *coinsurance* for certain drugs offered through the SaveOnSP Specialty Drugs Program (not applicable to *employees stationed* in the U.S. *territories* and their dependents; *copayments* in the chart above will apply to such *enrollees*)
- The Walgreens Smart90 retail program and SaveOnSP Program are not available for *employees stationed* in the U.S. *territories* (and their dependents)
- Mail order through the Accredo Specialty Pharmacy and use of the Medical Channel Management Program are not required for *employees stationed* in the U.S. *territories* (and their dependents)
- 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

Specialty Drugs

Specialty drugs can only be filled via mail order through Accredo Specialty Pharmacy (see www.accredo.com for details). For most specialty drugs, the *copayments* listed in the chart above will apply (but see the SaveOnSP Specialty Drugs Program section below for exceptions). Certain infusion or injectable specialty drugs are available only through the Medical Channel Management Program (see the Benefits Description – Prescription Drugs chapter for details).

SaveOnSP Specialty Drugs Program

A list of SaveOnSP Specialty Drugs may be found at www.saveonsp.com/adventistrisk

Coinsurance for these drugs is set at 30%. **However, if you sign up for the SaveOnSP Program, your out-of-pocket cost will be set by the *Plan* at $0 and you will not be required to pay anything for the drug.**

If you do not sign up for the SaveOnSP Program, then you will not have your out-of-pocket cost set by the *Plan* at $0, you will have to pay a high *coinsurance* for the drug (which is eligible for assistance from the drug manufacturer), and any amount you pay will not apply to your *Plan* deductible or your *Plan* prescription drug out-of-pocket maximum (because drugs eligible for the SaveOnSP Program are not considered ACA essential health benefits).

DENTAL BENEFITS – ACCESS OPTION

Benefits	In-Network*	Out-of-Network
	MEMBER RESPONSIBILITY	
PLAN YEAR DEDUCTIBLE • Individual/Family • Deductibles accumulate separately for in-network and out-of-network services.	$250 / $750	$500 / $1,500
COINSURANCE (AFTER DEDUCTIBLE)	20%	50%
ANNUAL MAXIMUM PAYABLE BENEFIT PER PLAN YEAR • Individual	$2,500	
DENTAL CARE PREVENTIVE CARE • Does not apply to plan year deductible • Does apply to plan year annual maximum payable benefit, except for pediatric (under age 19) preventive dental care	0%	0%
DENTAL CARE RESTORATIVE CARE • Applies to correlating plan year deductible	20%	50%
ORTHODONTIC CARE • $2,300 maximum lifetime payable • Eligible up to age 26 (through age 25)	50%	

*For *employees* (and their dependents) *stationed* in the *included U.S. territories*, "in-network" includes all dental *professional providers* rendering services within the scope of their license within the *included territories*.

VISION BENEFITS – ACCESS OPTION

Benefits	NO NETWORK REQUIRED
	MEMBER RESPONSIBILITY
VISION CARE • No deductible • Plan year annual maximum payable benefit $225 per member • Annual maximum payable does not apply to pediatric annual eye examination and one pair of standard, clear-lens, prescription glasses per plan year for those under age 19	20%

PRESCRIPTION BENEFITS – ACCESS OPTION

Prescription Drug	
Out-of-Pocket Maximums Individual/Family	$1,550 / $3,100
Prescription copayment responsibility*	
30 DAY SUPPLY – short term drugs **Tier 1 - Chronic Preventive Generics $2** **Tier 1 – Other Generics $10** **Tier 2 - Preferred Brand $55** **Tier 3 - Non-Preferred Brand $105**	**90 DAY SUPPLY – long term maintenance drugs (via Walgreen's Smart90, Express Scripts Home Delivery, or Accredo Specialty Pharmacy)** **Tier 1 - Chronic Preventive Generics $4** **Tier 1 – Other Generics $20** **Tier 2 - Preferred Brand $110** **Tier 3 - Non-Preferred Brand $210**

- This benefit only covers formulary supplies/services received from Express Scripts (ESI) or from a pharmacy contracted with ESI
- Copayments apply to the prescription benefit out-of-pocket maximum, except as noted for the SaveOn Specialty Program
- Penalties for non-compliance do not apply toward *plan year* out-of-pocket maximum
- The *Plan* pays 100% (and Members pay $0) for some chronic 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**)
- *Plan* members pay a lower copay ($2 copay per 30-days' supply or $4 per 90-days' supply) for certain chronic preventive generics used to treat osteoporosis, depression, diabetes, high blood pressure, and high cholesterol, etc.
- See below for *coinsurance* for certain drugs offered through the SaveOnSP Specialty Drugs Program (not applicable to *employees stationed* in the U.S. *territories* and their dependents; *copayments* in the chart above will apply to such *enrollees*)
- The Walgreens Smart90 retail program and SaveOnSP Program are not available for *employees stationed* in the U.S. *territories* (and their dependents)
- Mail order through the Accredo Specialty Pharmacy and use of the Medical Channel Management Program are not required for *employees stationed* in the U.S. *territories* (and their dependents)
- 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

Specialty Drugs

Specialty drugs can only be filled via mail order through Accredo Specialty Pharmacy (see www.accredo.com for details). For most specialty drugs, the *copayments* listed in the chart above will apply (but see the SaveOnSP Specialty Drugs Program section below for exceptions). Certain infusion or injectable specialty drugs are available only through the Medical Channel Management Program (see the Benefits Description – Prescription Drugs chapter for details).

SaveOnSP Specialty Drugs Program

A list of SaveOnSP Specialty Drugs may be found at www.saveonsp.com/adventistrisk

Coinsurance for these drugs is set at 30%. **However, if you sign up for the SaveOnSP Program, your out-of-pocket cost will be set by the *Plan* at $0 and you will not be required to pay anything for the drug.**

If you do not sign up for the SaveOnSP Program, then you will not have your out-of-pocket cost set by the *Plan* at $0, you will have to pay a high *coinsurance* for the drug (which is eligible for assistance from the drug manufacturer), and any amount you pay will not apply to your *Plan* deductible or your *Plan* prescription drug

out-of-pocket maximum (because drugs eligible for the SaveOnSP Program are not considered ACA essential health benefits).

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 for at least one complete *standard measurement period*.

ACA New Part-Time Employee means a new *employee* whom, based on the facts and circumstances on the employee's first day of *active employment*, the *employee* 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* 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 a *participating employer*, either at one of the *participating employer*'s regular places of business or at some location to which the *participating employer's* business requires you to travel to perform your regular duties or other duties assigned by your *participating employer*. 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 *participating employer* 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 also handles non-prescription drug appeals of *adverse benefit determinations* involving *medical judgment*.

Adventist Health Benefits Administration
PO Box 92010
Portland, OR 97292
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).

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 (i) an individual named on a completed Appointment of Authorized Representative form that is submitted by a *claimant*, (ii) a *physician* or *professional provider* with knowledge of the *claimant*'s *medical condition* (e.g., the *claimant*'s treating *physician*) or the *facility* where the *claimant* is/was treated, unless the *claimant* provides specific written direction otherwise, and (iii) an *employee* for his or her *covered dependent* who is under age 18. 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.

Coinsurance means the shared percentage cost of *covered services* that the *enrollee* pays.

Copayment 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 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 §54.9816-4T(c)(2)(i), or any successor law or regulation, with respect to an *emergency medical condition*, an appropriate medical screening examination which is within the capability of the emergency department of a *hospital* (or an independent freestanding emergency department), 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* (or the independent freestanding emergency department), 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 *copayments* or *coinsurance* 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*.

Facility means a *hospital*, *hospice facility*, *skilled nursing facility*, or mental health or *substance abuse* residential facility.

Final Internal Adverse Benefit Determination means the *Plan's adverse benefit determination* made after considering the final internal appeal of a denial of a *claim*.

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.

Included Territory(ies), ***Included U.S. Territory(ies)***, or ***Territory(ies)*** means the United States territories covered by this *Plan*, which are Guam and the Northern Mariana Islands.

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 (except where otherwise defined by your *participating employer*) 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 (except where otherwise defined by your *participating employer*) 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 (except where otherwise defined by your *participating employer*) 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 Judgment – Determinations involving *medical judgment* include, but are 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; the *Plan's* determination that a treatment is experimental or investigational; whether an *enrollee* is entitled to a reasonable alternative standard for a reward under a wellness program; or whether the *Plan* is complying with the nonquantitative treatment limitation provisions of Code Section 9812 and Regulation Section 54.9812 (which generally require, among other things, parity in the application of medical management techniques).

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 *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 (*i.e.*, diagnoses related to family problems, illegal behavior, low income, loneliness, abuse, neglect, deployment, imprisonment, discrimination, lifestyle, etc.), or any successor volumes.

(ii) Diagnosis or the treatment of any conditions with the following ICD-10 Classification of Mental and Behavioral Disorders codes: F06.0, F06.8, F60.9, F65.4, F65.1, F65.2, F64.2, R37, F52.0, F52.21, F528, F52.31, F52.32, F52.4, F52.6, F52.1, F65.0, F65.3, F65.51, F65.52, F64.1, F65.81, F66, F65.9, F98.4, F63.3, R45.1, F91.9, F63.9, F63.0, F63.2, F63.1, F63.81, F81.0, F81.2, F81.81, F81.89, F80.89, F54.

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*.

No Surprises Act **means** the "No Surprises Act," which was enacted to curtail "surprise billing" in Title I of Division BB of the Consolidated Appropriations Act of 2021, including the regulations and binding guidance issued thereunder, which generally governs patient cost sharing, balance billing, and payments to providers/facilities for *emergency services* (including certain post-stabilization care) rendered in *out-of-network facilities*, services rendered by *out-of-network providers* in *in-network facilities*, and services rendered by air ambulance providers. (For more details, see the Surprise Medical Bills Notice.)

Out-of-Network Facilities refers to any health care facility that is not an *in-network facility*. With the exception of *emergency services* (including certain post-stabilization care subject to the provisions of the *No Surprises Act*), *urgent care*, and approved Unavailable Service Request Form services, care received at *out-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* including emergency ground ambulance transportation, and including emergency air ambulance transportation (but only with *pre-certification* or when ground transportation would endanger the life of the member);

(ii) *Urgent care*;

(iii) Approved Unavailable Service Request Form ("USRF") services;

(iv) Service received at an *in-network facility* that is prescribed by a *PPO provider* (in which case the service will be covered at the PPO level even if performed by an *out-of-network provider*);

(v) Any other *medically necessary covered service* if coverage is required by the *No Surprises Act*; and

(vi) Service received in an *included territory* by an *employee stationed* in an *included territory* (or the *employee*'s *eligible dependent*).

The *Plan* recognizes at times the Medical/Dental PPO Networks may not have PPO Providers accessible to members that deliver needed medical/dental care. There are times members through the Unavailable Services Request Form (USRF) Pre-Certification process will receive approval for medical services from an Out-of-Network Provider or Out-of-Network Facility. Similarly, the USRF process may be used to obtain approval to use an Out-of-Network dental provider with In-Network cost sharing-requirements. While the following is not an exhaustive list, these are guidelines the *Plan* will use in determining approval of USRF.

- Medical Necessity
- Availability of providers who are in the PPO relative to the members home or work address
    - For rural areas the distances of Medical/Dental PPO Network Providers within approximately 25 miles, or approximately 35-40 minutes driving.
    - For metropolitan areas the distance of Medical/Dental PPO Network Providers within approximately 10 miles or approximately 35-40 minutes of driving.

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, inclusive of the General Conference of Seventh-day Adventists and its subsidiaries and affiliates, 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. *Participating 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 Plan for Employees of the Seventh-day Adventist Church Organizations based in the United States, Guam, and the Northern Mariana Islands.

Plan Administrator means the North American Division of Seventh-day Adventists. The *plan administrator* 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. The *plan administrator* may delegate any of these duties as it deems reasonable and appropriate, and the *plan administrator* has delegated its plan administrative duties to Adventist Risk Management ("ARM") and has authorized ARM to further delegate plan administrative duties to other entities. In administering the *Plan*, the *plan administrator* (including its delegate, ARM, and ARM's delegates) shall be guided by and adhere to the teachings and tenets of the Seventh-day Adventist Church. When the term "*plan administrator*" is used in this *Plan*, it generally refers to ARM in its role as the delegate of the North American Division of Seventh-day Adventists.

Plan Sponsor is the North American Division of Seventh-day Adventists; however, solely for certain purposes of the privacy obligations under Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and *Plan* financial liability, your *participating employer* is the *plan sponsor* for its piece of the *Plan*.. *Plan sponsor* status for HIPAA or financial liability purposes does not entitle a *participating employer* to access to your PHI or with the right to modify the terms of the *Plan*.

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* (for a list of contracted providers and facilities, please go to www.aetna.com/asa or call 888-276-4732). For *employees* (and their dependents) *stationed* in the *included territories* (and for other *enrollees* receiving *emergency services* in the *included territories*), the term "PPO Network" includes providers and facilities with which the *Plan* has contracted directly to provide *covered services* to *Plan enrollees* (for help locating such providers and facilities, please call 888-276-4732 or go to www.AscendtoWholeness.org).

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*.

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 Under Another Employer Plan. You or your *eligible dependent* is entitled to make a change to coverage (or the coverage of another of your *eligible dependents*) under an employer's plan due to a permitted election change or during the other employer's 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, *copayment*, 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.

- Enrollment in Another Plan Due to Reduction in Hours: If you had been reasonably expected to average at least 30 hours of service per week, and your hours have been reduced so that you now are expected to average fewer than 30 hours per week.

- Enrollment in a Marketplace Plan: You or a covered family member become eligible mid-year to enroll in a Marketplace plan (i.e., coverage on the health insurance Exchange) and that individual intends to enroll in a Marketplace plan that is effective the day following the election to drop coverage under this Plan.

Respite Care is temporary relief for the usual family caregiver of a covered *Plan member* who is receiving *hospice* care at home so long as the services constitute "medical care" within the meaning of Code Section 213(d) which can include such things as medication administration, changing dressings, bathing, and grooming but not general household services, such as doing dishes and laundry.

SPD means Summary Plan Document. See the Welcome chapter.

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 (except where otherwise defined by your *participating employer*) 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).

Stationed means assigned to work in a physical geographic location by your *participating employer* with the intention that you will work in that physical geographic location for at least six months.

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.

Telehealth benefit provides access to board-certified doctors through the *Plan's* contracted vendor, Amwell. Amwell provides *in-network* benefits for *covered services*, and their providers are available 24 hours a day using your phone, tablet, or computer. Telehealth benefits are also available through any *PPO provider,* and, in the case of *mental health services* and nutritional counseling, *out-of-network providers* (as long as the *PPO provider* or *out-of-network provider,* is appropriately licensed and has the appropriate technology to provide and bill for the *covered service*). A *telehealth* visit is a substitute for an in-person office visit with a provider using electronic information and telecommunications technologies such as videoconferencing, internet, streaming media, and terrestrial and wireless communications. Telephone consultations and routine phone calls with your provider (for example, follow-up calls with your doctor to go over lab test results or to request prescription drug refills) are not *telehealth* visits and are not a *covered service* of the *Plan*. For more information, go to ascendtowholeness.org.

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/facilities*, 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 80th 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 (except that the *U&C* for anesthesia is a flat rate). 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.

In the event a claim is received from an *out-of-network facility/provider* and there is no *U&C* for the services provided, the claim will pay at no more than 120% of Medicare.

For unlisted CPT codes ending in "99" for which there is no *U&C* for the service provided and no Medicare rate, the *U&C* will be 50% of billed charges.

In the event a claim is received for *emergency services* rendered outside of the United States, the billed charges will be considered the *U&C* for the services rendered unless the *plan administrator* or its delegate determines that the billed charges are unreasonable when compared to the charges submitted or made for similar services or supplies provided by other providers with like experience, education and training in the same country.

Notwithstanding the above, if a different rate is negotiated between an *out-of-network provider/facility* and the *plan administrator*, the *PPO Network*, or their delegates, then that negotiated rate will be used and will be considered the *U&C* for the services rendered that are subject to such different negotiated rates.

For purposes of *emergency services* rendered in the United States and any other services covered by the *No Surprises Act*, the "recognized amount" (as defined by the *No Surprises Act*) will be the *U&C* unless a different amount is negotiated per the above paragraph or unless a different amount is determined at independent dispute resolution (in which case such different amount will be the *U&C*).

(ii) 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.

(iii) 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.

(iv) 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. Adventist Health Benefits

Administration also hears non-prescription drug appeals of *adverse benefit determinations* involving *medical judgment*.

Eligibility, Enrollment and End of Coverage

ELIGIBILITY FOR THE ACCELERATE AND ACCESS OPTIONS

Both *Plan* options encourage active participation in wellness, health coaching and care coordination. For this purpose, all *enrollees* age 18 and older are eligible to use the wellness platform (but the wellness requirements/rewards described below apply only to *employees* and their *spouses*).

If you are *enrolled* in the *Plan* in 2025, then in order to enroll in the Accelerate option of this *Plan* for 2026, you and your *enrolled spouse dependent* (if applicable) must each earn 10,000 wellness participation points or reach Level 1 during the period of August 1, 2024 through July 31, 2025. (Points will be prorated if you initially enroll in this *Plan* on April 1, 2025 or later; and the point requirement will be waived if you initially enroll in this *Plan* on July 1, 2025 or later.) Wellness participation points may be earned by engaging in participatory activities, such as healthy lifestyle habits (e.g., tracking your healthy habits or sleep), participating in general health education opportunities via the wellness portal, or obtaining preventive care (e.g., dental cleanings or vaccinations). You may also earn points in additional ways, such as walking, but this is not required in order to earn enough points for an incentive or to enroll in the Accelerate option.

Additionally, the following wellness resources are made available to all members and you may earn points for participating (but participation is not required in order to earn enough points for an incentive or to enroll in the Accelerate option):

1. **Health Check Survey**; You may complete a free online wellness assessment called a Health Check Survey. The online Health Check Survey is a secure online tool that you use to provide information about your health and can be accessed on the Wellness Platform at www.ascendtowholeness.org. After you complete the Health Check Survey, 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.

2. **Biometric Screening**; You can complete your free Biometric Screening with a physician and in-network lab. 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.

You do not need to undergo a wellness assessment or biometric screening in order to enroll in the Accelerate option. And if you choose to complete the health check survey or biometric screening, you will not be required to take any further action based on the results of your health check survey or biometric screening.

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* if based in the United States or one of its *included territories*, 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 (for example, this might occur because you are working in the United States on a visa/work permit) or you refuse to disclose the dependent's Social Security number to the *Plan*, you can obtain coverage for the dependent by (i) annually completing the Center for Medicare and Medicaid Services HICN/SSN form (or any successor form), and (ii) executing a form wherein you both certify 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 and agree to indemnify 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 *participating employer* or other 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 (if you enroll within the 30-day period) 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 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 submit a completed electronic form, or alternatively, complete and sign a paper enrollment form and submit 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 60 days, for a newborn or newly adopted *child* (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 applicable 30-day or 60-day (newborn and newly adopted *children* only) 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 60 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 60 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.

Cash in Lieu of Health Coverage under the Plan

A *participating employer* may choose (but is not required) to offer its *employees* who opt out of coverage under the *Plan* a cash payment in lieu of health coverage. If your *employer* offers this option, then your *employer* will communicate the option and the amount of "cash in lieu" payment for the upcoming *plan year* prior to the start of the *plan year*. Note that a *participating employer* may only offer a cash in lieu payment to an *employee* who certifies that he or she is enrolled in major medical coverage under another employer plan, such as a major medical plan offered through a *spouse's* employer. If your *employer* offers a cash payment in lieu of health coverage and you elect that option, then you may only change your election during open enrollment or if you have a *qualifying status change* as described below.

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 60 days, for a newborn or newly adopted *child* (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 60 days, for a newborn or newly adopted *child* (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 your *employer*'s human resources department and complete and return any required forms within 30 days or 60 days, for a newborn or newly adopted *child,* 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 *employer*'s human resources department 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*.

An *employee* who participates in the *Plan* in the 2025 *plan year*, may only elect the Accelerate option of this *Plan* for 2026 if the *employee* and the *employee*'s *enrolled dependent spouse* (if applicable) each earned 10,000 wellness participation points during the period of August 1, 2024 through July 31, 2025. (Points will be prorated if you initially enroll in this *Plan* on April 1, 2025 or later; and the point requirement will be waived if you initially enroll in this *Plan* on July 1, 2025 or later.)

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 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. However, 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*. And in no event may the combined maximum benefits for you and/or your *spouse* and your *dependents* exceed 100% of the *usual, reasonable, & 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 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, and annually thereafter if requested by the *plan administrator*. 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, see below) 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) **Uniformed Services Employment and Reemployment Rights Act of 1994 ("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 as state law permits, the day your employment ends with a pro rata return of *employee-share contributions* already collected;
- the date your employment with your *employer* ends, if so elected by your *employer* and your coverage has been fully *employer* paid; 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 (and outside of the *territory* in which you are *stationed*, if you are *stationed* within an *included U.S. territory*). (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* has a policy to offer such coverage to all of its terminating *employees* who were enrolled in the *Plan*. The coverage may be granted for a period of up to the end of the second full calendar month after the month in which the *employee*'s coverage would otherwise terminate, 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).

Notwithstanding the above, if any required contribution for continuation coverage is not paid within 30 days of the due date for such contribution, continuation coverage will terminate immediately.

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.

Depending on your state or *territory* of residence, the provisions of this Continuation Coverage section may be superseded by law, and you may be entitled to additional benefits.

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* may be different for *full-time employees*, for those *employees* who are not categorized by their *employer* as full time (but are *ACA full-time employees*), and for those *employees* on certain leaves of absence or continuation coverage.

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 Member Services at (888) 276-4732.

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*. If the *Plan* determines that an admission, treatment or service is not *medically necessary*, then the admission, treatment or service will not be covered.

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, emergency room, or via *telehealth*.

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 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* via Member Services at 888-276-4732 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*. If you or your provider do not notify the *Plan* in accordance with this paragraph, then only *emergency services* (and certain post-stabilization services required to be covered by the *No Surprises Act*) will be covered.

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. This means that if you do not receive *pre-certification* for such service, you and/or your provider will not receive payment and so you will be responsible for any expense incurred.

You or your provider should call the *utilization review manager* at the phone number on 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 generally follows the guidelines set forth by the Milliman Care Guidelines (MCG) Health and Aetna in determining *medical necessity* and appropriateness of services. However, in so doing, the *Plan's utilization review manager* has discretionary authority to use other resources in addition to those already mentioned in determining *medical necessity*.

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.

1. All inpatient admissions and services (except for observation only of 72 hours or less in a *PPO facility* by a *PPO provider* and normal delivery in a *PPO facility* by a *PPO provider*);

2. All inpatient surgeries;

3. Specialty provider consultations and office visits with a non-*PPO provider* and/or in a non-*PPO facility*;

4. Maternity and pregnancy related care that is not preventive (as specified in Appendix A), routine pregnancy care (as specified at https://www.guideline.gov/summaries/summary/38256), or delivery with a hospital stay of up to 48 hours following a normal vaginal delivery or 96 hours following a cesarean delivery (normal delivery requires *pre-certification* if by a non-*PPO provider* and/or in a non-*PPO facility*);

5. Reserved

6. Reserved

7. Artificial pancreas device system and supplies;

8. Cardiac event recorder (implantable);

9. Cardiac Center of Excellence (CCOE) benefits (including surgery, related services, and travel/lodging);

10. Ventricular assist devices (including left ventricular assistive device (LVAD));

11. Artificial heart procedure and accessories

12. Treatment for temporomandibular disorders (non-surgical);

13. Dopamine Transporter Imaging Single-Photon Emission Computed Technology (DAT-SPECT);

14. Photochemotherapy (PUVA);

15. Autologous chondrocyte implantation, autologous chondrocyte transplantation, or osteochondral allograft;

16. High cost/specialty medications billed by the provider through the medical benefit require *pre-certification* though the *utilization review manager* (Adventist Health Benefits Administration). Examples of high cost/specialty medications commonly billed though the medical benefit by the provider are office-administered injectable medications, infusion therapy, chemotherapy, and home infusion therapy. (Some selected therapies intended for acute use, such as IV hydration and IV antibiotics, do not require *pre-certification*.) High cost/specialty medications processed through the pharmacy benefit (such as self-

injectable, oral medications, and certain infusion medications) require *pre-certification* through pharmacy benefit manager (Express Scripts);

17. Implantable infusion pumps for pain/spasms;

18. Genetic testing, except for standard prenatal testing for all pregnancies (i.e., aneuploidy, cystic fibrosis, spinal muscular atrophy and hemoglobinopathies);

19. Reserved

20. Endobronchial brachytherapy;

21. Transcranial magnetic stimulation (TMS) as treatment of depression and other psychiatric/neurologic disorders;

22. All plastic, cosmetic, or reconstructive surgery, including orthognathic surgery, and cosmetic procedures except initial breast reconstruction following medically necessary mastectomy;

23. Removal of breast implants or other prosthetic implants that were implanted for cosmetic purposes;

24. Nail debridement;

25. Pectus deformity repair;

26. Scar revision;

27. Varicose vein procedures (e.g., sclerotherapy, echosclerotherapy, endovenous ablation RF or laser, ligation, stab phlebectomy);

28. Pneumatic compression devices and garments;

29. Laser treatment for inflammatory skin disease (such as psoriasis, dermatitis, vitiligo;

30. Reserved

31. Continuous glucose monitoring (CGM) receivers and supplies;

32. Insulin pumps;

33. Assistive listening devices, FM/DM systems;

34. Bath/shower chairs, rails, transfer benches, ;

35. Spinal cord stimulation;

36. Kyphoplasty or vertebroplasty;

37. Artificial discs, cervical and lumbar;

38. Transplants (including workup);

39. Acute inpatient rehabilitation and/or skilled nursing facility admissions;

40. Cognitive rehabilitation;

41. Applied behavioral analysis (ABA) therapy;

42. Developmental, behavioral, neuropsychological, neuroCl testing – outside of a pediatrician's office;

43. Outpatient Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST), for habilitative and rehabilitative therapeutic services for visits beyond 60 in one year for any single therapeutic service category will require prior approval via additional *medical necessity* review;

44. Electroencephalogram, if performed as an inpatient, multi-day test;

45. External counterpulsation (EECP);

46. Oscillatory devices for respiratory disease (The Vest);

47. UV light therapy (including light therapy for Seasonal Affective Disorder); home UV light systems, and light boxes;

48. All inpatient behavioral health services, including psychiatric, detoxification and substance use disorder treatment. All partial hospitalization programs; residential psychiatric, substance use disorder or concurring psychiatric and substance use disorder treatment facilities; and intensive outpatient programs;

49. Durable medical equipment or repair with billed charges of $2,000 or more, all continuous passive motion (CPM) devices/machines, insulin pumps, continuous glucose monitor (CGM) and Dynasplints (regardless of cost);

50. Hospital beds with billed charges of $2,000 or more;

51. Prosthetics/orthotics and custom molded orthotics;

52. Radiofrequency ablation, except for pain management; microwave tumor ablation and radioembolization of tumors;

53. Mammography 3D Tomosynthesis screening if under the age of 40;

54. Sacral nerve stimulation (implanted) for pelvic floor dysfunction;

55. Sacroiliac joint fusion;

56. Sacrocolpopexy;

57. Vagus nerve stimulation;

58. Implantable intrastromal corneal ring;

59. Wound vacuum, canisters and dressings supplies;

60. Non-emergency ground ambulance transportation, except if hospital-to-hospital, and any air transportation (unless the *utilization review manager* determines that ground transportation would have endangered the life of the enrollee);

61. Any nonspecific codes (procedures and HCPCS codes ending in 99);

62. Surgical treatment of snoring and obstructive sleep apnea; laser-assisted uvulopalatoplasty (UPPP);

63. Back surgery (inpatient);

64. Bariatric surgery (all), including revision, replacement, reversal, or conversion;

65. Oral devices for sleep apnea if charges exceed $2,000;

66. Botox injections; dermal filler injections;

67. Reserved

68. Dental anesthesia when covered as a medical service (except for pediatric sedation);

69. Inpatient or facility hospice services;

70. Hyperbaric oxygen therapy;

71. Corneal collagen cross linking;

72. Vision therapy (orthoptics);

73. Abortion (also referred to as termination of pregnancy) will be reviewed for consistency with the coverage requirements set forth in the Benefits Description chapter which are based on Seventh-day Adventist Church teachings, and a Care Manager may be assigned to conduct a consultation;

74. Elective surgery for the prevention of cancer; and

75. Gene therapy and associated administration services.

If you are not sure whether your provider has requested *pre-certification*, you should call the *utilization review manager* via Member Services at 888-276-4732 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 *copayment* waived.

Care Management

Special care management is designed to help manage the care of patients who have special or extended care *illnesses* or injuries.

The primary objective of special care management is to identify and coordinate cost-effective medical care alternatives meeting accepted standards of medical practice. Special care management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among health care providers, patients and others. Patients are identified as possible candidates for care management using the following criteria:

(i) Patients with diagnoses including cancer, HIV/acquired immunodeficiency, degenerative nerve diseases, burns, major trauma, cystic fibrosis, high risk pregnancy and birth, depression, COPD, diabetes, infectious processes, GI disorders and complex co-morbidities;

(ii) Patients with very high-cost medical expense; or

(iii) Patients identified through the utilization management process, by their provider, or by themselves.

The Care Manager will contact *enrollees* to talk about the patient's condition, to offer educational information, and to identify available medical resources. The Care Manager will complete a comprehensive health assessment and enroll the *enrollee* in care management if appropriate. The Care Manager will work with the enrollee, family, physicians, and professional providers to optimize the enrollee's use of medical benefits and help the *enrollee* and family take charge of the enrollee's health and medical care. An individualized Care Management plan will be developed for the *enrollee* in collaboration with the *enrollee*, the Care Manager, Medical Director and/or Medical Advisor. The Care Manager follows the care and treatment of the patient enrolled in care management to verify that: recommendations to physicians and professional providers are followed, medical appointments are kept, the patient receives all necessary and appropriate medical treatment timely, the treatment is medically necessary and appropriate, that medical treatment is received in-network whenever possible (out-of-network providers and/or out-of-network facilities may be utilized as part of the treatment on an exception basis, but only with prior authorization and an approved Unavailable Service Request Form); and facilitates the provision of necessary and appropriate treatment of the patient. The Care Manager is available to talk with the patient and family to answer their questions and to facilitate the provision of needed support.

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 (unless they are certain post-stabilization services specifically required to be covered by the *No Surprises Act*). The expenses you incur for refusing medical transfer will not be applied to your deductible or out-of-pocket maximums (unless application to your deductible or out-of-pocket maximum is required because the services are subject to the *No Surprises Act*).

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 *utilization review manager* 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.

UNAVAILABLE SERVICES REQUEST PRIOR-AUTHORIZATION PROCESS

- **Member must contact the *utilization review manager* via Member Services at 888-276-4732 and request an Unavailable Service Request Form.**
- **Member should work with Provider to complete and return form.**
- **Approval of the Unavailable Service Request Form (letter of agreement) may take up to 30 calendar days.**
- **Final determination and meeting response time above is contingent on timely responses from the Provider and member.**

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*.

Your choice of providers/facilities may be subject to care management. See the Care 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 and the Surprise Medical Bills Notice.

Employees stationed in the *included U.S. territories* and their *eligible dependents* may choose to receive provider and facility medical services from any providers/facilities in the *included U.S. territories*. (But note that the use of pharmacies contracted with ESI is still required in the *territories*.)

Primary Care Provider

The *Plan* does not require you or your *covered dependents* to designate a primary care provider (PCP).

Membership Card

After enrolling, you and your *covered dependents* will receive your benefit ID card which will include your identification number 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 Member Services 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 and approved (via an Unavailable Service Request Form) 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. If you or your provider do not notify the *Plan* as required by this section, then only *emergency services* (and certain post-stabilization services required to be covered by the *No Surprises Act*) will be covered.

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, *copayments* or *coinsurance* under the *Plan*.

Continuity of Care

You may be eligible to continue care with a facility or provider that leaves the *PPO Network* (or if there is a change in the contract with that facility or provider that would terminate or result in a loss of your benefits with respect to the facility or provider) if you are a "continuing care patient" of that facility or provider at the time the facility or provider leaves the *PPO Network* (or at the time the contract change is effective). This provision does not apply if the contract for the facility or provider is terminated for failure to meet applicable quality standards or for fraud.

A "continuing care patient" is someone who, with respect to a specific facility or provider, is: (i) undergoing a course of treatment from that facility or provider for a "serious and complex condition," (ii) undergoing a course of institutional or inpatient care from that facility or provider, (iii) scheduled to undergo nonelective surgery from that facility or provider (including the receipt of postoperative care with respect to such surgery), (iv) pregnant and undergoing a course of treatment for the pregnancy from that facility or provider, or (v) terminally ill (or was terminally ill) as determined under Section 1861(dd)(3)(A) of the Social Security Act, and is receiving treatment for such illness from that facility or provider. A "serious and complex condition" is: (i) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or (ii) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and that requires specialized medical care over a prolonged period of time.

If the *plan administrator* or its delegate determines that you may be eligible for continued care pursuant to this section, then the *plan administrator* or its delegate will notify you and provide you with an opportunity to elect to continue care. **If you make such election**, then you may be able to continue care for up to 90 days from the date you receive the notice. Such continued transitional care would be provided under the same terms and conditions that would have applied and with respect to the items and services as would have been covered under the *Plan* if the termination or contract change had not occurred, with respect to the course of treatment relating to your status as a continuing care patient.

Please contact Member Service at 888-276-4732 if you do not receive a notice, but you think you may be eligible for continued care under this section.

Balance Billing

In the limited situations in which this *Plan* covers out-of-network services, the *Plan* will calculate and pay the provider/facility based on the *usual, reasonable, & customary charge*. Except for the situations discussed below, the provider/facility may then send you a "balance bill" to recover the full amount of their billed charges.

You should not receive balance bills from *out-of-network providers/facilities* (including independent freestanding emergency departments) for the provision of *emergency services* (and certain post-stabilization care), from air ambulance providers, or from certain *out-of-network providers* rendering *covered services* in *in-network facilities*. **In certain of these situations, an *out-of-network provider* may ask for your consent to balance bill. You are never required to consent to balance billing in these situations. If you consent, you may receive a balance bill.** (See full discussion of your balance billing protections under the *No Surprises Act* in the Surprise Medical Bills Notice below.)

Surprise Medical Bills Notice

This notice describes your rights under the *No Surprises Act*. This notice is not intended to expand those rights. To the extent there is any discrepancy between the content of this notice and the *No Surprises Act*, the *No Surprises Act* will control.

Your Rights and Protections

When you get *emergency services* or get treated by an out-of-network provider at an in-network hospital or ambulatory surgery center you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in the *Plan*'s network.

"Out-of-network" describes providers and facilities that haven't signed a contract either directly with the *Plan* or via the *Plan*'s preferred provider network (see definition of PPO Network in the Definitions chapter). These *out-of-network providers/facilities* are also sometimes referred to as "non-network", "non-participating", or "non-preferred" providers and facilities. *Out-of-network providers/facilities* may be permitted to bill you for the difference between what the *Plan* agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than *in-network* costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an *in-network facility* but are unexpectedly treated by an *out-of-network provider*.

You are protected from balance billing for:

Emergency Services
If you have an *emergency medical condition* and get *emergency services* from an *out-of-network provider/facility*, the most the provider or facility may bill you is your *Plan*'s *in-network* cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these *emergency services*. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services. **You are never required to give consent.**

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an *in-network hospital* or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is the *Plan*'s *in-network* cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at an *in-network hospital* or ambulatory surgical center, *out-of-network providers* **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in the *Plan*'s *network*.

Air Ambulance
You also have protection from balance billing for air ambulance services, but only if you meet the *Plan*'s requirements for coverage of air ambulance services (see the Ambulance Services section of the Benefits Description – Medical chapter), including the requirement that you obtain pre-certification (unless the utilization review manager ultimately determines that ground transportation would have endangered the life of the enrollee).

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). The *Plan* will pay *out-of-network providers/facilities* directly.
- The *Plan* generally must:
    - Cover *emergency services* without requiring you to get approval for services in advance (*pre-certification* or prior authorization).
    - Cover *emergency services* by *out-of-network providers*.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an *in-network provider/facility* and show that amount in your explanation of benefits.
    - Count any amount you pay for *emergency services* or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Member Services at 888-276-4732 or the federal No Surprises Helpdesk at 800-985-3059.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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, & 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* when required will result in non-payment by the *Plan* (unless payment is required by the *No Surprises Act*).

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: It is possible that you may receive additional benefits based on your *employer* and the location of your employment due to:

1. Specifications in the *PPO Network* contract with your provider; and/or

2. State, *territory*, or local laws that apply in your state, *territory*, or city (if applicable to the *Plan*).

ABORTION

Abortion (also referred to as termination of pregnancy) will be covered where the pregnancy poses significant threats to the pregnant woman's life or serious jeopardy to her health, where there are severe congenital defects incompatible with life carefully diagnosed in the fetus, or where the pregnancy resulted from rape or incest. Consistent with Seventh-day Adventist Church teachings, abortions for reasons of birth control, gender selection, or convenience are not condoned by or covered by the *Plan*. Care management staff are available to consult with a pregnant member and her physician about these issues and to ensure that these *Plan* requirements for coverage are met in any given situation.

In addition, the *Plan* will reimburse abortion Travel Related Expenses in situations where travel is necessary due to legal restrictions that would otherwise prevent a timely termination of pregnancy and if approved by the *plan administrator*. "Travel Related Expenses" for this purpose are the same as described under "Cardiac Center of Excellence (CCOE) Surgery Benefit" below.

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.

CARDIAC CENTER OF EXCELLENCE (CCOE) SURGERY BENEFIT

When non-emergency cardiac services may be needed by a *Member*, the *Plan* allows a *Member* access to a nationwide Cardiac Center of Excellence network through the *Plan's pre-certification* process. This benefit is only available to those *Members* who have primary coverage under the *Plan* and who have been approved by the CCOE based on a review of the *Member's* diagnosis and medical history. (See Coordination of Benefits section for determination of primary versus secondary coverage.)

The *Plan* will pay 100% of your CCOE Surgery Benefit (no deductible, *copayments* or *coinsurance* will apply) for approved services. CCOE Surgery Benefit expenses include all medical costs incurred under the CCOE Surgery Benefit as well Travel Expenses.

While at the CCOE the pre-operative visits and post-operative visits are included in the CCOE Surgery Benefit. Once the *Member* is transitioned from the Cardiac Center of Excellence networks care, future claims for services will be handled according to the provisions of the *Plan*.

If a change in surgery date is requested by the *Member*, the *Member* will be responsible for the cost associated with the change, including any transportation cancellation fees and/or higher costs.

To be eligible for Travel Related Expenses the Member must travel at least 50 miles one-way from home to the CCOE Provider.

Travel Related Expenses means;

Airfare: *Plan* will provide airfare (economy/coach class tickets, and up to one checked bag per person) for patient and one traveling companion. Airline reservations must be made by WebTPA. WebTPA will make any approved changes to flight schedules. The *Plan* will not pay for additional costs associated with non-approved changes in airfare unless approved by WebTPA.

Airport Parking

Personal vehicles will be covered for actual cost up to $15/day.

Alternate transportation to/from the airport, will be covered for actual cost up to a total of $100 round-trip.

Driving to/from CCOE Facility

Rental Car: Only one car rental, economy/standard class vehicle will be covered. Car rental insurance and liability are the responsibility of the member.

Personal Car: Members will be reimbursed at the IRS standard mileage rate (medical purposes). Mileage will be paid for travel to and from primary residence and the CCOE facility. Mileage incurred to transport patient to hospital, companion traveling to/from hospital while member is hospitalized will also be covered.

Lodging: The *Plan* will provide accommodations made by WebTPA for one room at a mid-market chain hotel. Lodging will include nights for the timeframe of pre-operative testing through initial recovery as determined by WebTPA. All additional charges are the responsibility of the Patient.

Miscellaneous Expenses: The plan will provide Member $50.00 per diem (each full or part day) while not admitted to the hospital.

Traveling Companion: $50.00 per diem (each full or part day) they are accompanying the Member while receiving services from the CCOE.

Taxable Expenses: Some of the Travel Related Expenses are taxable income to the Member and/or travel companion. The *plan administrator* will determine the taxable amount and report it to your employer, and your employer will report the taxable amount on your Form W-2.

Documentation: In order for the *plan administrator* to accurately determine covered travel expense amounts and taxation, you will be asked to submit receipts and, if traveling with a companion, you will be asked to produce a *Travel* Companion Medical Necessity Form completed by your physician.

All Other Travel Related Expenses Are Member Responsibility

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

The plan provides coverage for dialysis services. Dialysis can be an in-home service if the member is on peritoneal dialysis or hemodialysis. The plan does not require pre-certification for dialysis.

DURABLE MEDICAL EQUIPMENT

Durable medical equipment, supplies, and appliances include:

- Diabetic Supplies. If diabetic supplies are obtained through an *in-network* pharmacy, they will be covered under the pharmacy/Prescription Drugs benefit as described in the Prescription Benefits tables of the Schedule of Benefits. If not, they will be covered as provided under the Durable Medical Equipment section in the Schedule of Benefits.
- Foot orthotics are covered for the treatment of diabetic foot disease and severe peripheral vascular disease only. Foot orthotics are not covered in any other situations. Arch supports are not covered.
- Original fitting, adjustment and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus, orthotics, sleep apnea equipment or prosthetic appliances to replace lost body parts or to aid in their function when impaired.
- Artificial limbs, eyes, or other prosthetic appliances required for replacing natural limbs, eyes or other body parts lost or removed while the person is covered by this *Plan*. Replacement of artificial eyes, limbs or other prosthetic appliances if required due to a pathological change in patient's physical condition; or if required due to the growth of a child; or if replacement is less expensive than repair of existing prosthetic appliances.
- Initial prescription contact lenses or eyeglasses, including the examination and fitting of the lenses, to replace the human lens lost through intraocular *surgery* performed while covered under the *Plan*.
- Wigs and artificial hairpieces following radiation or chemotherapy, or when due to a pathological change in the body, covered under the Wig section of the Schedule of Benefits and subject to a $1,000 annual maximum.
- Blood or other fluids injected into the circulatory system. Expenses for blood salvage (i.e., blood donated by a covered person for his/her own use) will also be covered only if a *surgery* is scheduled for which there is reasonable chance that blood will be required.
- Sterile surgical supplies after surgery.
- Maternity support hose, only when prescribed by a *physician*.

- Lymphedema garments or compression garments.
- Oxygen and rental of equipment required for its use.
- Colostomy supplies.
- Orthopedic shoes are covered if they are an integral part of a leg brace or if a *physician* or *professional provider* has ordered that orthopedic shoes be individually designed for correction or support of a deformity. If such correction or support is accomplished by modification of a mass- produced shoe, then the covered expense will be limited to the cost of the modification. The covered expense will not include the original cost of the shoe.
- Diabetic shoes are covered if the member has a diagnosis of diabetes and has any of the following: foot deformity; (2) history of pre-ulcerative calluses; (3) history of previous ulceration; (4) peripheral neuropathy with evidence of callus formation; (5) poor circulation; or (6) previous amputation of the foot or part of the foot. Limit is 1 pair per year.
- Other durable medical equipment and supplies as determined to be medically necessary by the utilization review manager.

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 (not to exceed the purchase price of the equipment). 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

Pre-certification required for all durable medical equipment or repair with billed charges of $2,000 or more, and all continuous passive motion (CPM) devices, insulin pumps, continuous glucose monitor (CGM) and Dynasplints (regardless of cost).

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.

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

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. Emergency room visits are only covered when there is an *emergency medical condition*. 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.

GENETIC TESTING

Genetic tests are laboratory studies that look for changes in deoxyribonucleic acid (DNA). The testing looks for changes in genes, chromosomes, or proteins associated with genetic diseases, disease traits or carrier status. Genetic testing may also be done to assist in disease diagnosis and treatment. The Plan provides genetic testing coverage when determined as medically necessary through the Plan's utilization review manager.

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*.

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

Limited to 120 visits per *plan year*. Home Health Care visits related to wound vac related services count toward the Home Health Care visit total. Home Health Care visits related to IV infusions do not count toward the Home Health Care visit total.

Home Health Care does not include charges made for:

1. services of a person who usually lives with you or is a member of you or your spouse's family;

2. transportation; or

3. custodial care.

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 hospice physician can approve further care beyond the initial certified approval.

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.

4. Respite Care:

   - up to 5 days, may be taken intermittently

   - care can be at a certified hospice care facility or via in-home care.

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.

Hospice benefits will not be provided for:

- Private duty nursing care

- Care performed by family members, relatives and friends

- Treatment to cure the member's underlying illness

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.

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 (1) *employees*; (2) their *spouses*; and (3) post-pubertal *covered dependents* facing anticipated infertility resulting from *medically necessary* chemotherapy or radiation. Except as specified in the previous sentence, 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.

The *Plan* provides coverage for *in-network* midwives (or with an Unavailable Services Request Form approved by the *plan administrator*) 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. 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 that must be submitted with the claim to WebTPA. **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.**

The *Plan* provides facility coverage for delivery in *PPO facilities* only. The only exception is for *emergency* deliveries in facilities that conform to American Medical Association ("AMA") guidelines.

The *Plan* provides coverage for the *covered employee's* delivery complications or the *employee's* covered *spouse's* delivery complications, regardless of who delivers the child and/or the location of the birth.

Inpatient expenses that are incurred by a newborn child during hospitalization for delivery will be considered incurred by the newborn and thus subject to a separate deductible and out-of-pocket maximum at birth of the baby. A newborn child who is an *eligible dependent* must be enrolled in the *Plan* within 60 days of the date of birth in order to be covered under the *Plan* and in order to have the child's incurred expenses be eligible for coverage by the *Plan*.

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*. Intensive outpatient programs and partial hospitalization programs are not covered unless treatment is *in-network* and approved through the *utilization review manager* (except if service is not available *in-network* and *member* has an Unavailable Services Request Form approved by the *plan administrator*).

MEDICAL TRAVEL

The *Plan* covers certain "Travel Related Expenses" (for travel necessary to obtain a medical service that is not legally available within a specified distance of the covered individual's home. "Travel Related Expenses" for this purpose are the same as described under "Cardiac Center of Excellence (CCOE) Surgery Benefit" above.

NUTRITIONAL COUNSELING

Five visit annual limit applies to all *Plan* options. Additional visits may be authorized by the *utilization review manager*. *Telehealth* benefit available for *PPO* and *out-of-network* providers, as long as they are appropriately licensed and the appropriate technology in place to provide and bill for the covered service. See Schedule of Benefits for member responsibility.

OBESITY RELATED TREATMENT- MEDICALLY NECESSARY

The *Plan* covers obesity-related treatment, such as Gastric ("Bariatric") Surgery, or Prescription Drug Therapy for obesity treatment, only when the *Plan*'s utilization review manager and/or Express Scripts, approves 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 in certain medically necessary situations. Whether a surgery exception will be granted will be decided by the utilization review manager upon review of a completed bariatric precertification information request form and based on the obesity surgery medical clinical policy published by Aetna, which provides the *Plan*'s PPO network (contact the utilization review manager to request a copy of the policy). Any approved services will be limited to in-network providers at the PPO network's "Institutes of Quality" (IOQ).

ONCOLOGY

The plan covers oncology services. These services focus on the treatment of cancer and have three major areas based on treatments: medical (including medications), surgical, and radiation. The plan follows NCCN (National Comprehensive Cancer Network) clinical practice guidelines for medical necessity criteria.

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. Any approved services will be limited to *in-network providers* at the PPO network's "Institutes of Excellence" (IOE).

Enrollees may pursue listing at multiple sites. Evaluations are based on medical appropriateness reviews and are generally limited to one, and so the *Plan* will only pay for one evaluation and the *enrollee* would be responsible for any additional evaluations (unless the medical appropriateness review specifically allows coverage of an additional evaluation).

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.

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. Preventive health care may be subject to the same *pre-certification*, utilization review, and care management techniques as other *Plan covered services*.

  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 *copayment*, no *coinsurance*, 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 45 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 may apply.**

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.

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*.

SURGICAL SERVICES

In general, the Plan covers specified surgical services performed in inpatient and outpatient settings. The Plan requires pre-certification for many surgical services, including all inpatient surgeries (see “Services Requiring Pre-Certification” section of the Plan). The Plan also contains limitations or exclusions on certain surgical

services (see “Limitations and Exclusions” section of the Plan). Prior to having surgical services performed you should contact Member Services at 888-276-4732 to verify if your surgical services will be a covered service.

The following surgical services are covered by the Plan:

- Circumcision.
- Human organ and tissue transplants expenses determined to be medically necessary. Donor expenses will be considered if they are not eligible for reimbursement under any other group health plan or similar arrangement. The Plan will not pay personal service fees to the donor.
- Hysterectomy.
- Joint replacement surgery.
- Maternity and pregnancy related care.
- Oral surgery received immediately after an accidental injury, including replacement of teeth and related X-rays, and follow-up surgery that could not be performed during the original treatment because of the enrollee’s condition or the nature of the treatment/procedure.
- Orthognathic surgery.
- Outpatient surgery.
- Podiatry services.
- Reconstructive surgery, only when needed to: (1) improve or restore the functioning of a body part, (2) correct of the results of injury or deformity as the result of surgical treatment of malignancy (i.e., post-mastectomy breast reconstruction); or (3) treat certain congenital defects such as cleft lip or cleft palate. Scar revision is limited to scars that are disfiguring and extensive or cause a functional impairment. Coverage for reconstructive surgery following a mastectomy includes: (1) reconstruction of breast on which the mastectomy has been performed, including, nipple reconstruction, skin grafts, and stippling of the nipple and areola; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; (4) treatment of physical complications of the mastectomy, including lymphedema; and (5) inpatient care related to the mastectomy and post-mastectomy services.
- Spine surgery.
- Surgical reproductive sterilization.
- Surgical treatment of temporomandibular joint dysfunction (TMJ/TMD), limited to therapeutic arthroscopy, arthrocentesis, condylotomy/eminectomy, modified condylotomy, arthroplasty, and joint reconstruction using autogenous or alloplastic materials.
- Certain other expenses connected to a covered surgical service (anesthetic services, surgeon expenses, assistant surgeon expenses, and related Ancillary Services).
- Other surgical services as determined to be medically necessary by the utilization review manager.

THERAPEUTIC CARE

Physical Therapy

The *Plan* provides coverage for Physical Therapy within certain limitations stated in the Schedule of Benefits section of this document.

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.

A prescription from your MD/DO is required.

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.. 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 at 888-276-4732.

Payment Limits

There are annual individual 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 as a dental expense.

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 26 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. (Annual maximum payable does not apply to pediatric annual eye examination and one pair of standard, clear-lens, prescription glasses per *plan year* per child for those under age 19.) 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 *copayment* 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 members to use clinically appropriate drugs while helping to manage costs. A formulary is a list of drugs covered through the pharmacy benefit and presented 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 for short term drugs; and 90-day Mail Order or Walgreens Smart90 retail program for long term maintenance drugs. Your copayments will be lowest if you use 90-day Mail Order or the Walgreens Smart90 retail program. (The Walgreens Smart90 retail program is not available for *employees* (and their dependents) *stationed* in the U.S. *territories*.)

If you choose to purchase long-term maintenance drugs at retail pharmacies for 30 days' supply at a time rather than via mail order or Walgreen Smart 90 retail program, after three purchases of the same drug, you will have to pay the difference in the cost between the price of the drug at the retail pharmacy and the price of the drug 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. (The extra charge for using a retail pharmacy for a long-term maintenance drug will be waived for *employees* (and their dependents) *stationed* in the *included U.S. territories*.)

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

Generic (Tier 1):	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.
Preferred Brand (Tier 2):	Preferred formulary brand drugs cost less than the non-preferred brand drugs. The copayment for the preferred brand drugs is higher than it is for generic drugs.
Non-Preferred Brand (Tier 3):	Non-preferred formulary brand drugs are brand name drugs that have the highest copayment under the ESI national preferred formulary.

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 *physician* prescribes a brand-name drug that has an equivalent generic available, you may be required to pay your brand copayment **plus** the difference in cost between the brand and the generic drug. If your physician believes you should use the brand-name drug because of medical necessity, he or she can request a coverage review by visiting Express Scripts' online portal, esrx.com/PA.

Prescription Drug Pre-Certification Requirement

Some drugs require *pre-certification* through the pharmacy benefit manager (Express Scripts) before you fill a prescription. The *Plan* participates in Express Scripts' utilization management program which manages the list of drugs with *pre-certification* requirements. The select drugs with *pre-certification* requirements are subject to a review for *medical necessity pre-certification* criteria, and/or any *Plan* restrictions set by Express Scripts or the *plan administrator*.

If you are prescribed a drug that requires *pre-certification*, your pharmacy will be notified when processing your prescription. Please work with your provider to submit the additional clinical information requested by the *pre-certification* request to Express Scripts for review.

The list of drugs that require *pre-certification* 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 Program

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.

Medical Channel Management Program

Certain infusion or injectable specialty drugs are available through the Medical Channel Management Program and are only accessible through the pharmacy benefit and are subject to *pre-certification* requirements administered by Express Scripts. Accredo Specialty Pharmacy will contact all *members* impacted by letter and by phone call to educate them about the coverage of these drugs.

If your *provider* ordered an infusion or injectable drug for you that qualifies for the Medical Channel Management Program through Express Scripts and you do not obtain the drug through Accredo Specialty Pharmacy, you will be required to transfer the prescription to Accredo Specialty Pharmacy. If you continue to purchase your specialty drugs from your *provider*'s office, infusion center, or another pharmacy, you may be responsible for their full cost. When you or your *provider* order a covered specialty drug through Accredo, your out-of-pocket cost will be limited to the applicable prescription drug *copayment* instead of the 20% *coinsurance*

applicable through the medical benefit for outpatient services. (This program also includes drugs that might qualify for $0 SaveOnSP Specialty Drugs Program offered by Express Scripts).

In order to provide you with sufficient time to transfer your prescription to Accredo Specialty Pharmacy, you or your *provider* may submit a *pre-certification* request through the *utilization review manager* (Adventist Health Benefit Administration) for coverage of one additional prescription from your current *provider* through the medical benefit. In addition, if you have an extenuating medical condition that prevents you from transitioning the prescription to Accredo Specialty Pharmacy, you may be granted an override and continue on your coverage through the medical benefit as long as there is an approved medical reason to not transition. Services such as infusion drugs or injectables accessed through the medical benefit are subject to 20% *coinsurance* and the *pre-certification* requirements through Adventist Health Benefits Administration, and these services would not qualify for the $0 SaveOnSP Specialty Drugs Program offered by Express Scripts.

The list of drugs subject to the Express Scripts' Medical Channel Management Program may change, and you or your *provider* should contact Accredo Specialty Pharmacy to check a drug's availability before you fill a prescription for a specialty drug.

If you have questions about this program or need support transitioning your prescription to Accredo Specialty Pharmacy, please reach out to Adventist Health Benefits Administration at 888-276-4732 and select Adventist Health when prompted for guidance.

(The Medical Channel Management Program is not available for *employees* (and their dependents) *stationed* in the U.S. *territories*. If you are *stationed* in an *included U.S. territory*, then you and your *eligible dependents* may purchase covered infusion or injectable specialty drugs from your medical provider or infusion center, but such drugs will be subject to the cost sharing described in the Medical Benefits Schedule of Benefits for medical outpatient services.)

Embarc Benefit Protection Program:

Gene therapies are million-dollar therapies used to treat certain rare genetic diseases, and they are only available in a limited number of facilities that are specialized in providing these treatments. Starting October 1, 2022, gene therapies are covered through the Embarc benefit protection program managed by eviCore.

EviCore works with Express Scripts to ensure Embarc Benefit Protection medical criteria are met through Express Scripts' pre-certification program and then pay the dispensing pharmacy/facility for the drug. Then, the drug will be delivered by the dispensing pharmacy to the physician, who will provide the therapy to the member.

Members will have zero out-of-pocket costs for the drug itself through the Embarc Benefit Protection program. The gene therapy related administration cost (ex. hospitalization cost) and other professional fees for the administering provider are covered through the medical benefit. These service fees are subject to the same applicable deductible, coinsurance, and pre-certification requirements under the medical benefit.

With respect to Zolgensma, the Embarc benefit applies only to children born after October 1, 2022. Children born before the Embarc coverage start date will need pre-certification from the plan's utilization review manager and have coverage under their medical benefit, in which the plan deductible, coinsurance and copays will apply to both the gene therapy product and related administration costs.

Preventive Prescription Drugs

Preventive prescription drugs include the prescription drugs listed in (or included in the services listed in) 26 CFR § 54.9815-2713, or any successor regulation or statute. Such preventive prescription drugs include 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. See Appendix A for additional information about specific preventive care services and drugs. Preventive prescription drugs may be subject to the same *pre-certification* and step therapy requirements as other covered prescription drugs (described above).

Smoking cessation drugs that are prescribed by a *physician* and approved by the *plan administrator* are covered with no *copayment* 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 *coinsurance*, and no deductible; this is often referred to as "first-dollar coverage").

Chronic Preventive generic drugs:

The plan offers additional benefit to cover certain chronic preventive generics at a lower copayment ($2 copay per 30-days' supply or $4 per 90-days' supply). The list of chronic preventive generic drugs includes categories of formulary generic drugs that are used to manage certain chronic conditions with preventable complications, such as osteoporosis, depression, diabetes, hypertension, and cholesterol, etc. For a list of chronic preventive drugs that are covered at a lower copayment, please contact the ESI Member Services Department at 800-841-5396.

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 Option is limited to Chiropractic Treatment and Therapeutic Massage Therapy. Coverage under the Access Option 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. In particular, chiropractic visits are limited to 15 visits per year. Pre-certification is required for visits over 15.

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 ages 10 or older are 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 ages 18 or older are eligible for massage therapy 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. Abortion (also referred to as termination of pregnancy), except where the pregnancy poses significant threats to the pregnant woman's life or serious jeopardy to her health, where there are severe congenital defects incompatible with life carefully diagnosed in the fetus, or where the pregnancy resulted from rape or incest. Consistent with Seventh-day Adventist Church teachings, abortions for reasons of birth control, gender selection, or convenience are not condoned by or covered by the *Plan*. Care management staff are available to consult with a pregnant member and her physician about these issues and to ensure that these *Plan* requirements for coverage are met in any given situation.

2. Apolipoprotein E for Risk Assessment and Management of CV Disease.

3. Athletic training assessments.

4. Biofeedback.

5. Career or Financial Counseling Services (wellness program participants can access goal setting, tracking, educational content and fee-based financial services via the wellness platform).

6. Charges for Missed Appointments.

7. 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* to massage therapy and chiropractic treatment in the Accelerate option and limited to chiropractic treatment in the Access option. All other CAM therapies, services, tests, laboratory tests, procedures, products, and practices are not covered under the *Plan*.

8. 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*.

9. Custodial Care and Services. The *Plan* does not cover custodial care and services related to custodial care.

9. Elective surgeries for preventive reasons (there are exceptions for prevention of certain cancers with *pre-certification*).

10. Electrostimulation and electromagnetic therapy for wound care.

11. 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.

12. Extracorporeal shock wave therapy for plantar fasciitis.

13. First Aid Supplies.

14. Genetic testing for hereditary breast and/or ovarian cancer gene mutation(s) is not covered in members who have received an allogeneic bone marrow transplant if only blood or buccal samples are available. Multigene hereditary cancer panels that accompany BRCA testing are not covered.

15. 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.

16. 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, except as specifically outlined in Lifestyle Programs section of the Schedule of Benefits. The *Plan* would encourage you to engage in relevant and appropriate educational classes through your Health and Wellness benefit.

17. High cost and specialty medications provided and billed by *providers* directly to the medical benefit that are available through the pharmacy benefit's Medical Channel Management program with Express Scripts are not covered (except for the induction of therapy and those meeting site of care medical necessity policy and approved by Adventist Health Benefits Administration).

18. In Vivo Analysis of Colorectal Polyps.

19. Job-related or immigration-related immunizations that are not considered preventive (see Appendix A for details regarding preventive immunizations). Immunizations specific to mission trips and vacations are not excluded.

20. Joint lubricant injections.

21. Late Claims. The *Plan* does not cover claims submitted more than one year after the date of the service.

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

23. 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.

24. 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).

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

26. Non-emergency services/supplies received outside of the United States (except that *employees* (and their dependents) *stationed* in the *included U.S. territories* may receive non-emergency covered services/supplies in the *included U.S. territories*).

27. Non-prescription glasses or sunglasses.

28. 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*.

29. Obesity Related Treatment – Non-Medically Necessary. The *Plan* does not cover non-medically necessary obesity treatment (except as specifically outlined in Lifestyle Programs section of the Schedule of Benefits), including Gastric ("Bariatric") Surgery, or Prescription Drug Therapy for obesity treatment. For information on covered obesity related treatment, see the "Obesity-Related Treatment – Medically Necessary" section.

30. Oral Infant Formula (except for *physician*-prescribed special medical modified formula/food products for the treatment of an enrollee with an inborn error of metabolism, such as phenylketonuria or an inherited disease of amino and organic acids).

31. Pelvic floor stimulation (non-implanted).

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

33. 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 (for example, breast reconstruction after mastectomy, as described in the Rights Under the Women's Health and Cancer Rights Act section); or

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

34. Platelet rich plasma.

35. 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.

36. Prenatal and Parent Training Classes.

37. Sexual Transformations and Trans Gender procedures.

38. Stem cell therapy for orthopedic procedures.

39. Surrogate Mothers. The *Plan* does not cover all services related to surrogate parenting, including infertility testing and treatment, maternity care, birthing, hospitalization, professional services, etc.

40. Transportation and lodging except for ambulances and as described as part of the Cardiac Center of Excellence (CCOE) Surgery Benefit and Travel Benefit.

41. Telephone consultations and routine phone calls, except for formal *telehealth* visits that are a substitute for an in-person office visit with a provider and that are covered as described in the Schedule of Benefits.

42. Treatment by Patient, Individual Acting Under Patient's Supervision, or Patient's Household and/or Immediate Family Members. The *Plan* does not cover services of a person who ordinarily resides in the home of the patient or services performed by a patient, someone acting under a patient's supervision (such as a situation where the patient is a physician and services are

performed by a nurse or similar individual acting under the patient's supervision), or a patient's spouse, parent, stepparent, child, or stepchild.

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

44. Viscosupplements (injectable).

45. Virtual scans.

46. Vitamins, (except for physician prescribed vitamin B12 injections, Vitamin D, and prenatal care vitamin supplements), dietary supplements and foods, herbs, minerals, nutritional supplements.

47. Any services that are not permitted under applicable state or federal law.

Claims Procedures

ARTICLE 1 GENERAL CLAIM FILING PROCEDURES

Legally-compliant claims and appeals procedures are detailed in the numbered sections below. The following general summary is offered for your convenience and ease of use: **You must refer to the full language in the numbered sections below for details regarding the claims/appeal process and how to calculate your deadlines.** The main Member Services phone number is 888-276-4732, and they will route you to the appropriate decision-maker (listed below). For prescription drug pre-certifications, claims, and first appeals, please contact Express Scripts directly at 800-841-5396.

For pre-certification before you receive benefits or while you are receiving benefits:

For pre-certification for medical services	Utilization review manager	888-276-4732
For pre-certification for prescription drugs	Express Scripts	800-841-5396
For pre-certification for dental services	WebTPA	888-276-4732

To submit a claim after you receive benefits:

To submit a medical/dental claim	WebTPA	888-276-4732
To submit a prescription drug claim	Express Scripts	800-841-5396

If your claim is denied:

Deadline to file an appeal: 180 days from your receipt of a denial of the claim

Where to file your first appeal:

Medical denials (such as for no medical necessity)	Utilization review manager (Adventist Health)	888-276-4732
Non-medical denials (such as for no eligibility for coverage)	WebTPA	888-276-4732
Prescription drug denials	Express Scripts	800-841-5396

If **your first appeal is denied:**

Deadline to request second review: Four months from your receipt of the denial of the appeal

Where to file your request for review of your denied appeal:

Medical denials (such as for no medical necessity)	External review (coordinated by the utilization review manager)	888-276-4732
Non-medical denials (such as for no eligibility for coverage)	Plan administrator	888-276-4732
Prescription drug denials - involving medical judgment (such as for no medical necessity)	External review (coordinated by Express Scripts)	800-841-5396
Prescription drug denials – not involving medical judgment (such as for no eligibility for coverage)	Plan administrator	888-276-4732

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 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 services* (unless you are *stationed* in an *included U.S. territory*, in which case the *Plan* will also reimburse for non-emergency *covered services* rendered in an *included U.S. territory*). For *emergency services* 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 your ID card, and be sure it includes the information listed in Section 3.03. (If you are *stationed* in an *included U.S. territory* and receiving care from hospital, physician, or professional provider that contracts directly with the *Plan* to provide *covered services*, then you should present your benefit ID card and, in most cases, the hospital, physician, or professional provider will bill the *Plan* directly.)

Section 1.03 ***Physician and Professional Provider Benefits***
In most cases, your *in-network provider* will bill charges directly to the *Plan* via the third party administrator. You are required to pay any applicable *copayments* 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*.** If the *Plan* is not notified and/or if the patient does not consent to such transfer, then only *emergency services* (and certain post-stabilization services required to be covered by the *No Surprises Act*) will be covered.

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 determinations* 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 that involve *medical judgment* 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 WebTPA at 888-276-4732.

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. Additionally, the *Plan* shall, even in the absence of a signed Appointment of Authorized Representative form, recognize a *physician* or *professional provider* with knowledge of the *claimant's medical condition* (e.g., the treating *physician*) or the *facility* where the *claimant* is/was treated as the *claimant's authorized representative* unless the *claimant* provides specific written direction otherwise, and 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 WebTPA by calling 888-276-4732. Completed forms must be submitted to the *utilization review manager*, WebTPA, or Express Scripts (depending on the proper recipient of the *claim* or appeal). An attempted assignment for purposes of payment does not constitute appointment of an *authorized representative* under the Claims Procedures. Once an *authorized representative* is appointed, recognized, or deemed, 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 Member Services at 888-276-4732 before you receive the medical care. For prescription drug pre-certification, call Express Scripts at 800-841-5396. For dental pre-certification, call WebTPA via Member Services at 888-276-4732.

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 Member Services at 888-276-4732.

ARTICLE 3 HOW TO FILE A CLAIM FOR BENEFITS

Section 3.01 *General Filing Rules*
Claims for all medical 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 or your *authorized representative* must contact Member Services at 888-276-4732 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 or your *authorized representative* 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*.** If the *Plan* is not notified and/or if the patient does not consent to such transfer, then only *emergency services* (and certain post-stabilization services required to be covered by the *No Surprises Act*) will be covered.

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 WebTPA at the address on the second page of this SPD. The appropriate *claim* forms may be obtained by contacting Member Services at 888-276-4732.

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 WebTPA at the address on the second page of this SPD.

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 determinations, 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;

- 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; and

- 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

For a summary of these rules, please see the chart at the beginning of the Claims Procedures chapter. The chart is offered for your convenience and ease of use: You must refer to the full language in the numbered sections below for details regarding the appeal process and how to calculate your deadlines.

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*
A post-service appeal of an *adverse benefit determination* requiring a determination involving *medical judgment* 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 Member Services at 888-276-4732 for more information. Except in the case of an appeal relating to prescription drug benefits, a post-service appeal of an *adverse benefit determination* that does not require a determination involving *medical judgment* is filed by submitting a written Request for Review form to WebTPA. 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* or WebTPA via Member Services at 888-276-4732.

If you are unsure whether the *adverse benefit determination* involved *medical judgment*, you should contact the *utilization review manager* at (888) 276-4732.

Section 6.05 ***How to File Your Appeal: Prescription Drug Appeals***
To appeal a denied prescription drug benefit claim, follow the instructions on the *adverse benefit determination* you received from ESI. (See Section 1.04 for more information and for contact information for ESI.)

Section 6.06 ***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 JUDGMENT – SECOND APPEAL

Section 10.01 ***In General***
If your appeal did not involve a *medical judgment* (for example, the appeal involved *Plan* eligibility), then you may request a review of the appeal decision by contacting the *plan administrator* at:

Adventist Risk Management
12501 Old Columbia Pike
Silver Spring, MD 20904
888-276-4732
benefits@adventistrisk.org

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 Judgment***
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 next day that is not a Saturday, Sunday, or Federal holiday.

Section 10.03 ***Notification of Non-Medical Judgment 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 Judgment***
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 (i) you will not be eligible for external review unless the 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, and (ii) 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, or (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 JUDGMENT)

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.

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 (a) rescission of coverage, (b) application of the *No Surprises Act*, or (c) *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 internal 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* request is complete and 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.

Section 12.06 ***Assignment To and Consideration By Independent Review Organization***
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 12.07 ***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 Department of Labor 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 12.08 ***Reversal of Plan's Decision***
Upon receipt of a final external review decision reversing the *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 the maximum amount allowable under state law. 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.

(ii) 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.

(iii) 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 WebTPA 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.

(iv) 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.

(v) 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.

(vi) 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.

(vii) 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.

(viii) 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.

(ix) 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.

(x) 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.

(xi) 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

(xii) 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.

(xiii) 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.

(xiv) 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.

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

(xvi) 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.

(xvii) 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 Liability Section above. If we have paid benefits first, we are entitled to any reimbursement from the motor vehicle insurer, under the Third-Party Liability 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, *coinsurance* and *copayments*, 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. Except as provided in the following paragraph, 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.

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:

(i) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

(ii) 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

(iv) 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:

a.The Plan covering the Custodial parent;

b. The Plan covering the spouse of the Custodial parent;

c. The Plan covering the non-custodial parent; and then

d. 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.

(d) For a married dependent child covered under a spouse's plan:

(i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Paragraph D(5) ("Longer or Shorter Length of Coverage") applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the Birthday Rule in Subparagraph D(2)(a) to the dependent child's parent(s) and the dependent's spouse.

(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 *Pla*n 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, *territory*, 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 (if an external review is requested) or upon receipt of the *final internal adverse benefit determination* (in the event that an external review is not available or requested).

Plan 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, by the North American Division Risk Management Committee, or by the delegate of North American Division of Seventh-day Adventists, Adventist Risk Management, or any authorized representative of the North American Division of Seventh-day Adventists or its delegate, Adventist Risk Management. 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.

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 may either (1) remain covered under this *Plan* without reduction for Medicare benefits or (2) drop coverage under this *Plan* and 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-10-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.

6. Eligibility Audits, which may include dependent verification.

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 copayments 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 may 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 *copayments*, deductibles and *coinsurance*; 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"). In this HIPAA Privacy Policy, certain terms are used differently than in other Sections of the SPD:

- The terms "you" and "your" refer to the *Plan member*/enrollee *(*including a dependent enrollee).

- While the term "*plan sponsor*" as generally used in this SPD means the North American Division of Seventh-day Adventists (NAD), for HIPAA purposes, "plan sponsor" has a broader meaning and could include any *participating employer*. Except as otherwise provided below, in this HIPAA Privacy Policy, plan sponsor generally means NAD and Adventist Risk Management, Inc. (ARM) due to ARM's role as both a participating employer in and the *plan administrator* of the *Plan*.

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.

HIPAA allows medical information, including PHI, to be disclosed by the *Plan* to the plan sponsor and to be used by the plan sponsor in certain circumstances. This HIPAA Privacy Policy breaks plan sponsors into three separate categories: NAD, the official *plan sponsor*; ARM, a participating employer and the *plan administrator*; and all other *participating employers*. The permitted disclosures to and uses by the different categories of plan sponsors of medical information are as follows:

1. The *Plan* may disclose to your *participating employer*, and your *participating employer* may use, information on whether your or your dependents are participating in the *Plan* or enrolling or dis-enrolling in the *Plan*.

2. The *Plan* may disclose to your *participating employer* de-identified claims information (e.g., information that is stripped of all information that could be used to identify the individual incurring the claim) in order to facilitate your *participating employer's* obligation to fund claims incurred you or your dependents under the *Plan*.

3. The *Plan* may disclose summary health information (information that summarizes claims history, claims expenses or types of claims experienced by *Plan* members) to NAD or ARM if they request 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").

   NAD and ARM may use Summary Information so received from the *Plan* only for these two listed purposes.

4. The *Plan* may disclose PHI to NAD and ARM (to either NAD or ARM as a HIPAA plan sponsor and NAD as the *plan administrator*), and NAD and ARM may use PHI, to carry out plan administration functions, such as activities relating to:

a. obtaining employee-share contributions 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* 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 *copayments* 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.

As the only *plan sponsors* with access to PHI, NAD and ARM have agreed to (and the *Plan* has received a certification from ARM evidencing such agreement) the following restrictions with respect to their role as plan sponsors and all references to plan sponsor directly below are limited to NAD and ARM:

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 (or will cooperate with the plan administrator to) give you access and provide copies to you of your PHI in accordance with the HIPAA Regulations.

6. The plan sponsor will (or will cooperate with the plan administrator to) allow you to amend your PHI in accordance with the HIPAA Regulations.

7. The plan sponsor will (or will cooperate with the plan administrator to) make available PHI to you in order to make an accounting of PHI in accordance with the HIPAA Regulations.

8. The plan sponsor will (or will cooperate with the plan administrator to) 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. The following officers of the plan administrator: CEO/President, VP/Chief Healthcare & Benefits Officer

    b. Employees of the plan administrator in the Healthcare & Benefits Team only

    c. The following officer of NAD: Treasurer (or his or her single designee)

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 (and will cooperate with the plan administrator to) 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 ARM (and the *plan administrator*) performs for the *Plan*. This may involve sharing *Plan* enrollment information or de-identified information with your Participating Employer in connection with the Participating Employer's role as a *plan sponsor* in relation to financial liability for its employees under the *Plan*, but Participating Employers will not have access to any other PHI. 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 that explains the *Plan*'s privacy practices and your rights under HIPAA. This Notice is available by contacting the *Plan*'s Privacy/Security Officer, ARM's Vice-President, Chief Healthcare & Benefits Officer, at the following address: **Adventist Risk Management, 12501 Old Columbia Pike, Silver Spring, MD 20904 or email, privacyofficer@adventistrisk.org. The Privacy Notice is also available at http://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

You are responsible for providing a copy of this notice to your Medicare-eligible dependents.

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 Express Scripts at 1-800-841-5396. **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, 2024
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:	(301) 453-6969

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 July 31, 2024. Contact your state for more information on eligibility -

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration https://www.dol.gov/agencies/ebsa 1-866-444-EBSA (3272)	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services https://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 (https://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/talk-to-your-doctor-about-abdominal-aortic-aneurysm) for men of specified ages who have ever smoked.

2. Alcohol misuse screening and counseling (https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/heart-health/drink-alcohol-only-in-moderation).

3. Aspirin use (https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/heart-health/talk-with-your-doctor-about-taking-aspirin-every-day) to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk.

4. Blood pressure screening (https://health.gov/myhealthfinder/topics/doctor-visits/screening-tests/get-your-blood-pressure-checked).

5. Cholesterol screening (https://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-your-cholesterol-checked) for adults of certain ages or at higher risk.

6. Colorectal cancer screening (https://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-tested-for-colorectal-cancer) for adults 45 to 75.

7. Depression screening (https://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/talk-with-your-doctor-about-depression).

8. Diabetes (Type 2) screening (https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/take-steps-to-prevent-type-2-diabetes) for adults 40 to 70 years who are overweight or obese.

9. Diet Counseling (https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/eat-healthy) for adults at higher risk for chronic disease.

10. Falls prevention (https://healthfinder.gov/HealthTopics/Population/older-adults/safety/preventing-falls-conversation-starters) (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting.

11. Hepatitis B screening (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening?ds=1&s=hepatitis%20b) 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.

12. Hepatitis C screening (https://healthfinder.gov/HealthTopics/Category/doctor-visits/talking-with-the-doctor/hepatitis-c-screening) for adults age 18 to 19 years.

13. HIV screening (https://health.gov/myhealthfinder/topics/health-conditions/hiv-and-other-stds/get-tested-hiv) for everyone ages 15 to 65, and other ages at increased risk.

14. PrEP (pre-exposure prophylaxis) HIV prevention medication (https://www.hiv.gov/hiv-basics/hiv-prevention/using-hiv-medication-to-reduce-risk/pre-exposure-prophylaxis) for HIV-negative adults at high risk for getting HIV through sex or injection drug use.

15. Immunization vaccines (https://healthfinder.gov/HealthTopics/Category/doctor-visits/shotsvaccines/get-important-shots) for adults - doses, recommended ages, and recommended populations vary:

    - Diphtheria (https://www.hhs.gov/immunization/diseases/diphtheria/index.html)
    - Hepatitis A (https://www.hhs.gov/immunization/diseases/hepatitis-a/index.html)
    - Hepatitis B (https://www.hhs.gov/immunization/diseases/hepatitis-b/index.html)
    - Herpes Zoster (Shingles) (https://www.hhs.gov/immunization/diseases/shingles/index.html)
    - Human Papillomavirus (HPV) (https://www.hhs.gov/immunization/diseases/hpv/index.html)
    - Influenza (flu shot) (https://www.hhs.gov/immunization/diseases/flu/index.html)
    - Measles (https://www.hhs.gov/immunization/diseases/measles/index.html)
    - Meningococcal (https://www.hhs.gov/immunization/diseases/meningococcal/index.html)
    - Mumps (https://www.hhs.gov/immunization/diseases/mumps/index.html)
    - Pertussis (Whooping Cough) (https://www.hhs.gov/immunization/diseases/pertussis/index.html)
    - Pneumococcal (https://www.hhs.gov/immunization/diseases/pneumonia/index.html)
    - Rubella (https://www.hhs.gov/immunization/diseases/rubella/index.html)
    - Tetanus (https://www.hhs.gov/immunization/diseases/tetanus/index.html)
    - Varicella (Chickenpox) (https://www.hhs.gov/immunization/diseases/chickenpox/index.html)

16. Lung cancer screening (https://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/lung-cancer-screening) for adults 50 to 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years.

17. Obesity screening and Counseling (https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/watch-your-weight).

18. Sexually transmitted infection (STI) prevention counseling (https://healthfinder.gov/healthtopics/category/health-conditions-and-diseases/hiv-and-other-stds) for adults at higher risk.

19. Statin preventive medication (https://healthfinder.gov/healthtopics/category/doctor-visits/talking-with-the-doctor/medicines-to-prevent-heart-attack-and-stroke-questions-for-the-doctor) for adults 40 to 75 at high risk

20. Syphilis screening (https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/syphilis-testing-questions-for-the-doctor) for adults at higher risk.

21. Tobacco Use screening (https://health.gov/myhealthfinder/topics/health-conditions/diabetes/quit-smoking) for all adults and cessation interventions for tobacco users.

22. Tuberculosis screening (https://healthfinder.gov/HealthTopics/Category/doctor-visits/talking-with-the-doctor/testing-for-latent-tuberculosis) for certain adults without symptoms at high risk.

MORE ON PREVENTION

- Learn more about preventive care from the CDC (https://www.cdc.gov/prevention/).
- See preventive services covered for children (https://www.healthcare.gov/preventive-care-children/) and women (https://www.healthcare.gov/preventive-care-women/).
- Learn more about what else Marketplace health insurance plans cover (https://www.healthcare.gov/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. Breastfeeding support and counseling (https://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.

2. Birth Control (https://health.gov/myhealthfinder/topics/everyday-healthy-living/sexual-health/choose-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." Learn more about contraceptive coverage (https://www.healthcare.gov/coverage/birth-control-benefits/).

3. Folic acid (https://health.gov/myhealthfinder/topics/everyday-healthy-living/nutrition/get-enough-folic-acid) supplements for women who may become pregnant.

4. Gestational diabetes screening (https://healthfinder.gov/HealthTopics/Category/doctor-visits/talking-with-the-doctor/gestational-diabetes-screening-questions-for-the-doctor) for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes.

5. Gonorrhea screening (https://health.gov/myhealthfinder/topics/health-conditions/hiv-and-other-stds/get-tested-chlamydia-and-gonorrhea) for all women at higher risk.

6. Hepatitis B screening (https://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/have-a-healthy-pregnancy) for pregnant women at their first prenatal visit.

7. Maternal depression screening for mothers at well-baby visits.

8. Preeclampsia prevention and screening (https://healthfinder.gov/healthtopics/category/pregnancy/doctor-and-midwife-visits/preventing-preeclampsia-questions-for-the-doctor) for pregnant women with high blood pressure.

9. Rh Incompatibility screening (https://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.

10. Syphilis screening (https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/syphilis-testing-questions-for-the-doctor).

11. Expanded tobacco intervention and counseling (https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/quit-smoking) for pregnant tobacco users.

12. Urinary tract or other infection screening (https://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/have-a-healthy-pregnancy)

Get more information about services for pregnant women from HealthFinder.gov (https://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/have-a-healthy-pregnancy)

Other covered preventive services for women:

1. Bone density screening (https://health.gov/myhealthfinder/topics/doctor-visits/screening-tests/get-bone-density-test) for all women over age 65 or women age 64 and younger that have gone through menopause.

2. Breast cancer genetic test counseling (BRCA) (https://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.

3. Breast cancer mammography screenings (https://health.gov/myhealthfinder/topics/health-conditions/cancer/get-tested-breast-cancer) every 2 years for women 40 and over.

4. Breast cancer chemoprevention counseling (https://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.

5. Cervical cancer screening (https://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-screened-for-cervical-cancer) Pap test (also called a Pap smear) for women age 21 to 65.

6. Chlamydia infection screening (https://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.

7. Diabetes screening (https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes) for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before.

8. Domestic and interpersonal violence screening and counseling (https://healthfinder.gov/HealthTopics/Category/everyday-healthy-living/mental-health-and-relationship/watch-for-warning-signs-of-relationship-violence) for all women.

9. Gonorrhea screening (https://health.gov/myhealthfinder/topics/health-conditions/hiv-and-other-stds/get-tested-chlamydia-and-gonorrhea) for all women at higher risk.

10. HIV screening and counseling (https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/get-tested-for-hiv) for everyone age 15 to 65, and other ages at increased risk.

11. PrEP (pre-exposure prophylaxis) HIV prevention medication (https://www.hiv.gov/hiv-basics/hiv-prevention/using-hiv-medication-to-reduce-risk/pre-exposure-prophylaxis) for HIV-negative women at high risk for getting HIV through sex or injection drug use.

12. Sexually transmitted infections counseling (https://healthfinder.gov/healthtopics/category/health-conditions-and-diseases/hiv-and-other-stds) for sexually active women.

13. Tobacco use screening and interventions (https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/quit-smoking).

14. Urinary incontinence screening (https://www.womenspreventivehealth.org/recommendations/screening-for-urinary-incontinence/) for women yearly.

15. Well-woman visits (https://healthfinder.gov/HealthTopics/Category/everyday-healthy-living/sexual-health/get-your-well-woman-visit-every-year) to get recommended services for all women.

MORE ON PREVENTION

- Learn more about preventive care from the CDC (https://www.cdc.gov/prevention/).
- See preventive services covered for all adults (https://www.healthcare.gov/preventive-care-adults/) and children (https://www.healthcare.gov/preventive-care-children/).
- Learn more about what else Marketplace health insurance plans cover (https://www.healthcare.gov/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 copayment (/glossary/copayment) or coinsurance (/glossary/co insurance). This is true even if you haven't met your yearly deductible (/glossary/deductible).

1. Alcohol, tobacco, and drug use assessments (https://healthfinder.gov/HealthTopics/Category/parenting/healthy-communication-and-relationships/talk-to-your-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** (https://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** (https://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** (https://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** (https://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-teens-visit-to-the-doctor-ages-15-to-17).

4. Bilirubin concentration screening (https://health.gov/myhealthfinder/topics/pregnancy/doctor-and-midwife-visits/talk-your-doctor-about-newborn-screening#panel-1) for newborns.

5. Blood pressure screening for children ages: **0 to 11 months** (https://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** (https://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** (https://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** (https://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-teens-visit-to-the-doctor-ages-15-to-17).

6. Blood screening (https://health.gov/myhealthfinder/topics/pregnancy/doctor-and-midwife-visits/talk-your-doctor-about-newborn-screening#panel-1) for newborns.

7. Depression screening (https://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-your-teen-screened-for-depression) for adolescents beginning routinely at age 12.

8. Developmental screening (https://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/watch-for-signs-of-speech-or-language-delay) for children under age 3.

9. Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders.

10. Fluoride supplements (https://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/take-care-of-your-childs-teeth) for children without fluoride in their water source.

11. Fluoride varnish (https://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/take-care-of-your-childs-teeth) for all infants and children as soon as teeth are present.

12. Gonorrhea preventive medication (https://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/talk-with-your-doctor-about-newborn-screening) for the eyes of all newborns.

13. Hearing screening (https://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/talk-with-your-doctor-about-newborn-screening) for all newborns; and regular screenings for children and adolescents as recommended by their provider.

14. Height, weight and body mass index (BMI) measurements taken regularly for all children.

15. 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.

16. Hemoglobinopathies or sickle cell screening (https://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/talk-with-your-doctor-about-newborn-screening) for newborns.

17. Hepatitis B screening (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening?ds=1&s=hepatitis%20b) for adolescents at higher risk.

18. HIV screening (https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/get-tested-for-hiv) for adolescents at higher risk.

19. Hypothyroidism screening (https://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/talk-with-your-doctor-about-newborn-screening) for newborns.

20. PrEP (pre-exposure prophylaxis) HIV prevention medication (https://www.hiv.gov/hiv-basics/hiv-prevention/using-hiv-medication-to-reduce-risk/pre-exposure-prophylaxis) for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use.

21. Immunization vaccines (https://healthfinder.gov/HealthTopics/Category/doctor-visits/shotsvaccines/get-your-childs-shots-on-schedule) for children from birth to age 18 - doses, recommended ages, and recommended populations vary:

    - Diphtheria (https://www.cdc.gov/vaccines/parents/diseases/diphtheria.html), Tetanus (https://www.cdc.gov/vaccines/parents/diseases/tetanus.html), Pertussis (Whooping Cough) (https://www.cdc.gov/vaccines/parents/diseases/pertussis.html).

    - Haemophilus influenza type b (https://www.cdc.gov/vaccines/parents/diseases/hib.html)

- Hepatitis A (https://www.cdc.gov/vaccines/parents/diseases/hepa.html)
- Hepatitis B (https://www.cdc.gov/vaccines/parents/diseases/hepb.html)
- Human Papillomavirus (HPV) (https://www.cdc.gov/vaccines/parents/diseases/hpv.html)
- Inactivated Poliovirus (https://www.cdc.gov/vaccines/parents/diseases/polio.html)
- Influenza (flu shot) (https://www.cdc.gov/vaccines/parents/diseases/flu.html)
- Measles (https://www.cdc.gov/vaccines/parents/diseases/measles.html)
- Meningococcal (https://www.cdc.gov/vaccines/parents/diseases/mening.html)
- Pneumococcal (https://www.cdc.gov/vaccines/parents/diseases/pneumo.html)
- Rotavirus (https://www.cdc.gov/vaccines/parents/diseases/rotavirus.html)
- Rubella (https://www.cdc.gov/vaccines/parents/diseases/rubella.html)
- Varicella (Chickenpox) (https://www.cdc.gov/vaccines/parents/diseases/varicella.html)

22. Lead screening (https://www.aap.org/en/patient-care/lead-exposure/ for children at risk of exposure.

23. Obesity screening and counseling (https://healthfinder.gov/HealthTopics/Category/parenting/nutrition-and-physical-activity/help-your-child-stay-at-a-healthy-weight).

24. Oral health risk assessment for young children from 6 months to 6 years.

25. Phenylketonuria (PKU) screening (https://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/talk-with-your-doctor-about-newborn-screening) for newborns.

26. Sexually transmitted infection (STI) prevention counseling and screening (https://health.gov/myhealthfinder/topics/health-conditions/hiv-and-other-stds) for adolescents at higher risk.

27. Tuberculin testing for children at higher risk of tuberculosis ages: : **0 to 11 months** (https://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** (https://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** (https://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** (https://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-teens-visit-to-the-doctor-ages-15-to-17).

28. Vision screening (https://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-your-childs-vision-checked) for all children.

29. Well-baby and well-child visits (https://health.gov/myhealthfinder/topics/doctor-visits/regular-checkups)

More information about preventive services for children

- Preventive services for children age **0 to 11 months** (https://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-babys-visit-to-the-doctor-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** (https://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** (https://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** (https://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 (https://www.healthcare.gov/preventive-care-adults/) and women (https://www.healthcare.gov/preventive-care-women/).
- Learn more about what else Marketplace health insurance plans cover (https://www.healthcare.gov/coverage/what-marketplace-plans-cover/).