Seventh-day Adventist® Church
NORTH AMERICAN DIVISION

ADVENTIST RETIREMENT

SHARP

Supplemental
Healthcare
Adventist
Retirement
Plan

2024

Pre-Medicare Non-Medicare

For Retirees and Spouses Less than 65 years and Dependent Children less than 26 years

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4854-4526-6583.6

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INTRODUCTION

The North American Division of Seventh-day Adventists (NAD) offers a healthcare assistance plan for certain Eligible Retirees and their Eligible Spouses and Eligible Dependent children through the Adventist Retirement Plans office. The Adventist Retirement Board administers the Plan. The North American Division of Seventh-day Adventists ("NAD") established this "Supplemental Healthcare, Adventist Retirement Plan (Pre-Medicare and Non-Medicare)" as a church plan and an auxiliary benefit of the Seventh-day Adventist Retirement Plan of the North American Division to benefit vested retirees (and dependents of vested retirees) of the Adventist Retirement Plans. 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 Adventist Retirement Board has appointed Adventist Risk Management, Inc. as plan administrator. This document describes the Supplemental Healthcare, Adventist Retirement Plan (SHARP) Pre-Medicare/Non-Medicare Option for the 2024 Plan Year. ***Capitalized terms used are defined in the SHARP Glossary and the Definitions section of this document.***

This Plan is a retirement medical benefit for those who have met vesting requirements under a NAD Defined Benefit and/or Defined Contribution retirement plan. The SHARP Pre-Medicare/Non-Medicare Option is not an insurance program or policy.

The Plan provides a broad range of benefit choices for medical, vision, dental, and prescription expenses which you, your Eligible Spouse and your Eligible Dependents may incur in the United States. In addition, the SHARP Pre-Medicare/Non-Medicare Option Plan pays benefits for "emergency" medical expenses incurred anywhere in the world for hospital care, surgery, pre-admission testing and prescription drugs. The Plan pays a portion of the cost of these medical services according to the Schedule of Benefits.

The Summary Plan Description (SPD) is designed to provide you with important information about your Plan's benefits, limitations and procedures. Benefits described in this document are effective January 1, 2024. This SPD is the Plan document. This SPD describes the benefits available to all members of the Plan; however, depending on your state of residence, you may be entitled to additional benefits under state law. In this SPD, the terms, "you" and "your" refer to the retiree/member. The terms "we," "us" and "our" refer to the plan administrator. Questions about the Plan should be directed to the phone numbers on your benefit ID cards or to www.webtpa.com.

Plan Year: January 1 – December 31

Under the SHARP Pre-Medicare Option, retirees may choose among the following:

- SHARP Pre-Medicare Option, medical benefit
- SHARP DVH Option (Dental, Vision and Hearing benefits)
- Rx Option (Prescription Drug benefit), or
- A combination of these Options

The SHARP Non-Medicare Option provides medical, dental, vision, hearing and prescription benefits for Eligible Dependent children up to age 26.

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 health care services and products that are available, particularly treatment that is not medically necessary.

This Plan document describes the Plan's provisions for the period of January 1, 2024, through December 31, 2024. All benefit limits and deductibles are based on the Plan Year. A member who enrolls in SHARP during the Plan Year will have access to full limits and will be subject to full deductible without pro-ration.

Retirees Share in SHARP Cost

The Adventist Retirement Plan pays part of the cost for SHARP Pre-Medicare/Non-Medicare coverage through a monthly contribution. This is based primarily on years of qualifying church service credit and the policies in place at retirement as described in the Earned Credit section. The Eligible Retiree pays the remainder of the cost.

Timely Enrollment is Important

There is no automatic enrollment in SHARP. Retirees who do not enroll within thirty days of the eligibility will not be eligible for assistance with health care costs. Enrollment forms are included at the end of this booklet and online at www.adventistretirement.org.

Limited Options for Changing Benefits

There are limited opportunities to change benefit selections under SHARP Pre-Medicare/Non-Medicare. It is important to read this document carefully to fully understand these limits and then select the benefit options that make sense for the Eligible Retiree and the Eligible Spouse and /or Eligible Dependent children.

If you have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you choices about your prescription drug coverage. Please see the section of this booklet entitled "Medicare Prescription Drug Plan Information" for more details.

ELIGIBILITY

The persons described below, referred to throughout this document as Members, are eligible to choose to participate in the SHARP Pre-Medicare/Non-Medicare Option, SHARP DVH Option and Rx (prescription drug) Option.

Retiree Eligibility

To be an Eligible Retiree in SHARP Pre-Medicare/Non-Medicare, SHARP DVH or Rx Options, a retiree must have at least 15 years of Service Credit by July 1, 2020 (as defined by Retirement Plan Service in the Glossary) and be:

1. a beneficiary of one of the Seventh-day Adventist Retirement Plan of the North American Division and Auxiliary Benefits Z 15, The Seventh-day Adventist Hospital Retirement Plan Article I Section 1.26, 1.33, 1.34 (see page 10 for reference to years of service policy) or the Adventist Retirement Plan (Defined Contribution Plan). Or

2. a beneficiary with Pre-2000 service in the Canadian Retirement Plan operated by the Seventh-day Adventist Church in Canada and have a retirement benefit resulting from Retirement Plan

Service in either the Pre-2000 Defined Benefit Plan or the Adventist Retirement Plan Defined Contribution Plan.

In addition, certain individuals who are otherwise eligible for healthcare assistance under special arrangements with foreign Seventh-day Adventist church entities for their resident retirees, or through other policy provisions, can remain eligible for SHARP. Non-NAD service in foreign divisions does not qualify a retiree for healthcare assistance under SHARP for those who transfer to and begin employment in the NAD after 1999.

A retired minister who has opted out of Social Security and is 65 or older, must still enroll in Medicare, paying the substantial premiums Medicare may require. Without Medicare A and B, the retiree would not be eligible to participate in SHARP Ex. The DVH Option is the only benefit available to this category of retiree.

An Eligible Retiree who is:

1. less than age 65 may select coverage under Pre-Medicare SHARP, which offers choices of medical, DVH and Rx options.
2. less than age 65 but *is enrolled for Medicare Parts A and B because of a Social Security disability,* may select coverage only from the SHARP Base, Rx and DVH Options. Please refer to the SHARP Standard Less than Age 65 with Medicare as Primary Coverage booklet for coverage and enrollment.
3. age 65 or older may select coverage only from the SHARP-Ex Options. Please refer to the SHARP-Ex booklet for coverage and enrollment.

Spouse Eligibility

To be an Eligible Spouse in SHARP Pre-Medicare, an Eligible Retiree's spouse:

1. must be covered for a joint and survivor (J&S) spouse benefit by the Eligible Retiree under the Defined Benefit Plan prior to July 1, 2020, (or have a similar status by election under the Defined Contribution Plan in accordance with procedures established by the Adventist Retirement Office) or be eligible under the special rules described in the section on Special Enrollment Rights – Family Status Changes.

An Eligible Spouse who is:

1. less than age 65 may select Pre-Medicare SHARP coverage, which offers choices of medical, DVH and Rx options.
2. less than age 65 but *enrolled for Medicare Parts A and B because of Social Security disability,* may select coverage only from the SHARP options found in the SHARP Less Than age 65 with Medicare as Primary Coverage Option.
3. age 65 or older may select coverage only from the SHARP-Ex Options. Please refer to the SHARP-Ex booklet for coverage and enrollment.

An Eligible Retiree's spouse who works full-time and is eligible for coverage under his/her employer's healthcare plan is not an Eligible Spouse unless he/she takes primary coverage under the other employer's healthcare plan.

In instances of a previous marriage, the policy regarding retirement benefits, including healthcare, is directed by the NAD Retirement policy and guidelines which may include a requirement for a court order (sometimes referred to as a QDRO). This order may affect the healthcare eligibility for the current spouse and may also result in reduced healthcare assistance for that spouse.

The Plan reserves the right to review and approve spouse eligibility in the year of the retiree's retirement. Retirees who have been married less than one year prior to retirement, may enroll their spouse in SHARP at full cost at their retirement effective date. No earned credit is applied.

Retirees who marry after their retirement effective date have a limited opportunity (30 days from date of marriage) to enroll their new spouse in SHARP. The new non-eligible spouse is not eligible for Earned Credit, Additional Church Accrued Pension Supplement, or the Health Reimbursement Account benefits. (See Section on Special Enrollment Rights).

Dependent Children Eligibility

A dependent child of an Eligible Retiree or Eligible Spouse may be eligible for coverage under Non-Medicare SHARP.

An Eligible Dependent is:

1. the child (including a child born to you and/or your spouse, adopted child or child under legal guardianship) of an Eligible Retiree or Eligible Spouse prior to the date of Eligible Retiree's retirement, or a child who becomes eligible under the special rules described in the section on Special Enrollment Rights – Family Status Changes; and
2. under age 26;
3. a disabled child who is covered under Medicare Disability benefits, until the child attains age 26.

An Eligible Dependent described above shall remain an Eligible Dependent for 60 days following the death of the Eligible Retiree (or the second to die of both the Eligible Retiree and Eligible Spouse) and shall remain covered by the then existing coverage options until the end of such 60 days, unless an earlier termination of coverage is requested in writing on behalf of the Eligible Dependent. If there is no monthly pension benefit to cover healthcare enrollment costs, payment will be required in advance for the remaining enrollment period.

Medicaid

Medicaid is considered secondary healthcare coverage for all covered members who are receiving Medicaid benefits. The member may consult with the appropriate state agency to determine benefit rules. SHARP will abide by state rules and regulations. Enrollees who are participants in Medicaid or State aid should contact SHARP immediately as this may impact their SHARP healthcare benefits. SHARP may terminate coverage based on the member's Medicaid enrollment.

Eligibility Exclusions

1. Beneficiaries who elect or receive healthcare benefits from the Regional Retirement Plan are not eligible to participate in SHARP.

   a. Policy Z 10 25 & Z 20 05 of the North America Division Working policy.
2. The SHARP Pre-Medicare/Non-Medicare Options are not available to individuals who have primary residence outside of the continental United States. (Enrollment in SHARP DVH, with eligible Earned Credit, is allowed.)
3. Employees hired on or after July 1, 2020 are not eligible to participate in SHARP upon retirement.
4. Retirees who receive healthcare benefits under the Canadian Adventist Retirement Plan may not enroll under SHARP concurrently.

ENROLLMENT AND ENROLLMENT CHANGES

The effective date for SHARP Pre-Medicare/Non-Medicare coverage is generally the same as the retirement effective date for the Eligible Retiree. An Eligible Retiree must select SHARP Options including Pre-Medicare/Non-Medicare for himself/herself, as well as for any Eligible Spouse or Eligible Dependent child, within 30 days of the retirement effective date.

Without a timely (within thirty days of eligibility) submitted and signed enrollment form from the Eligible Retiree, healthcare assistance will *not* be provided under SHARP.

Limits for Enrollment Changes

Except as provided below in the section on Delayed Enrollment Due to Other Coverage and the section on Special Enrollment Rights, each Eligible Retiree and Eligible Spouse has only the following opportunities to *elect* SHARP Pre-Medicare/Non-Medicare benefits.

1. Within 30 days of the Eligible Retiree's effective date of retirement (or loss of other coverage as described under the Delayed Enrollment Due to Other Coverage – New Retiree Only provision below).
2. Within 30 days of loss of other coverage as described under the Delayed Enrollment Due to Other Coverage – New Retiree Only provision below.

Additionally, an Eligible Retiree or Eligible Spouse will be offered an enrollment in SHARP-Ex within 30 days of reaching age 65. The Eligible Retiree or Eligible Spouse may select any of the SHARP-Ex Options. SHARP abides by the Medicare enrollment rules for medical and prescription drug coverage. If SHARP Ex benefits are declined at age 65, it is considered a permanent opt-out of benefits.

> ➢ **Important Note**: With very limited exceptions identified below, the coverage selected during the above-listed enrollment opportunities will remain in effect during the life of the Eligible Retiree and the Eligible Spouse.

Delayed Enrollment Due to Other Coverage – New Retiree Only

A newly Eligible Retiree may choose to delay ALL SHARP coverage, for himself/herself or an Eligible Spouse or Eligible Dependent, if at his/her retirement effective date, other healthcare coverage (VA, Tricare, Medicaid, state/federal plan, other retirement plan healthcare coverage, employer coverage. This does not include

other Medicare supplemental coverage elected by the retiree.) is in place. If SHARP coverage is delayed for this reason, it can only be obtained in the future if one of the criteria listed in the section 'Loss of Coverage' are met.

For such a delay to be approved, the following must occur:

1. Within 30 days of retirement, the Eligible Retiree must provide the following information to the SHARP Office:
    a. the name of each person with current other coverage
    b. the effective date of the other coverage
2. Within 30 days of the loss of other coverage, the Eligible Retiree must contact the SHARP Office and complete all required SHARP enrollment forms.

Loss of Coverage

For the purposes of this section, a "loss of coverage" means an involuntary loss of healthcare coverage in any one of the following events:

1. loss of eligibility for coverage due to termination of employment (such as an Eligible Spouse's termination of employment),
2. (ii) loss of healthcare benefits from VA, Tricare, Medicaid, state/federal plan or other retiree plan healthcare coverage.
3. (iii) loss of healthcare benefits by an Eligible Retiree or Eligible Spouse as a result of legal separation, divorce or death.

"Loss of Coverage" does not include the voluntary decision of an Eligible Retiree or Eligible Spouse to terminate other employer healthcare coverage except for a reason described above.

The Eligible Retiree must notify SHARP of a "loss of coverage" within 30 days of the loss. Failure to notify SHARP within 30 days of a loss of coverage results in a permanent forfeiture of SHARP and SHARP Ex benefits.

Special Enrollment Rights –Changes in Family Status

An Eligible Retiree may enroll his/her newly married non-Eligible Spouse or any other Eligible Dependent in SHARP as a "special enrollee" if any one of the qualifying events happens:

1. Marriage
2. Birth of a newborn
3. Adoption or placement of a child in the home for adoption.
4. Loss of healthcare coverage as described under the Loss of Coverage section of the plan.

If any one of these events happens, the Eligible Retiree **must enroll** the newly acquired non-eligible spouse and/or Eligible Dependent within 30 days of the qualifying event. (Refer to the Glossary for the definition and rules regarding a non-eligible spouse.) Failure to notify SHARP within 30 days of the qualifying event results in a permanent forfeiture of SHARP and SHARP Ex benefits.

Discretionary Special Enrollment

The Adventist Retirement Board may find it necessary to make significant changes in SHARP. Should this occur SHARP may provide an opportunity to change some or all elections previously made under SHARP.

High Inflation Special Enrollment

Healthcare costs can fluctuate significantly. The Adventist Retirement Board will monitor costs and reserves the right to adjust retiree contributions with appropriate notice. If the three-year average percentage increase of contributions towards the Pre-Medicare, Non-Medicare and DVH options exceeds the Consumer Price Index for the previous year, SHARP may allow a special enrollment period in which Eligible Retirees are permitted to drop one or more options.

Pre-Medicare SHARP Expiration

If an Eligible Retiree or Eligible Spouse is enrolled in Pre-Medicare SHARP, upon reaching age 65 the Pre-Medicare and Rx SHARP coverage will be terminated. An open enrollment is available to the individual turning age 65 to enroll in the SHARP-Ex and SHARP DVH. Refer to the SHARP-Ex document for plan guidelines.

Re-Employment

If an Eligible Retiree or Eligible Spouse returns to full-time employment for a participating church employer, subsequent to enrollment in SHARP and becomes eligible for participating church employer healthcare coverage, SHARP requires the Eligible Retiree and/or Eligible Spouse to terminate benefits in SHARP. To be reinstated into SHARP, a written request, with documentation of loss of coverage, must be submitted to the SHARP Office within 30 days of the loss of other coverage.

Surviving Retiree or Eligible Spouse

Upon the death of either the enrolled Eligible Retiree or Eligible Spouse/Eligible Dependent, SHARP will cease deductions for the deceased beneficiary. However, a surviving Eligible Retiree or Eligible Spouse will have a 30-day open enrollment period during which he/she may amend the coverages which are in place at the covered beneficiary's date of death. The enrollment for coverage rules is described in the Enrollment section above.

If an eligible Retiree dies prior to retirement, the surviving Eligible Spouse may enroll in SHARP upon the deceased Eligible Retiree's 65th birthday and completion of a retirement application.

A surviving non-eligible or non-Joint and Survivor spouse enrolled in SHARP benefits will have coverage terminated 30 days following the death of the Eligible Retiree.

Requested Termination of Benefit

If, at the request of the Eligible Retiree or Eligible Spouse, SHARP Pre-Medicare/Non-Medicare, SHARP DVH or Rx benefits are discontinued at a non-open enrollment period, the termination of benefits will be considered permanent and will not be reinstated. This termination rule applies until age 65 Open Enrollment for SHARP-Ex.

If an Eligible Retiree or Eligible Spouse currently enrolled in the SHARP DVH Option, then terminates the SHARP DVH Option, the termination is a permanent and lifetime stop of the benefit. This includes requests to

temporarily stop the benefit while residing outside of the United States. Mid-year terminations are not permitted.

If coverage is terminated due to a return to employer healthcare coverage, the Eligible Retiree, Eligible Spouse and Eligible Dependent will be eligible to re-enroll upon meeting the Loss of Coverage rules outlined in this document.

Your Responsibility to Report Family Changes

Since SHARP may be unaware of family changes that affect you or your family member's eligibility for the Plan or the proper administration of the Plan, it is your responsibility to report changes in eligibility, general family or other status to SHARP within 30 days of the change. Failure to do so may reduce SHARP's ability to effectively administer benefits under the Plan. Examples of the types of changes that you must report are marital status changes such as divorce, new employment status of your spouse, return to full-time employment, change in disability status or medical condition of a dependent child, change in Medicare eligibility status, address/telephone changes, child custody changes, loss of eligibility for Medicaid or CHIP, and eligibility for Medicaid or CHIP premium assistance.

It is your responsibility to report changes in eligibility, general family or other status changes to SHARP. This includes divorce and children turning age 26. It is considered fraud on the Plan if you fail to report events that result in an individual's ceasing to be eligible for the Plan. You must repay to the Plan any benefits that were erroneously paid for ineligible family member (such as a child who lost eligibility for the Plan) due to your failure to report family changes to the Plan.

Pre-Existing Conditions

The Plan does not have exclusions for pre-existing conditions.

WHEN COVERAGE ENDS

Your coverage ends the earliest of:

- The date on which you turn age 65;
- The date on which you return to full-time employment with any participating employer of the Plan (and become eligible for health coverage through the participating employer).

Coverage for your covered spouse ends the earliest of:

- The date on which your spouse turns age 65;
- The date on which your spouse returns to full-time employment with any participating employer of the Plan (and becomes eligible for health coverage through the participating employer);
- The date of a divorce or annulment, unless there is a qualified domestic relations order extending continued rights to coverage under the Plan post-divorce or annulment.

Coverage for your covered dependent child ends the earliest of:

- 60 days after the death of the Eligible Retiree (or 60 days after the death of the second to die of both the Eligible Retiree and the Eligible Spouse); coverage costs must be paid in advance or benefits will be terminated;
- The dependent child's attainment of age 26;
- The date the dependent child no longer meets the eligibility requirements, including, if applicable, the date you are no longer legally required to provide medical coverage for the dependent child.

If the Plan is terminated, coverage ends for you and your covered spouse and covered dependents on the date the Plan ends unless an extension of coverage is 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.

MARKETPLACE COVERAGE CONTINUATION OPTIONS

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. See www.healthcare.gov for additional information.

SHARP Options and Costs

The SHARP Options may be selected individually or in combination with each other as noted in this document. The costs for each option may also be found on the enrollment form at the back of this document.

- SHARP Pre-Medicare Option $517/month/person
- SHARP DVH Option $105/month/person
- SHARP Rx Option $154/month/person
- SHARP Non-Medicare Option $184/month/person

EARNED CREDIT – ELIGIBILITY AND AMOUNTS

SHARP Earned Credit – In General

An Earned Credit is calculated for Eligible Retirees based on years of Retirement Plan Service. The Earned Credit is the monthly amount made available to assist an Eligible Retiree with the costs of the SHARP Options selected. The Earned Credit eligibility rules are described below.

Each Eligible Retiree (and each Eligible Spouse) will receive his/her own Earned Credit. This means that if the Eligible Retiree and Eligible Spouse is covered under SHARP Pre-Medicare/Non-Medicare, each will receive an Earned Credit for SHARP. If eligible for an Earned Credit, an Eligible Retiree or Eligible Spouse who selects benefits under SHARP Pre-Medicare will receive two Earned Credits, one for SHARP DVH Option & Rx Option combined and another Earned Credit for SHARP Pre-Medicare.

The Earned Credit is applied to the total cost of the Options that each individual selects. If the costs of the selections exceed the Earned Credit, the balance will be withheld from the Eligible Retiree's monthly

retirement benefits (or direct billing arrangements are made if no retirement benefit is available). If the cost of the SHARP Options is less than the Earned Credit, the amount left over is neither paid to the Eligible Retiree, nor can it be used to cover another family member.

SHARP Earned Credit may only be used for SHARP Pre-Medicare and SHARP Non-Medicare. SHARP Pre-Medicare and SHARP Non-Medicare covered members may only use their Earned Credit for that category of coverage.

Determining the Earned Credit Category

The category in the Earned Credit Table is determined based on the sum of years of Retirement Plan Service credit from the following sources:

- Pre-2000 years under the Defined Benefit Plan
- Post-1999 years under the Defined Contribution Plan for employees hired before January 1, 2000
- Years from January 1, 2000 through June 30, 2020 under the Defined Contribution Plan for employees hired on or after January 1, 2000. Employees with only Defined Contribution Plan service cease accruing service credit for SHARP healthcare assistance beginning July 1, 2020.
- 2000-2004 under the "career completion option" under the Defined Contribution Plan
- Pre-2000 Canadian Retirement Plan
- Non-NAD service in foreign divisions for those who transferred to and began employment in the NAD before 2000.
- Pre-2000 years under the Bermuda Retirement Plan
- Pre-2000 years under the Kettering College of Medical Arts

Important Note for retirees with Adventist hospital service: Years of service with the Adventist hospital system generally do not count as Retirement Plan Service under SHARP. Exceptions to this exclusion include those who retired prior to 1991 and those 'grandfathered' employees who, on December 31, 1991, were in denominational employment and were 55+ years of age with 25+ years of service credit, as determined under the Defined Benefit Pan in effect in 1991.

Eligibility for Earned Credit

Those eligible to participate in SHARP are eligible for an Earned Credit as follows:

- **For an Eligible Retiree:**
  - The Eligible Retiree is at least age 65, or
  - The Eligible Retiree is less than age 65 but has 40 years of qualifying Retirement Plan Service, or
  - The Eligible Retiree was eligible for early retirement prior to 2003, regardless of when retirement occurred, and was determined eligible for healthcare assistance with 15 or more years of Retirement Plan Service Credit.
  - The Eligible Retiree's primary residence is within the United States

- **For an Eligible Spouse:**
  - The Eligible Retiree must be eligible for an HRA or Earned Credit,
  - The Eligible Spouse must have been an Eligible Spouse as of the retiree's retirement effective date
  - No age requirement applies for the Eligible Spouse.
  - The Eligible Retiree/Eligible Spouse primary residence is within the United States.

- **For Dependent Children:**
  - The Eligible Retiree must be eligible for Earned Credit,
  - The Eligible Dependent must be under age 26, and
  - The child must have been determined to be an Eligible Dependent as of the Eligible Retiree's retirement effective date or meet the rules of Special Enrollment Rights – Changes in Family Status Requirements.
  - The Eligible Retiree/Eligible Dependent's primary residence is within the United States.

- **Future Eligibility for Earned Credit**
  - Retirees who are under age 65 and have fewer than 40 years of Retirement Plan Service (who are thus not eligible for an Earned Credit) may participate in SHARP Pre-Medicare, and the SHARP DVH or Rx Options, at their own cost.
  - An Eligible Retiree will become entitled to Earned Credit once he/she meets the Earned Credit eligibility as noted above. An Eligible Spouse and/or Eligible Dependent children will qualify for an Earned Credit only when the Eligible Retiree qualifies for an Earned Credit.

2024 Pre-Medicare/Non-Medicare EC Table*							
Years of qualifying church service	**35+**	**30-34**	**25-29**	**20-24**	**15-19**	**8-14***	**1-7***
Category	**A**	**B**	**C**	**D**	**E**	**F**	**G**
Pre-Medicare Medical	$440	$385	$330	$275	$220	$170	$110
Pre-Medicare Rx/DVH	$200	$180	$160	$140	$120	$100	$80
Non-Medicare	$130	$115	$100	$80	$65	$50	$35

***Based on eligibility**

****Note:** The columns above showing less than 15 years are for special situations such as divorce and pre-retirement re-marriage where a residual amount of healthcare is available to a new spouse. Eligibility for SHARP participation requires 15 years of Retirement Plan Service.

SHARP BILLING PROCESS

SHARP Monthly Statement/Invoice Process

SHARP deducts the monthly cost for the SHARP coverage selected from the retiree pension. If there are no monthly pension funds or the pension funds are insufficient to cover the cost, the retiree must make advance monthly payments to SHARP. This payment must be received by the SHARP department prior to the start of coverage. If there is a default on payment of the monthly cost, the SHARP coverage will be terminated. This will be a lifetime termination of the coverage.

Retirees are required to participate in an ACH/Automatic Debit payment to be enrolled in SHARP Billing. Upon enrollment, the retiree will provide SHARP with a signed ACH Authorization form including bank information for the ACH withdrawal.

Retirees are billed monthly. Payments are withdrawn/debited by the 15th of each month prior to coverage. If the initial enrollment is such that a retroactive payment is required, the retroactive payment will be separate from the regular monthly or annual payment.

An enrollment letter will provide the retiree with the guidelines and the ACH process. See Appendix for additional information.

SHARP PRE-MEDICARE/NON-MEDICARE PLAN VENDOR PARTICIPANTS

SHARP, through Adventist Risk Management, Inc. as Plan Administrator, has contracted services from the following three vendors to assist in health plan functional processes.

PLAN ADMINISTRATOR
Adventist Risk Management, Inc.
12501 Old Columbia Pike
Silver Spring, MD 20904
www.adventistrisk.org

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

MEDICAL, DENTAL, VISION & HEARING CLAIMS PROCESSING
WebTPA (Language Line Solutions)
PO Box 1928
Grapevine, TX 76099-1928
1-800-447-5002
Envoy Payer ID: 75261

UTILIZATION REVIEW MANAGER
(Medical Necessity, Pre-Certification, And Appeals)
Adventist Health Benefits Administration
PO Box 92101
Portland, OR 97292
1-800-447-5002

PRESCRIPTION CLAIMS PROCESSING

Express Scripts 1-800-841-5396

SHARP ELIGIBILTY
1-443-391-7338
SHARP@nadadventist.org

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next twelve (12) months, a Federal Law gives you more choices about your prescription drug coverage. Please see page 100 for more details.

BENEFIT PLAN PROVISIONS

The Schedule of Benefits table (page 23) summarizes your *Plan* benefits applicable deductibles, the annual out-of-pocket maximums, and the *co-payments* and *co-insurance* applicable to your coverage. This section only provides a summary of benefits available. For a complete discussion of the services covered under the *Plan*, as well as applicable benefit limitations, exclusions from coverage, and conditions of service that apply to your coverage, please refer to the subsequent chapters in this SPD.

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

Plan Coverage Levels – PPO Network

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

Deductibles and Annual Out-of-Pocket Maximum Deductible

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

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

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

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

Annual Out-of-Pocket Maximum

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

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

- Your required monthly *contribution*
- 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 under drug manufacturer patient assistance programs; for example, copay coupons (these are not true out-of-pocket costs)
- Amounts you pay for services listed in the Schedule of Benefits under "No PPO Network Utilization Required," such as alternative therapies, refractive eye surgery and hearing aids
- Amounts you pay for dental and vision benefits

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

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

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 80% of the *usual, reasonable, & customary charge* for *covered services* until you reach your out-of-pocket maximum.

The percentages the *Plan* pays apply only to *covered service* expenses that do not exceed *usual, reasonable & customary charges*. You are 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 *co-insurance* percentage of the cost of *covered services* (up to the *usual, reasonable, and customary charge*). *Co-insurance* percentages are the portions of *covered service* expenses paid by you after satisfaction of any applicable deductible. For example, if the listed percentage in the chart below is 20%, then for *in-network providers* your *co-insurance* would be 20% of the *network rate.*

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

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

SCHEDULE OF BENEFITS

Plan Benefits Designated Provider Program January 1 – December 31, 2024

NOTE: For all Plan benefits, the following apply:

- Copayments do not accrue towards the annual deductible and apply only to the office visit charge.
- All other U&C (Usual, Reasonable & Customary) charges apply to deductible and out-of-pocket maximum unless otherwise noted.
- After you pay your deductible, the Plan will pay 80% of the Network or U&C for covered services until you reach your out-of-pocket maximum.
- Pre-certification is required for some services, and expenses incurred due to non-compliance do not accrue toward deductible or out-of-pocket maximum.
- Out-of-network services are only covered in very limited circumstances. Where the below chart says "not covered" in the Out-of-Network column, services will not be covered without an approved Unavailable Service Request Form ("USRF"). See the Continuity of Care section of the Providers and Facilities Available Under the Plan chapter for short-term transition service available in limited circumstances when an in-network provider/facility leaves the network. The services listed in the "Ancillary Medicare Benefits" chart are covered both in-network and out-of-network.
- Charges in excess of U & C (Usual, Reasonable & Customary) are the 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 certain limited situations).
- The Schedule of Benefits is only a brief summary. You should read the appropriate Plan sections for additional information about your coverage.
- Only Eligible Retirees who have 40 or more years of Service Credit are eligible for the Low Deductible Plan. Other Eligible Retirees are eligible for the High Deductible Plan.

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

MAJOR MEDICAL BENEFITS January 1 – December 31, 2024

MEDICAL BENEFITS

Benefits	Low Deductible Plan	High Deductible Plan	Out-of-Network *Usually Not Covered. Even If Covered, You May Be Subject To Balance Billing.*
	MEMBER RESPONSIBILITY		
DEDUCTIBLE • Individual/Family • Services subject to deductible are marked with (D)	$350 / $700	$650 / $1,300	Not Covered
COINSURANCE (AFTER DEDUCTIBLE) PAID BY MEMBER	20%, unless otherwise noted	20%, unless otherwise noted	
OUT-OF-POCKET MAXIMUMS • Individual/Family	$2,850 / $5,700	$5,700 / $11,400	Not Covered
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	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	Low Deductible Plan	High Deductible Plan	Out-of-Network *Usually Not Covered. Even If Covered, You May Be Subject To Balance Billing.*
	MEMBER RESPONSIBILITY		
THERAPEUTIC SERVICES - Rehabilitative **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
THERAPEUTIC SERVICES – Habilitative **Physical Therapy** **Occupational Therapy** **Speech Therapy** **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 Only covered as noted in this Plan document	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 $200 copay (D)*	Same benefit applies
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)

Benefits	Low Deductible Plan	High Deductible Plan	Out-of-Network *Usually Not Covered. Even If Covered, You May Be Subject To Balance Billing.*
	MEMBER RESPONSIBILITY		
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)
URGENT CARE CENTERS • May be paid as either an office visit or as an Emergency room visit according to provider contract • Deductible does not apply regardless of how billed • Facility fees for office visits are not paid	20% after $25 copayment – when paid as Office Visit **Or** $100 + 20% – when paid as ER visit	20% after $50 copayment – when paid as Office Visit **Or** $200 + 20% – when paid as ER visit	Same benefit applies
EQUIPMENT / SUPPLIES			
DURABLE MEDICAL EQUIPMENT • Benefits include purchase or rental, not to exceed the purchase price of the equipment. • *Pre-certification* required for any continuous passive motion (CPM) devices/machines, Dynasplints, insulin pump, and continuous glucose monitor (CGM). • *Pre-certification* required for other durable medical equipment or repair with billed charges of $2,000 or more • *Pre-certification* required for any custom orthotics and for orthotics/prosthetics with billed charges of $2,000 or more	20% (D)	20% (D)	Not covered
WIG AS A RESULT OF RADIATION, CHEMOTHERAPY, OR PATHOLOGICAL CHANGE IN THE BODY • Plan year maximum benefit $1,000	20% (D)	20% (D)	20% (D)
MENTAL HEALTH / SUBSTANCE ABUSE			
MENTAL HEALTH COUNSELING SESSIONS	$25	$50	Same benefit applies
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	$25	$50	Same benefit applies
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	Low Deductible Plan	High Deductible Plan	Out-of-Network *Usually Not Covered. Even If Covered, You May Be Subject To Balance Billing.*
	MEMBER RESPONSIBILITY		
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%
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 (do not require PPO network utilization, if covered)	Low Deductible Plan	High Deductible Plan
	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 = 30 •Must be age 10 or older •Does not apply to plan year deductible or out-of-pocket maximum	50%	50%
ALTERNATIVE THERAPIES ACUPUNCTURE THERAPY	Not covered	Not covered
ALTERNATIVE THERAPIES MASSAGE THERAPY	Not covered	Not covered
ALTERNATIVE THERAPIES LIFESTYLE PROGRAMS	Not covered	Not covered
REFRACTIVE EYE SURGERY • Lifetime maximum payable benefit of $2,400 • Does not apply to plan year deductible or out-of-pocket maximum	50%	50%
HEARING AIDS • Plan year maximum payable benefit of $2,200 • Has a one-year lookback benefit • No deductible	20%	20%
VISION BENEFIT • Plan year maximum payable benefit of $400 • No deductible • Plan year maximum payable benefit does not apply to pediatric (under age 19) annual eye examination and one pair of standard, clear-lens, prescription glasses per Plan year • Co-insurance amounts paid toward pediatric (under age 19) annual eye examination and one pair of standard, clear-lens, prescription glasses per Plan Year will be applied toward out-of-pocket maximum	20%	20%
DENTAL BENEFIT • Plan year maximum payable benefit (Individual) of $2,200 DENTAL CARE • No deductible • Usual, Reasonable and Customary (U&C) applies • Annual maximum payable does not apply to pediatric dental preventive care for eligible dependents who are under age 19. Co-insurance amounts paid towards pediatric (under age 19) dental preventive care applies to the ACA out-of-pocket maximum.	20%	20%
ORTHODONTIC CARE – NON-MEDICARE MEMBER ONLY • Lifetime maximum payable benefit of $2,300 • Eligible up to age 24 (through age 23)	50%	50%

PRESCRIPTION BENEFITS

Prescription Drug Same For High And Low Deductible Plans	
Deductible Individual/Family	$400 / $800
Out-of-Pocket Maximums Individual/Family	$1,600 / $3,200
Prescription copayment responsibility	
30 DAY SUPPLY – short term drugs	**90 DAY SUPPLY – long term maintenance drugs (via Walgreen's Smart90, Express Scripts Home Delivery, or Accredo Specialty Pharmacy)**
Tier 1 – Generics $12 **Tier 2 – Preferred Brand $29** **Tier 3 – Non-Preferred Brand $45** **Specialty Drugs – prior authorization required**	**Tier 1 – Generics $29** **Tier 2 – Preferred Brand $70** **Tier 3 – Non-Preferred Brand $110** **Specialty Drugs – prior authorization required**

- 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 maximums
- The Plan pays 100% (and member pay $0) for some chronic and 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)
- See below for *coinsurance* for certain drugs offered through the SaveOnSP Specialty Drugs Program
- 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 (See the SaveonSP Specialty Drugs Program section below for exceptions).

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, and 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).

**NOTE: The Schedule of Benefits is only a brief summary. You should read the appropriate Plan sections for additional information about your coverage.

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 Out-of-Pocket Maximum is $9450 per person and $18,900 per family in 2024. Except as otherwise specified, unreimbursed in-network covered services that are medical or prescription drug expenses (except for chiropractic services, refractive eye surgery, and all services that are covered under the SHARP DVH Option other than under age 19 pediatric preventive dental, pediatric annual eye examination, and pediatric eyeglasses) are applied to the ACA out-of-pocket maximum includes any co-payments, co-insurances, and deductibles, but does not include the member share contribution costs. Amounts in excess of usual, reasonable, and customary do not apply to the ACA out-of-pocket maximum.

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

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

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

Canadian Retirement Plan means the Seventh-day Adventist Retirement Plan for the church in Canada.

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 Centers for Medicare and Medicaid Services, the agency that administers Medicare, Medicaid, and Child Health Insurance Program.

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

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

Condition means a *medical condition*.

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).

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, orthotics and oxygen tanks.

Earned Credit means the amount of health care assistance under SHARP based upon retirement plan service described in this document.

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 place the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn *child*) in serious jeopardy, (ii) cause serious impairment to bodily functions or (iii) cause serious dysfunction of any bodily organ or part.

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

of the *condition* is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman who is having contractions, to deliver (including the placenta).

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 chapter.

Enrollee means a covered retiree, a covered spouse or a covered dependent child.

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 to identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

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.

Illness means a disease or bodily disorder.

Implant means a material inserted or grafted into tissue.

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

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

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

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

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

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

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

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

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

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

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

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

Member means *enrollee*.

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

1. 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.
2. 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, F552.32, 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, F63.2, 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."

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:

- *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);
- *Urgent care*: Approved Unavailable Service Request Form ("USRF") services;
- 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*);
- Any other *medically necessary covered service* if coverage is required by the *No Surprises Act*; and
- 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 PPO Network may not have PPO providers accessible to members that deliver needed medical 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. 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 PPO Network Providers within approximately 25 miles, or approximately 35-40 minutes driving.
    - For metropolitan areas the distance of Medical 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.

Physician means a Doctor of Medicine or Osteopathy.

Plan means this SHARP Pre-Medicare/Non-Medicare Plan.

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

Plan Sponsor is North America Division of Seventh-day Adventist, Adventist Retirement Board.

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

PPO means Preferred Provider Organization, a type of managed care health insurance plan that provides maximum benefits if you visit an in-network physician or provider**.**

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.

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*. See page 35 for additional details.

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

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

SPD means Summary Plan Description.

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

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.

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

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

(i) For *out-of-network providers*, the normal and necessary charges submitted or made for similar services or supplies provided by other providers of medical or dental services with like experience, education and training in the same geographical area. The term "geographic area" as it applies to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a statistically representative cross-section of the level of charges. Determination of the *U&C* for a medicine, service, or supply shall be made by the *U&C* contract administrator, using the 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 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 service 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 submit 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 lower of billed charges or the "qualifying payment 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. Adventist Health Benefits Administration also hears non-prescription drug appeals of *adverse benefit determinations* involving *medical judgment*.

PRE-CERTIFICATION PROGRAM

The *Plan* has certain procedures that must be followed to reduce the cost of *Plan* benefits, such as a pre-admission/pre-service review process called *pre-certification*, which is performed by the *Plan's* utilization review manager. The *Plan's* utilization review manager can be reached by calling the number on your benefit ID card. (800-447-5002)

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*.

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 providers or suppliers 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.

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.

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, outpatient 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 ID 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 need to be hospitalized, you or your provider must contact the utilization review manager at the phone number on your benefit ID card before the hospitalization.

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

Services Requiring Pre-Certification

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

You or your provider should call the utilization review manager at the phone number on your benefit ID 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 MCG Health (Milliman Care Guidelines) 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 require 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 Admission (except for observation only 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 an non-PPO provider and/or in a non-PPO facility
4. (reserved)
5. Athletic training assessment
6. Artificial implantable cardiac-defibrillator (AICD), wearable (external) cardiac defibrillator, and implantable cardioverter defibrillator
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 (LAVD)
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 allography
16. High cost/specialty medications billed by the provider through the medical benefit require pre-certification through the utilization review manager (call the number on your ID card, 800-447-5002). Examples of high cost/specialty medications commonly billed through 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)
19. Proton Beam
20. Reserved
21. Endobronchial brachytherapy
22. Transcranial magnetic stimulation (TMS) as treatment of depression and other psychiatric/neurologic disorders
23. All plastic, cosmetic, or reconstructive surgery, including orthognathic surgery, and cosmetic procedures except initial breast reconstruction following medically necessary mastectomy
24. Removal of breast implants or other prosthetic implants that were implanted for cosmetic purposes
25. Nail debridement
26. Pectus deformity repair
27. Scar revision
28. Varicose vein procedures (e.g., sclerotherapy, echosclerotherapy, endovenous ablation RF or laser, ligation, stab phlebectomy)
29. Pneumatic compression devices and garments
30. Laser treatment for inflammatory skin disease (such as psoriasis, dermatitis, vitiglio)
31. Capsule endoscopy
32. Continuous glucose monitoring receivers and supplies when exceeding manufacturer recommended quantity limits
33. Insulin pumps
34. Assistive listening devices, FM/DM systems
35. Reserved
36. Bath/shower chairs, rails, transfer benches, hospital beds
37. Spinal cord stimulation
38. Kyphoplasty or vertebroplasty
39. Reserved
40. Artificial discs, cervical and lumbar
41. Transplants (including workup)
42. Acute inpatient rehabilitation and/or skilled nursing facility admissions
43. Cognitive rehabilitation
44. Applied behavioral analysis therapy

45. Developmental, behavioral, neuropsychological, neuroCI testing – outside of a pediatrician's office
46. Outpatient physical therapy (PT), occupational therapy (OT) and speech therapy (ST), for habilitative therapeutic services or for visits beyond 60 in one year for any single therapeutic service category will require prior approval via additional medical necessity review
47. Electroencephalogram, if performed as an inpatient, multi-day test
48. External counterpulsation (EECP)
49. Oscillatory devices for respiratory disease (The Vest)
50. UV light therapy (including light therapy for Seasonal Affective Disorder): home UV light systems and light boxes
51. 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;
52. Durable Medical Equipment or repair with billed charges of $2000 or more, all CPM devise/machines and Dynasplints (regardless of cost)
53. Orthotics/Prosthetics with billed charges over $2000 and/or custom orthotics
54. Radio frequency ablation, except for pain management; microwave tumor ablation and radioembolization of tumors
55. Mammography 3D Tomosynthesis screening if under the age of 40
56. Reserved
57. Reserved
58. Reserved
59. Sacral nerve stimulation (implanted) for pelvic floor dysfunction
60. Sacroiliac joint fusion
61. Sacrocolpopexy
62. Vagus nerve stimulation
63. Implantable intrastromal corneal ring
64. Cochlear implants (including supplies and replacements) and bone-anchored hearing aides
65. Wound vacuum therapy and supplies
66. Non-emergency ground ambulance transportation and air transportation (unless the utilization review manager determines that ground transportation would have endangered the life of the enrollee
67. Any nonspecific codes (procedures and HCPCS codes ending in 99)
68. Surgical treatment of snoring and obstructive sleep apnea, laser-assisted uvulopalatoplasty (UPPP)
69. Back surgery (all)
70. Bariatric surgery (all), including revision, replacement, reversal or conversion
71. Reserved
72. Oral devices for sleep apnea if charges exceed $2000
73. Botox injections; dermal filler injections
74. Spinal column or spinal cord procedures, decompression surgery (posterior fossa decompression), or Chiari malformation procedures; image-guided minimally invasive lumbar decompression for spinal stenosis; neurostimulator or neuromuscular stimulator (implantable) receiver or transmitter, generator, and supplies, discectomy (anterior approach lumbar spine);
75. Dental anesthesia when covered as a medical service (except for pediatric sedation)

76. Home health services (will require submission of a home health care plan)
77. Inpatient or facility hospice services
78. Hyperbaric oxygen therapy
79. Corneal collagen cross-linking
80. Vision therapy (orthoptics)
81. Abortion (also referred to as termination of pregnancy) will be reviewed for consistency with the coverage requirements set forth in the Benefits Description section which are based on Seventh-day Adventist Church teachings, and Care Management may be assigned to conduce a consultation
82. Elective surgery for the prevention of cancer
83. 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 at the number on the back of your ID card to verify that pre-certification has been initiated.

Failure to Obtain Pre-Certification

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

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

Effect on Deductibles and Out-of-Pocket Limit

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

Required Second Surgical Opinion

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

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 800-447-5002. 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 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 outlines 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 Customer Service at 800-447-5002 and request an Unavailable Service Request Form
- Member should work with Provider to complete and return form
- Approval of 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: 1-800-841-5396
Pharmacists: 1-800-922-1557

Providers and Facilities Available Under the Plan

Choice of Providers and Facilities

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

If you have cancer, your choice of providers/facilities may be subject to case 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.

Primary Care Provider

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

Membership Card

After enrolling, you and your covered dependents will receive your benefit ID card which will include your identification numbers and instructions for medical necessity pre-certification. You will need to present your card each time you receive services from a physician or professional provider.

If you lose your benefit ID card, we will issue a replacement. Contact the plan administrator at 1-800-447-5002.

Unavailable Services

Member must contact the utilization review manager via Customer Service at 800-447-5002 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.

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.

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-admissions process elaborated in the Pre-Certification Program section has been followed.

Cost-Effectiveness Services

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

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

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) 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 such 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 Customer Service at 800-447-5002 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 healthcare 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 healthcare 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 an "non-network," "non-participant," 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 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 Customer Service at 888-276-4732 or Federal No Surprises Helpdesk at 800-985-3059.

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

Case Management

Case Management is a voluntary service in which a case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and patient. This plan of care may include some or all of the following:

- personal support of the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other covered person, not shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan. The Plan Administrator may utilize its choice of vendors for Case Management services, as deemed necessary.

Note: There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

General Benefit Rules

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

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

- Are medically necessary or are for preventive services (listed in Appendix A) covered by the Plan;
- Represent a commonly accepted form of treatment and meet professionally recognized national standards of quality.
- Are recognized as generally accepted by the American medical community;

- Result from a non-occupational illness, injury or other event or cause;
- Are a type specifically listed in the Benefits description sections of this document;
- Are a type of expense for which the Plan does not otherwise limit or exclude payment; and
- Do not exceed Plan Year or Lifetime Maximum limits.

All covered services, other than preventive 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 care is *medically necessary.*

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

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

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

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

In addition, expenses must be incurred while the coverage is in effect. All expenses are treated as being incurred on the date 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.

Benefit Descriptions – Medical

Note: Plan provisions may vary based on your location. Your benefits and other Plan provisions under the Plan may vary from state to state dependent on:

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

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 difficulty of breathing, 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 mean 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 near-by and the hospital or facility is adequate and available to treat your medical condition.
4. Coverage for air ambulance services has been *pre-certified* by the utilization review manager, or if not *pre-certified*, the utilization review manager determined that ground transportation would have endangered the life of the enrollee.
5. Any ambulance transportation other than to a facility for emergency treatment must have pre-certification or it will not be paid.

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

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

Hospitalization and Surgery - Hospital and 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 or ambulatory surgery center service is when an enrollee 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.

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. Case Management is required.

Recipient Benefits
If an enrollee is receiving a transplant, the Plan covers inpatient hospital and professional services and supplies furnished to the recipient during the hospital stay in which the transplant is performed. Benefits for bone marrow/stem cell transfer transplants include coverage for chemotherapy and radiation therapy that is a part of the inpatient care under this provision.

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

Home Health Care
The Plan provides benefits for Home Health Care if provided by an appropriately licensed entity staffed by licensed and credentialed home health care professional 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 does not include charges for:

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

Skilled Nursing Facilities/Long Term Acute Care

In order for the charges to be covered under the Plan, the care requires medical necessity review and Skilled Nursing or Long Term Acute Care 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 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 facility must maintain a complete record on each patient.
6. The facility must have an effective utilization review plan.
7. Limitation: 120-day stay per Plan Year.

Hospice Care

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

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

Specific Limitations

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

Durable Medical Equipment

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 $1000 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.
- Jobst 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; (6) previous amputation of the foot or part of the foot. Limit is 1 pair per year.

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. 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 $2000 or more, and all CPM devices, and Dynasplints (regardless of cost). The Plan does not cover charges for more than one item of equipment for the same or similar purpose.

Prosthetics
The Plan provides coverage for evaluation, fabrication, and custom fitting of artificial limbs. See page 32 for Pre-Certification requirements.

Therapeutic Care

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

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

Occupational Therapy
The Plan provides coverage for Occupational Therapy within certain visit 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.

Speech and Language Pathology Therapy
The Plan provides coverage for Speech Therapy within certain visit limitations stated in the Schedule of Benefits section of 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 within certain visit limitations stated in the Schedule of Benefits section of this document.

Hearing Care
Services for hearing care assistance include:

1. Audiometricians;
2. Hearing specialist;

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 devises such as a cochlear implant upon *pre-certification* by the Plan's utilization review manager

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

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

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.

Maternity and Obstetric Benefits
Under the Plan, pregnancy-related and obstetric expenses are covered for the eligible spouse in the same way as medical expenses for illness or injury, except that full coverage is provided only to retirees 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 a retiree or spouse. See Preventive Care Services section.

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

The Plan provides coverage for midwives who are certified nurse midwives who have met the graduate training standards of the American College of Nurse Midwives and are licensed to practice in that state.

The majority of qualified midwives practice in a hospital, or in a free standing or hospital-based facility that provides a "home-like" atmosphere for childbirth; deliveries may also be in the home. A midwife often attends childbirth, or a physician may assist a midwife. The midwife must meet all state licensing requirements and provide proof of liability insurance. **The plan will not pay for nor reimburse for midwife services if no proof of liability insurance is provided even if the state does not require liability insurance.**

Complementary and Alternative Medicine
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 of CAM is limited under the Plan.

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

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

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

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.

Preventive Health Care

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

1. 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;
2. 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 for the Centers for Disease Control and Prevention);

3. 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
4. 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 any guideline described in 1-4 above after the recommendation or guideline is no longer described in 1-4 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 in this section are covered with no cost-sharing required on your part (that is, no co-payment, no co-insurance, and no deductible; this is often referred to as "first-dollar coverage"). If a preventive service is provided as part of an office visit and the office visit is not itself a preventive service covered under this section, the following rules apply:

a. 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 copayment);
b. 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;
c. 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 (4), 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 ages 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); fecal occult blood testing. Colon cancer testing for diagnostic purposes, as opposed to general screening, is not preventive care and cost-sharing requirements will apply.

DENTAL, VISION, HEARING (DVH) OPTION

The DVH Option includes coverage for dental, vision and hearing services.

A retiree must make the decision to enroll in the SHARP DVH Option within 30 days of the retirement effective date or the Loss of Coverage effective date. If the retiree/spouse will be billed by SHARP for the monthly cost of the DVH Option, the ACH Authorization Form must be completed before the DVH Option will be activated. Once enrolled the retiree/spouse must remain enrolled in the benefit for the full calendar year and make the required monthly payments. Non-payment of the SHARP DVH Option monthly costs may impact access to other benefits. If a retiree/spouse terminates the SHARP DVH Option during a non-open enrollment period, the termination will be a permanent and lifetime stop of the benefit.

A retiree or eligible spouse who enrolls in the SHARP DVH Option at any time during a plan year must remain in the benefit and pay the premiums for the benefit, for the full year. Failure to pay premiums will result in a permanent termination of the benefit.

The Dental benefit provides coverage for dental services based upon reasonable and customary fees for the geographical area in which the services are rendered. SHARP will pay 80% of reasonable and customary fees, subject to a calendar year SHARP maximum paid amount of $2,200. Any expenses above this maximum amount are not eligible expenses under SHARP. Unused dental benefits may not be rolled over into the next calendar year. Services that begin in one calendar year will have a date of service in that calendar year. Prior authorization is not required.

The covered member is responsible for the 20% coinsurance on approved charges. Fees above the annual SHARP maximum paid amount and any charges above reasonable and customary fees are the responsibility of the member.

Covered Dental Benefits

- Two cleanings per calendar year. Up to two additional cleanings may be authorized if recommended by a dentist for treatment of periodontal disease
- One set of bite wing x-rays per calendar year
- Extractions and periodontal treatments
- Full mouth/panorex x-rays every three calendar years
- Implants (Caution: one implant may take your full annual limit)
- Application of fluoride twice per calendar year
- Fillings
- Root canal therapy
- Crown/bridges/partials/dentures
- Anesthesia, if medically necessary

Dental Exclusions

- Orthodontic treatment (for Pre-Medicare Enrollees)
- TMJ/TMD treatment

- Jaw surgery
- Temporary crowns or bridges
- Experimental treatments/procedures
- Cosmetic services
- Toothbrushes
- Treatment by household members – the Plan does not cover services of a person who ordinarily resides in the home of the patient

Orthodontia Treatment – Non-Medicare Option Only
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 Plan is notified of the banding date. Subsequent payments will be made on a monthly basis as services are rendered and provider billing is received during the course of treatment.
2. Enrollees are not eligible for Orthodontia benefits after attaining 24 years of age. The orthodontic lifetime maximum in effect at the time of banding is the orthodontic lifetime maximum benefit that will apply for these services.
3. 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.

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

The Vision benefit provides coverage for services including refraction exam, corrective lenses, frames and related expenses. SHARP will pay 80% of the billed costs subject to a calendar year SHARP maximum paid amount of $400. The covered member is responsible for the 20% coinsurance, Medicare disallowed amounts and charges above the calendar year maximum SHARP paid amount. Surgery or other procedures considered to be medical in nature are not covered under the Vision benefit but may be covered by SHARP Pre-Medicare/Non-Medicare. Unused benefits are not rolled over into the next calendar year.

The Hearing benefit provides coverage for services including hearing tests, hearing aids and the repair of hearing aids. SHARP will pay 80% of the costs subject to a calendar year SHARP maximum paid amount of $2,200. The covered member is responsible for the 20% coinsurance and charges above the calendar year SHARP maximum paid amount. The Hearing benefit has a one-year 'look-back' provision which allows the payment of any unused benefits from the previous calendar year to be used in the current calendar year.

SHARP RX OPTION: BENEFIT DESCRIPTION – PRESCRIPTION DRUGS

The Eligible Retiree or Eligible Spouse, less than age 65, may choose the SHARP Rx Option benefit. For the Eligible Dependent child, the Rx Option is included in the Non-Medicare benefit. The Rx Option is a prescription drug program that requires the covered member to pay a portion of the cost of medication in the form of a copayment. Please refer to the Schedule of Benefits section of this document for the outline of the amount of the copayment levels. Non-compliance with the cost containment rules may result in additional out-of-pocket costs to the covered member. Express Scripts is the pharmacy benefit manager for the SHARP Rx Option.

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

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

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

Generic: A generic drug is a safe, effective drug approved by the U.S. Food and Drug Administration (FDA) that also costs less. You pay the lowest copayment for generic drugs.

Brand: Formulary brand (or preferred) drugs are brand name drugs. The copayment for formulary brand drugs is higher than it is for generic drugs.

Non-formulary: Non-formulary (or non-preferred) drugs are brand name drugs that are not covered under the ESI national preferred formulary. The copayment for non-formulary drugs is higher than it is for formulary brand (preferred) or generic drugs.

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

If your *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, including the following drugs:

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

Alzheimer's Therapy Drugs
Analgesics (Stadol)
Anti-Emetics
Appetite Suppressants
Cancer Therapy
COX 2 Inhibitors
Erectile Dysfunction
Fertility Agents
Hypnotic Agents (sleep aids)
Interferons
Multiple Sclerosis Medications
Ophthalmic (select agents)
Rheumatological
Amphetamines
Androgens/Anabolic Steroids
Anti-Narcoleptic Agents
Biotechnological Agents/Specialty drugs
CNS Stimulants
Select Dermatological
Erythroid Stimulants
Growth Hormones
Immune Globulins
Migraine Therapy Drugs
Myeloid Stimulants
Pulmonary (select agents)

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

Step Therapy Drugs– Case Management

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

1. You first try one or more less costly drugs (which may include over-the-counter drugs) that are normally available and used to treat a particular medical condition, and your doctor certifies that these less costly drugs are not effectively treating your condition or other medical reasons why the less costly drugs cannot or should not be used to treat your medical condition; or
2. Your doctor certifies to the Plan the medical reasons for your use of the Step-Therapy Drugs in lieu of less costly drugs that are normally available and used to treat this condition.

If you are taking a Step-Therapy Drug, you or your doctor will receive a letter explaining this program. If you receive a letter, consult with your doctor immediately concerning your use of Step-Therapy Drugs. *Do not stop taking any medication prescribed by your doctor without first consulting your doctor.*

Please call Express Scripts' Member Services, (800) 841-5396, or visit Express Scripts' website at https://www.express-scripts.com/login for further details.

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

1. 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;

2. 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);
3. 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
4. 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.

Preventive prescription drugs will not include any items or services specified in any recommendation or guideline described in (1)-(4) above after the recommendation or guideline is no longer described in (1)-(4) above.

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

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

Rx Option Exclusions:

1. Compound Medications: Compounds without NDC ingredients are not covered. Prior authorization is required.
2. Vitamins and/or dietary supplements are not covered.

Maximum Out-of-Pocket Limit for Medical and Prescription Drug Benefits

Out-of-pocket eligible medical and prescription drug expenses under SHARP are limited to $9,450 per person and $18,900 per family in 2024. This out-of-pocket limit includes any co-payments and deductibles but does not include the premium costs.

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. Career or Financial Counseling Services.
3. Charges for Missed Appointments.
4. Complementary and Alternative Medicine that is not specifically and expressly covered by the Plan. The *Plan* recognizes the National Center for Complementary and Integrative Health (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*. The exceptions are limited to chiropractic treatment. All other CAM therapies, services, tests, laboratory tests, procedures, products, and practices are not covered under the *Plan*.
5. Complications from, or expenses incidental to or incurred as a direct consequence of, a treatment, service, or supply that is excluded from coverage under this Plan.
6. Vitamins, (except for physician prescribed vitamin B12 injections, Vitamin D, and prenatal care vitamin supplements), dietary supplements and foods, herbs, minerals, nutritional supplements.
7. Custodial Care and Services. The *Plan* does not cover *custodial care* and services related to *custodial care*. See Definitions.
8. Elective surgeries for preventive reasons.
9. Experimental Services and Procedures. Except as permitted by participation in an approved clinical trial, the *Plan* does not cover procedures, services, drugs or other supplies that are experimental or still under clinical investigation. A procedure is considered to be experimental if it is generally deemed so by medical professionals, the Food and Drug Administration, the National Institutes of Health or by Medicare and/or Medicaid guidelines.
10. First Aid Supplies.
11. Genetic testing, except as preventive care benefits required by federal law.
12. Governmental Treatment. Except as otherwise provided by law, the *Plan* does not cover services or supplies for care or treatment provided by the United States Government or any state or local government when, without Plan coverage, the person would not be required to make payment.

13. Health Enhancement Programs, Lifestyle 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.

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

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

16. Not Medically Necessary**.** 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 Appendix A.

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

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

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

20. Non-prescription glasses or sunglasses.

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

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

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

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

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

25. Plastic, Reconstructive, Cosmetic Procedures and Surgeries. The *Plan* does not cover charges for plastic, reconstructive, or cosmetic procedures, surgeries, services or supplies (whether or not for psychological or emotional reasons) for the purpose of enhancing, altering, or improving personal appearance or comfort. Limited exceptions may be obtained after first being reviewed by the *Plan's utilization review manager*, to the extent that the surgery or procedure is necessary to:
    a. improve the function of a part of the body that is malformed; or
    b. correct a condition resulting from a severe birth defect; or
    c. correct a condition that is a direct result of a disease or surgery performed to treat a disease or injury; or
    d. repair an injury, but only if the surgery is performed within twenty-four months of the accident causing the injury.

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

27. Prenatal and Parent Training Classes.

28. Sexual Transformations and Transgender procedures.

29. Stem Cell for orthopedic procedures.

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

31. Transportation and lodging except for ambulance and as described as part of the cardiac center of excellence (CCOE) surgery benefit.

32. 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.

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

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

35. Viscosupplements (injectables)

36. Virtual scans and virtual physicals.

37. Vitamins (except for physician prescribed Vitamin B 12 injections, Vitamin D, and prenatal care vitamin supplements), dietary supplements and foods, herbs, minerals, nutritional supplements.

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 Customer Service phone number is 800-447-5002, 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	Adventist Health Utilization Review Manager	1-800-447-5002
For pre-certification for prescription drugs	Express Scripts	1-800-841-5396

To submit a claim after you receive benefits:

To submit a medical/dental/vision/hearing claim	WebTPA	1-800-447-5002
To submit a prescription drug claim	Express Scripts	1-800-841-5396

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	Adventist Health Utilization Review	1-800-447-5002
Non-medical denials	WebTPA	1-800-447-5002
Prescription drug denials	Express Scripts	1-800-841-5396

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	External Review	1-800-447-5002
Non-medical denials (such as for eligibility coverage)	Plan Administrator	1-800-447-5002
Prescription drug denials	External Review	1-800-841-5396
Prescription drug denials – not involving medical judgement (such as for eligibility coverage)	Plan Administrator	1-800-447-5002

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

Section 1.03 ***Physician and Professional Provider Benefits***

In most cases, the *in-network provider* will bill charges directly to the *Plan* via WebTPA (third party-administrator). You are required to pay any applicable *co-payments* at the time of service.

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

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 Express Scripts. 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.

For prescription drug claims, ESI is the claims reviewer and will handle all claims for prescription drug benefits and is responsible for deciding appeals of any *adverse benefit determination*s pertaining to prescription drug benefits. However, the *plan administrator* has the final authority in deciding whether an internal *claim* or appeal will be approved or denied. External review of claims for prescription drug benefits will be performed by the *independent review organizations* with which ESI has contracted. The provisions of this Section 1.04 supersede any inconsistent *Plan* provisions.

Section 1.05 ***Ambulance Benefits***

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

Section 1.06 ***Claims Inquiries***

If you have any questions about how to file a *claim*, the status of a pending *claim*, or any action taken on a *claim*, call WebTPA at 1-800-447-5002.

Section 1.07 ***Appointment of Authorized Representative***

A *claimant* may appoint an *authorized representative* in writing to act on his or her behalf with respect to *claims* and appeals under these Claims Procedures. However, no person (including a treating health care professional) will be recognized as an *authorized representative* until the *Plan* receives an Appointment of

Authorized Representative form signed by the *claimant*, except that (i) for urgent pre-service *claims* the *Plan* shall, even in the absence of a signed Appointment of Authorized Representative form, recognize a health care professional with knowledge of the *claimant's medical condition* (e.g., the treating *physician*) as the *claimant's authorized representative* unless the *claimant* provides specific written direction otherwise and (ii) an *employee* is automatically deemed to be the *authorized representative* of his or her *covered dependent* who is under age 18. An Appointment of Authorized Representative form may be obtained from WebTPA by calling 800-447-5002. Completed forms must be submitted to Adventist Risk Management, P O Box 1928, Grapevine, TX 76099. An assignment for purposes of payment (e.g., to a health care professional) does not constitute appointment of an *authorized representative* under the Claims Procedures. Once an *authorized representative* is appointed, the *Plan* shall direct all information, notification, etc. regarding the *claim* to the *authorized representative*. The *claimant* shall be copied on all notifications regarding decisions, unless the *claimant* provides specific written direction otherwise. Any reference in the Claims Procedures to "*claimant*" is intended to include the *authorized representative* of such *claimant* appointed in compliance with the above procedures.

ARTICLE 2 FOUR TYPES OF CLAIMS

Section 2.01 *Different Rules Apply*

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

Section 2.02 *Pre-Certification Claim*

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

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

To receive *medical necessity pre-certification,* you must contact WebTPA at the number on the front of your ID card, 800-447-5002, before you receive the medical care. For prescription drug pre-certification, call Express Scripts at 800-841-5396.

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 WebTPA at the phone number on your ID card.

ARTICLE 3 **HOW TO FILE A CLAIM FOR BENEFITS**

Section 3.01 ***General Filing Rules***

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

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

To file a *pre-certification claim* or an *urgent pre-certification claim* (usually to obtain pre-certification of *medical necessity*), you, your *authorized representative*, or your *provider* must contact WebTPA at the number on your ID card before you receive the medical care.

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

The decision to provide retroactive certification of *medical necessity* will be made in the sole discretion of the *utilization review manager*.

Section 3.03 ***Post-Service Claims***

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

For benefits received at a *PPO facility* or through a *PPO provider*, your provider will, generally, file required *post-service claims*. For *out-of-network* services, your provider may not file *post-service claims* on your behalf.

All out-of-network services must be pre-certified by the Plan's utilization review manager except in the case of an emergency, in which case the Plan must be notified within 24 hours of the admission/treatment.

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 first page of the SPD. The appropriate *claim* forms may be obtained by contacting WebTPA at the number on the front of your ID card.

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

1. Complete the *member information* portion of the *claim* form in full, available on the Adventist Retirement website here. Answer all questions, even if the answer is "none" or "N/A" (not applicable).
2. Attach all necessary documentation of expenses to the *claim* form. Documentation must include:
    - The *member'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).
3. Complete a separate *claim* form for each person for whom benefits are being **requested.**
4. **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, P O Box 1928, Grapevine, TX 76099.

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, considering the medical exigencies, but no later than 72 hours after receipt of the *claim*.

Section 4.03 ***Concurrent Care Extension Request***

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

Section 4.04 ***Concurrent Care Early Termination***

A decision by the *Plan* to reduce or terminate a previously approved course of treatment is an *adverse benefit determination* that may be appealed by the *claimant* under these Claims Procedures, as explained below.

Notification to the *claimant* of a decision by the *Plan* to reduce or terminate an initially approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow the *claimant* to appeal the adverse decision and receive a decision on review under these procedures prior to the reduction or termination.

Section 4.05 ***Post-Service Claim***

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

Section 4.06 ***When Extensions of Time Are Permitted***

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

Section 4.07 ***Incomplete Claims***

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

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

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

Section 4.09 ***How Other Incomplete Claims Are Treated***

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

ARTICLE 5 NOTIFICATION OF INITIAL BENEFIT DECISION BY PLAN

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

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

Section 5.02 ***Notification of Adverse Benefit Determination***

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

- information sufficient to identify the *claim* involved, including, if applicable: (i) the date of service, (ii) the health care *provider*, (iii) the *claim* amount, and (iv) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a statement of the specific reason(s) for the decision, including (i) the *Plan*'s denial code and its corresponding meaning (ii) the *Plan*'s standard, if any, that was used in denying the appeal; and (iii), for *final internal* adverse benefit determination*s*, a

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

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

ARTICLE 6 HOW TO APPEAL AN ADVERSE BENEFIT DETERMINATION

Section 6.01 *Right to Appeal*

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

Section 6.02 *How to File Your Appeal*

For an appeal of Dental, Vision, or Hearing claim for benefits, an appeal of a SHARP eligibility determination, or an appeal of earned credit calculation may be submitted in writing to:

Attn. Administrative Appeal
Adventist Retirement Plans
9705 Patuxent Woods Dr.
Columbia, MD 21046

Section 6.03 *How to File Your Appeal: Medical 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 800-447-5002. 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 6.04 ***How to File Your Appeal: Medical Non-Urgent Precertification Appeals***

An appeal of an *adverse benefit determination* regarding *medical necessity* should be submitted to the *utilization review manager*. Details on how to submit an appeal to the *utilization review manager* will be provided by the *utilization review manager* upon an *adverse benefit determination*. You may call the *utilization review manager* at (800) 447-5002 for more information.

Section 6.05 ***How to File Your Appeal: Post-Service Appeals***

Except in the case of an appeal relating to prescription drug benefits, an appeal of an *adverse benefit determination* regarding *medical necessity* is filed by submitting a written Request for Review form to the *utilization review manager*. A *claimant* has the right to submit documents, written comments, or other information in support of an appeal. Request for Review forms may be obtained by contacting the *utilization review manager*. See Section 1.04 for instructions on filing an appeal relating to prescription drug benefits.

To appeal an *adverse benefit determination* not involving *medical necessity*, or if you are unsure whether the *adverse benefit determination* involved *medical necessity*, you should contact the *plan administrator* at (800) 447-5002.

Section 6.06 ***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 contact information for ESI.

Section 6.07 ***Important Appeal Deadlines***

An appeal of a Dental, Vision, Hearing Aid claim, or a SHARP eligibility determination or earned credit calculation, must be filed within 45 days of the date of the notification of adverse benefit determination.

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 these important deadlines 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 consider 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 ***Dental, Vision, Hearing Aid Claims, and SHARP Eligibility Determinations and Earned Credit Calculations***

The appeal of an adverse benefit determination involving a Dental, Vision or Hearing Aid claim for benefits, or an appeal of a SHARP eligibility determination or earned credit calculation, shall be decided within a reasonable time appropriate to the circumstances but no later than 45 days after receipt of the appeal.

Section 8.02 **Medical *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 8.03 **Medical *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 8.04 **Medical *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 8.05 **Medical *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*. If the adverse benefit determination concerns Dental, Vision, or Hearing Aid benefits, or involves a SHARP eligibility determination or earned credit calculation, you will receive a notification, but it will not contain all of the information in Section 5.02.

Notification of an adverse benefit determination on appeal of an urgent pre-certification claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

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

Section 10.01 ***In General***

If your appeal involved a Dental, Vision, or Hearing Aid claim for benefits, or an appeal of a SHARP eligibility determination or earned credit calculation, then you may request a review of the appeal decision in writing to:

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

The review will consider 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 written 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 and not subordinate to the other decision makers.

Section 10.02 ***Deadline for Request for Second Appeal for Decisions that does not involve medical judgement***

You must submit your request for a second appeal within 45 days of the date of the notice of *adverse benefit determination* from your first appeal.

Section 10.03 ***Notification Decision of Non-Medical Judgement Decision of 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 a 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 healthcare 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 notice is not in writing, will provide written confirmation within 48 hours of the initial verbal notice).

Article 11 REVIEW OF SECOND APPEAL DECISION THAT CONCERNS SHARP DENTAL, VISION, OR HEARING AID BENEFITS, OR INVOLVES A SHARP ELIGIBILITY DETERMINATION OR EARNED CREDIT CALCULATION – THIRD APPEAL

Section 11.01 ***In General***

If your appeal involved a SHARP Dental, Vision, or Hearing Aid claim for benefits, or an appeal of a SHARP eligibility determination or earned credit calculation, then you may request a review of the second appeal decision in writing to:

Chairman, Retirement Appeals Committee
Adventist Retirement Plans
9705 Patuxent Woods Drive
Columbia, MD 21046

The review will consider 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 written evidence and testimony pertaining to the *claim*.

No deference will be given to the initial benefit decision, the first appeal, or the second appeal, and the person who reviews and decides the third appeal will be different from and not subordinate to the other decision makers.

Section 11.02 ***Deadline for Appeal Decision that Concerns SHARP Dental, Vision, or Hearing Aid Benefits, or Involves a SHARP Eligibility Determination or Earned Credit Calculation***

You must submit your request for a third appeal within 45 days of the date of the notification of *adverse benefit determination* from your second appeal.

Section 11.03 ***Notification of Decision that Concerns SHARP Dental, Vision, or Hearing Aid Benefits, or Involves a SHARP Eligibility Determination or Earned Credit Calculation on Third Appeal***

The Retirement Appeals Committee will provide written notice of the *Plan's* decision within 45 days of its receipt of your request for third appeal.

Section 11.04 ***Exhaustion and Deemed Exhaustion of a Claim Concerning SHARP Dental, Vision, or Hearing Aid Benefits, or Involves a SHARP Eligibility Determination or Earned Credit Calculation***

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.

Article 12 EXHAUSTION AND DEEMED EXHAUSTION OF INTERNAL CLAIMS AND APPEALS PROCESSES

If you fail to follow these Claims Procedures, if you miss any of the above-stated deadlines for filing a *claim* or an appeal, or if you otherwise fail to exhaust all of the administrative remedies under the *Plan*, then you will not be eligible for external review unless you meet the requirements of both 13.02(i) and (ii) below; and you

will forfeit any right to pursue any remedies under State or federal law. This means that if you do not comply with the deadlines and fully exhaust these Claims Procedures, you may not sue the *Plan*.

If the *Plan* fails to strictly adhere to these Claims Procedures when reviewing your *claim* or appeal, you will be deemed to have exhausted the *Plan*'s internal claims and appeals process, unless the violation is de minimis, non-prejudicial, is attributable to good cause or matters beyond the *Plan*'s control, occurred in the context of an ongoing, good faith exchange of information between you and the *Plan*, and is not reflective of a pattern or practice of non-compliance. If the *Plan* claims that a violation occurred that meets the above exception, you may request a written explanation of the violation; the *Plan* will reply within 10 days to such a request and will include a description of the reasons for asserting that the violation did not cause the Claims Procedures to be deemed exhausted. If you have been deemed to have exhausted the *Plan*'s internal claims and appeals process, you may (i) initiate an external review (if eligible), 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 13 EXTERNAL REVIEW (GENERALLY ONLY FOR REVIEW OF A MEDICAL CLAIM APPEAL DECISION THAT INVOLVES A MEDICAL JUDGMENT)

Section 13.01 *In General*

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

For prescription drug claims, Express Scripts will arrange for the external review if you are eligible. Please contact Express Scripts for additional information.

Section 13.02 *Eligibility for External Review*

Dental, Vision, and Hearing Aid appeals, and SHARP eligibility and earned credit appeals are generally not eligible for external review. Rather, the third appeal described in Article 11 is the final appeal for such claims. (There are exceptions to this general rule for (i) Non-Medicare DVH appeals of claims for dependent children that involve medical judgment, and (ii) retroactive rescissions of coverage.)

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

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

(ii) The a*dverse benefit determination* must 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 if 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 13.03 ***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 13.04 ***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:

1. 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;
2. The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (for example, worker classification or similar determination);
3. 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 12; and
4. The *claimant* has provided all the information and forms required to process an external review.

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

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

Section 13.05 ***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 13.04 above for standard external review. The *Plan* will immediately send the notice required under Section 13.04 above for standard external review to the *claimant* of its eligibility determination.

Upon a determination that a request is eligible for external review following the preliminary review, the *Plan* will assign an *independent review organization* pursuant to Section 13.04 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 13.06 ***Notification of Final External Review Decision***

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

The notification of a final external review decision will contain all information required by the Department of Labor Guidance, including the following:

1. 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);

2. The date the *independent review organization* received the assignment to conduct the external review and the date of the *independent review organization* decision;
3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
4. 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;
5. 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*;
6. A statement that judicial review may be available to the *claimant*; and
7. 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 13.07 ***Reversal of Plan's Decision***

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

ARTICLE 14 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 spouse* or *covered dependent* has healthcare coverage under more than one plan. For a complete explanation of COB see the section titled **Coordination of Benefits**.

B. ***Third-Party Liability***

An individual covered by us may have a legal right to recover benefits or healthcare costs from another person, organization or entity, or an insurer as a result of an *illness* or *injury* for which benefits, or healthcare costs were paid by us. For example, an individual who is injured may be able to recover the benefits or healthcare costs from an individual or entity responsible for the injury or from an insurer, including different forms of liability insurance, uninsured motorist coverage or under-insured motorist coverage. As another example, an individual may become sick or be injured in the course of employment, in which case the employer or a workers' compensation insurer may be responsible for healthcare expenses connected with the *illness* or *injury*.

If a covered individual, as defined below, has a right to recover benefits or healthcare costs from a third party, we will pay the covered individuals' expenses subject to an automatic lien in the *Plan*'s favor to the extent of benefits paid, upon any compensation received from the other party, up to the sum of the amount paid by the *Plan* to perfect the lien and the amount paid by the *Plan* for your benefits. The total lien amount will not exceed one-third of the money awarded to you under any final judgment, compromise, or settlement agreement if you retained an attorney, or one-half of the money awarded to you under any final judgment, compromise, or settlement agreement if you did not retain an attorney. If you are found by a judge, jury or arbitrator to be partially at fault then the lien shall be reduced by the same comparative fault percentage by which your recovery was reduced. The lien amount is also subject to pro rata reduction, commensurate with your reasonable attorney's fees and costs, in accordance with common fund doctrine. The above-described limitations on the total amount of the lien do not apply to liens made against workers' compensation claims, liens for Medicaid benefits, or liens for *hospital* services and *hospital*-affiliated health facility services.

If benefits have been paid, or payment of benefits is pending, we are entitled to recover the amount paid or the amount pending payment from the proceeds of any recovery made by a covered individual against a third party.

This Section applies to any covered individual for whom payment of benefits is made by us whether or not the event giving rise to the covered individual's injuries occurred before the individual became covered by us.

***Definitions**:*

For purposes of this Section relating to third party recoveries, the following definitions apply:

- **Covered Individual** means an individual covered by us, including a dependent of a member. "Covered individual" also includes the estate, heirs, guardian or conservator of the individual for whom benefits have been paid or may be paid by us, and includes any trust established for the purpose of receiving "Recovery Funds" and paying for the future income, care or medical expenses of such individual.
- **Benefits** means any amount paid by us or submitted to us for payment to or on behalf of the covered individual. Bills, statements or invoices submitted to us by a provider of services, supplies or facilities to or on behalf of a covered individual are considered requests for payment of "benefits" by the covered individual.
- **Third Party Claim** means any claim, settlement, award, lawsuit, verdict, judgment, arbitration decision or other action against a third party (or any right to assert the foregoing) by or on behalf of a covered individual, regardless of the characterization of the claims or damages of the covered individual, and regardless of the characterization of the recovery funds. (For example, a covered individual who has received payment of medical expenses from us, may file a third-party claim against the party responsible for the covered individual's injuries, but only seek the recovery of non-economic damages. In that case, we are still entitled to recover benefits as described herein.)
- **Third Party** means any individual or entity responsible for the *injury* or *illness*, or the aggravation of an *injury* or *illness*, of the covered individual. Third party includes any insurer of such individual or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the covered individual including uninsured motorist coverage, under-insured motorist coverage, and workers' compensation insurance.
- **Recovery Funds** means any amount recovered from a third party.

Under this Section relating to third party recoveries, if we have paid any benefits, we will be entitled to recover the amount we have paid from the proceeds of any recovery made by a covered individual against a third party. Upon claiming benefits, or accepting payment of benefits, or claiming or accepting the provision of benefits from us, the covered individual agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, our right of reimbursement or subrogation as discussed in this Section. In connection with our rights to obtain reimbursement or exercise our rights as described below, the covered individual shall do one or more of the following things and agrees that we may do one or more of the following things, at our discretion:

(1) 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.

(2) 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.

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

(4) 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.

(5) 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.

(6) 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.

(7) 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.

b. 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.

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

(8) 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.

(9) 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.

(10) 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.

(11) 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

(12) 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.

(13) 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.

(14) 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.

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

(16) 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.

(17) 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 spouse* or *covered dependent* is covered by motor vehicle insurance. But we will advance payment of benefits over the amount covered by the motor vehicle insurance, subject to the third- party recovery Section above. If we have paid benefits first, we are entitled to any reimbursement from the motor vehicle insurer, under the third- party recovery Section above.

You must give us information about any medical insurance payments available to the covered individual or the covered individual's *covered spouse* or *covered dependents*.

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

COORDINATION OF BENEFITS

For the DVH Option only, this plan will always be primary. For all other options under the plan, the below Coordination of Benefits will apply.

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

D. Allowable expense is a health care expense, including deductibles, *co-insurance* and *co-payments*, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

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

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

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

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

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

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

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

B. 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.

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

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

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

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

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

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

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

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

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

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

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

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

(3) 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.

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

GENERAL PLAN INFORMATION

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

The *Plan* may, without the consent of or notice to any person, release to or obtain from any organization or person, information needed to implement *Plan* provisions. When you request benefits, you must furnish all the information required to implement *Plan* provisions. When necessary to process *claims*, we may require that you submit information concerning benefits to which you or your *covered spouse* or *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 spouse* or *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 you and your *covered spouse* and *covered dependents*' benefits to any *PPO provider* or *PPO facility* used by you or your *covered spouse* or *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 your *covered spouse* or *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 spouse* or *covered dependent*'s future benefits until the amount withheld equals the amount of the overpayment.

UNCASHED CHECKS

Uncashed reimbursement checks will not be re-issued after more than 12 months from the date of issue.

RESPONSIBILITY FOR QUALITY OF MEDICAL CARE

In all cases, you or your *covered spouse* or *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 for damages

connected with injuries you or your *covered spouse* or *covered dependent* suffer while receiving medical services or supplies.

GOVERNING LAW

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

WHERE LEGAL ACTION MUST BE FILED

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

TIME LIMITS FOR FILING A LAWSUIT

Any legal action arising out of, or related to, this *Plan* and filed against the *Plan* by you, any of your dependents, any *member*, 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 13 of the Claims Procedures section has ended.

STOP LOSS COVERAGE

The Plan or Plan Sponsor may (but is not required to) purchase stop-loss insurance. Any stop-loss insurance purchased shall provide payments solely to the *Plan* or *plan sponsor*. No stop-loss benefits are provided directly to any *member* in the Plan.

PLAN AMENDMENT AND TERMINATION

The Plan may be amended at any time without prior notice by a resolution of the Adventist Retirement Board. The right to amend includes the right to curtail or eliminate coverage for any treatment, procedure, or service, regardless of whether any covered employee is receiving such treatment for an injury, defect, illness, or disease contracted prior to the effective date of the amendment. Amendments may be made retroactively.

The Plan may be terminated by action of the North American Division Committee.

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.

CLAIM REVIEW

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

HEALTH CARE FRAUD AND ABUSE

The *Plan* screens and audits claims for health care fraud. Under HIPAA, fraud is defined as knowingly, and willfully executing or attempting to execute a scheme or artifice (i) to defraud any healthcare benefit program or (ii) to obtain by means of false or fraudulent pretenses, representations, or promises any of the money or property owned by any healthcare benefit program. Abuse is more generally considered acts that are

inconsistent with sound medical or business practice where abuse activities cannot be clearly established as willful or intentional misrepresentation.

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

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

HEALTH CARE CLAIMS AUDITS

As part of an ongoing program to provide outstanding customer service and cost-effective medical care and as a supplement to other associated *Plan* initiatives, such as utilization management, the *Plan* shall exercise the right to analyze claims data and carry out audit procedures. The objective of the audit process is to ensure that the *Plan* fulfills its responsibility to its partners, members, 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 members* 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:
    - Diagnosis coding,
    - Procedure coding,
    - Units or keystroke errors,
    - Diagnosis Related Grouping (DRG),
    - Ambulatory Payment Classification (APC),
    - Ambulatory surgery payment groupings (ASC),
    - Discharge disposition,
    - Present on Admission (POA) indicators,
    - HAC, Medical/Surgical Misadventure or Medical Never Event,
    - National Correct Coding Initiative (NCCI) edits,
    - Outpatient Code Editor (OCE) edits,
    - Modifiers, etc.
2. Charge Audits may encompass not only accuracy of the charges but appropriateness of the charges when items may not be consistent with uniform billing practices (for example, unbundling of items from the room rate such as venipuncture, pulse oximetry, oxygen, floor stock supplies, etc.).
3. Assessing if services provided were reasonable and necessary (for example, level of care or setting, experimental and investigational usage of drugs or devices).

4. Covered Services.
5. Readmissions up to 30 days.

NO WAIVER

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

RIGHTS UNDER NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

Specifically, health plans must cover:

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

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

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, the terms "you" and "your" refer to the Plan member/enrollee. 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 health care to you or
3. past, present, or future payment for health care

However, HIPAA allows medical information, including PHI, to be disclosed by the Plan to the Plan Sponsor and to be used by the Plan Sponsor. (This plan limits any such disclosures to the Plan Sponsor's designated Benefit Coordinator and Controlling Committee.) The permitted disclosures to and uses by the Plan Sponsor of medical information are as follows:

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

f. payment under a contract for reinsurance
g. review of health care 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 pre-authorization 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 health care provider performance or Plan performance
p. securing or placing a contract for reinsurance of risk relating to health care claims, other activities relating to the renewal or replacement of stop-loss or excess of loss insurance
q. contacting health care providers and patients with information about treatment alternatives in accordance with HIPAA regulations.

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

1. The Plan Sponsor will not use or further disclose the PHI except a) as described above or b) 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 members benefit plan of the Plan Sponsor.
4. The Plan Sponsor will report to the Plan any use or disclosure of the PHI that is inconsistent with the permitted uses and disclosures of which the Plan Sponsor becomes aware. The Plan Sponsor will report to the Plan any security incident of which the Plan Sponsor becomes aware.
5. The Plan Sponsor will give you access and provide copies to you of your PHI in accordance with the HIPAA Regulations.
6. The Plan Sponsor will (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. Officers of the Plan Administrator
    b. Employees of the Plan Administrator (Adventist Risk Management)
    c. Plan Sponsor's designated Benefit Coordinator and Controlling Committee
11. The Plan Sponsor will ensure that this adequate separation is supported by reasonable and appropriate security measures to the extent that these individuals have access to electronic PHI.
12. The Plan Sponsor will (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 Plan Sponsor (and the Plan Sponsor's delegee, the Plan Administrator) performs for the Plan. Employees who violate this section are subject to disciplinary action by the Plan Sponsor, including, but not limited to, reprimands and termination.

The Plan has issued a Privacy Notice which explains the Plan's privacy practices and your rights under HIPAA. This Notice is available by contacting the Plan's Privacy/Security Officer at the following address: Adventist Risk Management, Inc., 12501 Old Columbia Pike, Silver Spring, MD 20914 or email, privacyofficer@adventistrisk.org. The Privacy Notice is also available at www.AscendtoWholeness.org.

RELEASE OF MEDICAL INFORMATION

Any member covered by the Plan, on behalf of himself or herself and the member'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 a retiree, other Member and/or medical provider may be required to make up any overpayments, and the Plan may make up any underpayments.

NO ASSIGNMENT OF BENEFITS

Plan benefits are not assignable except to the specific person or entity that provided the service or supply and except as otherwise required by law.

LEGAL ACTIONS

No action at law or in equity may be brought to recover under this Plan unless brought within three years after the date of rendition of the services for which a claim is made.

NO WAIVER

Failure of the Plan Administrator or SHARP 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.

FOREIGN LANGUAGE NOTICE

This booklet contains a summary in English of your rights and benefits under the Plan. If you have difficulty understanding any part of this booklet, please contact the Plan Administrator or WebTPA for language service assistance.

OTHER PLAN INFORMATION

Plan Name

The official name of the Plan is the North American Division Supplemental Healthcare, Adventist Retirement Plan. The Plan is an employer-sponsored trust fund benefit plan maintained for the purpose of providing participating retirees of participating employers with medical, surgical and hospital care assistance.

Plan Sponsor

The Plan is sponsored by the North American Division Committee. As such it qualifies as a "Church Plan" as defined by the Internal Revenue Service. Seventh-day Adventist organizations of the North American Division who comply with its provisions are exempt from the continuation of benefit requirements of COBRA and ERISA and certain other laws that do not apply to church plans.

Plan Documents

The current full SHARP Pre-Medicare/Non-Medicare document is available online at www.adventistretirement.org and may be downloaded or printed.

MEDICARE PART D NOTICE

Important Notice about the SHARP 2023 Prescription Drug Coverage (Rx Option) available for Pre-Medicare and Non-Medicare dependents only, and the Medicare Prescription Drug Coverage for those with Medicare as Primary Healthcare coverage.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Supplemental Healthcare, Adventist Retirement Plan (SHARP) Rx Option[1]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 under the SHARP Rx Option, 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 provided at the end of this notice.

There are two important things you need to know about your current SHARP Rx Option coverage and Medicare's prescription drug coverage.

1. Medicare prescription drug coverage is available 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. This coverage is sometimes referred to as Medicare Part D prescription drug coverage. In general Medicare Part D provides coverage for prescription drugs not covered under Medicare Part A and Part B. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some Medicare plans may also offer more coverage for a higher monthly premium.
2. The Supplemental Healthcare, Adventist Retirement Plan has determined that the prescription drug coverage offered under its Rx Option is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage under Medicare. Because your prescription drug coverage under SHARP's Rx Option is, on average, at least as good as standard Medicare prescription drug coverage, you can keep (or enroll in) SHARP's Rx Option coverage (instead of enrolling in a Medicare prescription drug plan) and not pay a higher premium (a penalty) if you later decide to join a Medicare prescription drug plan.

When Can You Join a Medicare Drug Plan?
You can join a Medicare prescription 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 also will 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 decide to enroll in a Medicare prescription drug plan and drop (or decline to enroll in) SHARP Rx Option coverage, be aware that you will not be able to get the SHARP Rx Option coverage back.
Under SHARP Plan rules, you are not allowed to receive prescription drug coverage under both Medicare prescription drug coverage and the SHARP Rx Option. You must choose one or the other. Therefore, it is

important to make an informed deliberate decision. Do not enroll in Medicare prescription drug coverage "just in case."

You have the following two options concerning prescription drug coverage in the SHARP:

1. You may stay with SHARP's Rx Option coverage and not enroll in the Medicare prescription drug coverage at this time. You will be able to enroll in the Medicare prescription drug coverage at a later date without penalty, either (1) during a Medicare prescription drug open enrollment period; or (2) if you lose coverage under SHARP.

2. You may drop your SHARP's Rx Option coverage (when allowed to do so under SHARP), or decline to enroll in the Rx Option, and instead enroll in Medicare prescription drug coverage. If and when you enroll in a Medicare prescription drug plan, you become ineligible to participate in SHARP's Rx Option, and SHARP will not assist you with the premium you will pay to participate in a Medicare prescription drug plan. You will not be able to enroll or re-enroll in SHARP's Rx Option coverage until the next open enrollment period for such coverage, and you will only be able to enroll or re-enroll if you drop your Medicare prescription drug coverage. **If you decide to enroll in a Medicare prescription drug plan and decline or drop SHARP Rx Option prescription drug coverage, be aware that you may not be able to get SHARP Rx Option drug coverage until the next open enrollment period.** If you have chosen not to participate in the SHARP Rx Option, you may continue to participate in other SHARP options provided, such as Dental/Vision/Hearing.

If you have questions, please contact us for more information about what happens to your coverage under the Rx Option if you enroll in a Medicare prescription drug plan.

As stated above, if you enroll in a Medicare prescription drug, SHARP will drop your Rx Option (or not allow you to enroll in the Rx Option) and will not assist you with the premium you will pay to participate in a Medicare prescription drug plan. Although SHARP cannot state that in all cases its Rx Option prescription drug coverage is more advantageous than Medicare prescription drug coverage, in most cases you will have better prescription drug coverage under SHARP Rx Option than under Medicare prescription drug coverage and you will not benefit from enrolling in Medicare prescription drug coverage. One situation in which Medicare Prescription drug coverage may be more advantageous is if you qualify as a low-income retiree. If you have received an application to apply for low-income Medicare prescription drug coverage, you should carefully review our plan and Medicare Prescription drug coverage and judge for yourself.

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

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

If you go 63 continuous days or longer without prescription drug coverage that's creditable coverage (at least as good as Medicare's prescription drug coverage), your monthly premium for Medicare prescription drug coverage may go up at least 1% per month of the 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 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 enroll.

For More Information about This Notice or Your Current Prescription Drug Coverage:
Contact Express Scripts at 1-800-841-5396. NOTE: you will 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 available in the "Medicare & You" handbook. You'll get a copy of the handbook every year in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see Section 9 of the "Medicare and You" handbook for the phone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan 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 whether or not you are required to pay a higher premium (a penalty).

Date:	December 1, 2023
Name of Entity/Sender:	Adventist Risk Management
Contact--Position/Office:	Administrator
Address:	12501 Old Columbia Pike Silver Spring, MD 20904
Phone Number:	800-447-5002

MEDICAID AND CHIP NOTICE

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 are 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 https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or call **1-866- 444-EBSA (3272)**

To see if your state has a premium assistance program, or for more information on Special Enrollment Rights, contact either:

- US Department of Labor, US Department of Health and Human Services, Employee Benefits Security Administration, www.dol.gov/agencies/ebsa
- Centers for Medicare and Medicaid Services, www.cms.gov

SHARP GLOSSARY

"Adventist Retirement Board" means the board established by the NAD to maintain and amend from time to time SHARP and the various other NAD programs available to NAD retirees.

"Adventist Retirement Plan" means the Seventh-day Adventist Retirement Plan of the North American Division and Auxiliary Benefits and the Adventist Retirement Plan.

"ARM" means Adventist Risk Management, Inc.

"Canadian Retirement Plan" means the retirement plan sponsored by the Seventh-day Adventist - Canadian Division.

"Defined Benefit Plan" means the Seventh-day Adventist Retirement Plan of the North American Division and/or the Seventh-day Adventist Hospital Retirement Plan.

"Defined Contribution Plan" means the Adventist Retirement Plan.

"DVH" means the SHARP dental, vision and hearing coverage option described in this document.

"Earned Credit" means the amount of health care assistance under SHARP based on Retirement Plan Service described in this document.

"Eligible Dependent" means a child of an Eligible Retiree who satisfies the requirements for eligibility described in the Eligibility section of this document.

"Eligible Retiree" means a retiree of a NAD participating employer organization hired before July 1, 2020, who satisfies the requirements for eligibility described in the Eligibility section of this document.

"Eligible Spouse" means a spouse of an Eligible Retiree who satisfies the requirements for eligibility described in the Eligibility section of this document, or an ex-spouse who is an Eligible Spouse with rights to coverage as an Eligible Spouse pursuant to a court order recognized by SHARP. A Spouse must be married to the retiree at least one year prior to the effective retirement date. A Spouse married after the retiree's effective retirement date is considered a non-eligible spouse for purposes of the Plan. [See "Spouse"]

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Non-Medicare SHARP" means the health care plan offered to a child of an Eligible Retiree.

"North American Division" or "NAD" means the North American Division of the General Conference of Seventh-day Adventists.

"Plan Year" means the calendar year.

"Pre-Medicare SHARP" means the health care plan offered to retirees and their spouses who are not currently entitled to enroll for Medicare benefits, but who otherwise meet the requirements for eligibility described in the Eligibility section.

"Retirement Plan" means Seventh-day Adventist Retirement Plan of the North American Division and Auxiliary Benefits and the Adventist Retirement Plan.

"Retirement Plan Service" means the service credited under the NAD Defined Benefit Plan, the NAD Defined Contribution Plan or the Canadian Retirement Plan as described in this document and NAD Retirement policy documents. Qualifying service records are maintained in the eAdventist Personnel database. Service under the Seventh-Day Adventist Hospital Plan does not count as Retirement Plan Service for purposes of SHARP Earned Credit.

- Employees hired before January 1, 2000 with Defined Benefit Plan service shall continue to accrue service credit toward SHARP healthcare assistance.
- Employees hired between January 1, 2000 and June 30, 2020 with only Defined Contribution Plan service shall cease accruing service credit toward SHARP healthcare assistance beginning on July 1, 2020.
- Employees hired on or after July 1, 2020 are not eligible to participate in SHARP.

"Rx Option" means the SHARP prescription drug coverage option described in this document.

"SHARP" means the Supplemental Healthcare, Adventist Retirement Plan and the plan of benefit options described in the current SHARP document.

"SHARP-Ex" means the medical and prescription drug benefits offered through the private Medicare Exchange Marketplace vendor, Alight Retiree Health Solutions.

"SHARP Office" means the SHARP administrative staff of the NAD Adventist Retirement Plans office listed in the Contact Information section of this document.

"Spouse" means a participant's spouse, as determined under the policies of the participating employer or parent organization of the participant.

APPENDIX A – LIST OF COVERED PREVENTIVE SERVICES

Preventive care benefits for adults

See also: https://www.healthcare.gov/preventive-care-adults/

IMPORTANT - these services are free only when delivered by a doctor or other provider in your plan's network.

Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked https://healthfinder.gov/healthtopics/category/doctor-visits/screening-tests/talk-to-your-doctor-about-abdominal-aortic-aneurysm

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

Aspirin use every day to prevent cardiovascular disease for men and women of certain ages https://healthfinder.gov/healthtopics/category/health-conditions-and-diseases/heart-health/talk-with-your-doctor-about-taking-aspirin-every-day

Blood pressure screening https://healthfinder.gov/healthtopics/category/doctor-visits/screening-tests/get-your-blood-pressure-checked

Cholesterol screening https://healthfinder.gov/healthtopics/category/doctor-visits/screening-tests/get-your-cholesterol-checked

Colorectal cancer screening for adults age 50 and older https://healthfinder.gov/healthtopics/shared-decision-making/colorectal-cancer-screening

Depression screening https://healthfinder.gov/HealthTopics/Population/older-adults/mental-health-and-relationships/talk-with-your-doctor-about-depression

Diabetes (Type 2) screening https://healthfinder.gov/healthtopics/category/health-conditions-and-diseases/diabetes/take-steps-to-prevent-type-2-diabetes

Diet Counseling for adults at higher risk for chronic disease https://healthfinder.gov/healthtopics/category/everyday-healthy-living/nutrition/eat-healthy

Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and US-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.

https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/hepatitis-b-virus-infection-screening-2014

Hepatitis C screening for adults at increased risk, and one time for everyone born between 1945 – 1965 https://healthfinder.gov/HealthTopics/Category/doctor-visits/talking-with-the-doctor/hepatitis-c-screening

HIV screening for everyone ages 15 to 65, and other ages at increased risk; https://healthfinder.gov/healthtopics/category/health-conditions-and-diseases/hiv-and-other-stds

Immunization vaccines for adults – doses, recommended ages and recommended populations vary; https://healthfinder.gov/healthtopics/category/doctor-visits/shotsvaccines

- Diphtheria https://www.vaccines.gov/diseases/diphtheria/index.html
- Hepatitis A https://www.vaccines.gov/diseases/hepatitis_a/index.html
- Hepatitis B https://www.vaccines.gov/diseases/hepatitis_b/index.html
- Herpes Zoster https://www.vaccines.gov/diseases/shingles/index.html
- Human Papillomavirus (HPV) https://www.vaccines.gov/diseases/hpv/index.html
- Influenza (flu shot) https://www.vaccines.gov/diseases/flu/index.html
- Measles https://www.vaccines.gov/diseases/measles/index.html
- Meningococci https://www.vaccines.gov/diseases/meningitis/index.html
- Mumps https://www.vaccines.gov/diseases/mumps/index.html
- Pertussis https://www.vaccines.gov/diseases/pertussis/index.html
- Pneumococci (http://www.vaccines.gov/diseases/pneumonia/index.html
- Rubella https://www.vaccines.gov/diseases/rubella/index.html
- Tetanus https://www.vaccines.gov/diseases/tetanus/index.html
- Varicella (Chicken pox) https://www.vaccines.gov/diseases/chickenpox/index.html

Lung cancer screening for adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/lung-cancer-screening;

Obesity screening and Counseling https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/watch-your-weight
Sexually transmitted infection (STI) prevention counseling for adults at higher risk; https://healthfinder.gov/healthtopics/category/health-conditions-and-diseases/hiv-and-other-stds

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

Tobacco Use screening for all adults and cessation interventions for tobacco users. https://healthfinder.gov/healthtopics/category/health-conditions-and-diseases/cancer/quit-smoking

More on Prevention

- Learn more about preventive care from the CDC http://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

See also: https://www.healthcare.gov/preventive-care-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:

Anemia Screening on a routine basis https://healthfinder.gov/healthtopics/category/pregnancy/doctor-and-midwife-visits/have-a-healthy-pregnancy

Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women https://healthfinder.gov/HealthTopics/Category/pregnancy/getting-ready-for-your-baby/breastfeed-your-baby

Contraception: 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." https://healthfinder.gov/HealthTopics/Category/pregnancy/getting-ready-for-your-baby/breastfeed-your-baby

Folic acid supplements for women who may become pregnant https://healthfinder.gov/HealthTopics/Category/nutrition-and-physicaI-activity/nutrition/get-enough-folic-acid

Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes. https://healthfinder.gov/HealthTopics/Category/doctor-visits/talking-with-the-doctor/gestational-diabetes-screening-questions-for-the-doctor
Gonorrhea Screening for all women at higher risk https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/HIV and-other-stds/get-tested-for-chlamydia-and-gonorrhea

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

Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk https://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and- midwife-visits/have-a-healthy-pregnancy

Syphilis Screening https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and other-studs/syphilis-testing-questions-for-the-doctor

Expanded Tobacco Intervention and Counseling for pregnant tobacco users https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/quit-smoking

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://healthflnder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/have-a-healthy-pregnancy

Other covered preventive services for women:

1. *Breast cancer genetic test counseling (BRCA)* for women at higher risk https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/cancer/talk-with-a-doctor-if-breast-or ovarian-cancer-runs-in-your-family
2. *Breast cancer mammography screenings* every 1 to 2 years for women over 40 https://healthfinder.gov/HealthTopics/Category/doctorvisits/ screening-tests/get-tested-for-breast-cancer
3. *Breast cancer chemo prevention counseling* for women at higher risk https://healthfinder.gov/HealthTopics/Category/health- conditions-and-diseases/cancer/talk-with-a-doctor-if-breast-or-ovarian-cancer-runs-in-your-family
4. *Cervical cancer screening* for sexually active women https://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-tested-for-cervical-cancer
5. *Chlamydia infection screening* for younger women and other women at higher risk https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/get-tested-for-chlamydia-and-gonorrhea
6. *Domestic and interpersonal violence screening and counseling* for all women https://healthfinder.gov/HealthTopics/ Category/everyday-healthy-living/mental-health-and-relationship/take-steps-toprotect-yourself-from-relationship-violence
7. *Gonorrhea screening* for all women at higher risk https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/ HIV and-other-stds/get-tested-for-chlamydia-and-gonorrhea
8. *HIV screening and counseling* for sexually active women https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/HIV-and-other-stds/get-tested-for-HIV
9. *Human Papillomavirus (HPV) DNA test* every 3 years for women with normal cytology results who are 30 or older https://healthfinder.gov/HealthTopics/Category/doctorvisits/screening-tests/get-tested-for-cervical-cancer

10. *Osteoporosis Screening* for women over age 60 depending on risk factors https://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-a bone-density-test
11. *Rh incompatibility Screening* follow-up testing for women at higher risk https://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/have-a-healthy-pregnancy
12. *HIV Screening* for sexually active women https://healthfinder.gov/healthtopics/category/health-conditions-and-diseases/HIV-and-other-stds
13. *Syphilis Screening* for women at increased risk https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and other-stds/syphilis-testing-questions-for-the-doctor
14. *Tobacco use screening and interventions* https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/quit-smoking
15. *Well-woman Visit* to get recommended services for women under 65 https://healthfinder.gov/HealthTopics/Category/everyday-healthy-living/sexual-health/get-your-well-woman-visit-every-year

Preventive Care Benefits for Children

See also: https://www.healthcare.gov/preventive-care-children/

IMPORTANT - These services are free only when delivered by a doctor or other provider in your plan's network.

Coverage for children's preventive health services

All Marketplace health plans, and many other plans must cover the following list of preventive services for children without charging you a co-payment (/glossary/co-payment) or co-insurance (/glossary/co-insurance). This is true even if you haven't met your yearly deductible (/glossary/deductible).

Alcohol and drug use assessments for adolescents https://healthfinder.gov/HealthTopics/Category/parenting/healthy-communication-and-relationships/talk-to-your-kids-about-tobacco-alcohol-and-drugs

Autism screening for children at 18 and 24 months https://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4

Behavioral assessments and blood pressing 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 https://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

Cervical dysplasia screening for sexually active females
https://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-screened-for-cervical-cancer

Depression screening for adolescents
https://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-your-teen-screened-for-depression

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

Dyslipidemia screening for children at higher risk of lipid disorders 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 https://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

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

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

Hearing Screening for all newborns https://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/talk-with-your-doctor-about-newborn-screening

Height, weight and body mass index (BMI) measurements 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 https://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

Hematocrit or hemoglobin screening for all children https://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4

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

Hepatitis B screening for adolescents 11 – 17 years old at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and US-born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryDraft/hepatitis-b-virus-infection-screening-nonpregnant

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

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

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

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

Hemophilus influenza type b
https://www.vaccines.gov/diseases/hib/index.html

Hepatitis A
https://www.vaccines.gov/diseases/hepatitis_a/index.html

Hepatitis B
https://www.vaccines.gov/diseases/hepatitis_b/index.html

Human Papillomavirus (PVU)
https://www.vaccines.gov/diseases/hpv/index.html

Inactivated Poliovirus
https://www.vaccines.gov/diseases/polio/index.html

Influenza (flu shot)
https://www.vaccines.gov/diseases/tlu/index.html

Measles
https://www.vaccines.gov/diseases/measles/index.html

Meningococcal
https://www.vaccines.gov/diseases/meningitis/index.html

Pneumococcal
https://www.vaccines.gov/diseases/pneumonia/index.html

Rotavirus
https://www.vaccines.gov/diseases/rotavirus/index.html

Varicella (Chickenpox)
https://www.vaccines.gov/diseases/chickenpox/index.html

Iron supplements for children ages 6 to 12 months at risk for anemia
https://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-babys-visit-to-the-doctor-ages-0-to-11-months.

Lead screening for all children throughout development ages
https://healthfinder.gov/HealthTopics/Category/pregnancy/getting-ready-for-your-baby/protect-your-family-from-lead-poisoning

Medical history for all children throughout development ages:

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

Oral health risk assessment for young 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 https://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

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

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

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 https://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

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

More information about preventive services for children

- **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** https://healthfinder.gov/search/?q=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

More on Prevention

- Learn more about preventive care from the CDC https://www.cdc.gov/prevention
- Learn more about what else Marketplace health insurance plans cover https://www.healthcare.gov/coverage/what-marketplace-plans-cover/

SHARP APPENDIX B - MEDICARE ENROLLMENT RULES

Important Medicare Rules You Need to Understand Relating to Alight Retiree Health Solutions
There are specific Medicare-mandated enrollment windows called "Special Enrollment Periods" or "SEP." You are limited in when and how often you can join, change, or leave a Medicare plan depending on the type of plan or certain qualifying events.

Due to some "qualifying event," usually a retiree becoming eligible for new coverage, or losing their current coverage, retirees may enroll in a new plan outside of IEP (initial enrollment period)/AEP. The details depend on the specific qualifying event.

Enrolling in a Medicare Advantage Plan or Medicare Prescription Drug Plan (Part D, or PDP): Your chance to enroll begins prior to your retirement date and lasts for two (2) full months after your coverage ends.

Enrolling in a Medicare Supplement (also called a Medigap) Plan through Alight Retiree Health Solutions: You may enroll up to 63 days after the date your qualifying coverage ends with Guaranteed Issue in select plans through Alight Retiree Health Solutions. Guaranteed Issue means you cannot be denied coverage, or have a premium increase based on past or present health issues. If you had creditable coverage, the carrier also cannot exclude any preexisting conditions, with limited exceptions. Please contact Alight Retiree Health Solutions at 1-844-360-4714.

It is important to select your new plans and enroll within the appropriate time frame, to avoid a lapse in your insurance coverage.

If you are moving: You must notify Social Security of your move date to create an SEP. If you are enrolled in a Medigap plan, the plan will follow you to the new state of residence. You may pay a higher or lower premium based upon the insurance carrier offerings in that state. If you are enrolled in a Medicare Advantage plan and move out of state or to a new region within a state, you are entitled to an SEP to enroll into another Med-Advantage or Medigap plan of your choice. Again, you may pay a higher or lower premium based upon the insurance carrier offerings in that state. Alight Retiree Health Solutions participants are responsible for contacting a benefits advisor at Alight to discuss your move and whether or not enrollment is a new plan is necessary. Please call 1-844-360-4714 and ask to speak to a benefits advisor about your move.

Medicare Part D Late Enrollment Penalty (LEP)
If you do not join a Medicare Prescription Drug Plan (PDP) when you are first eligible OR if you have a period of 63 or more days in a row without "creditable drug coverage," Medicare will assess a penalty for every month you were not covered under a drug plan. This LEP is permanent and is an amount added to your Medicare Part D monthly premium. The penalty depends on how long you went without Part D or other creditable prescription drug coverage. A *Part D Late Enrollment Penalty (LEP) Reconsideration Request Form* is available online at:
https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Downloads/Part-D-Late-Enrollment-Penalty-Reconsideration-Request-Form-.pdf

Medicare Part B Late Enrollment Penalty (LEP)
In most cases, if you don't sign up for Medicare Part B when you're first eligible, you'll have to pay a late enrollment penalty. You'll have to pay this penalty for as long as you have Medicare Part B. Your monthly premium for Medicare Part B may go up 10% for each full 12-month period that you were eligible for Part B but didn't sign up for it. Also, you may have to wait until the General Enrollment Period (from January 1 to March 31) to enroll in Part B. Coverage will start July 1 of that year.

See www.medicare.gov for additional information.

INSTRUCTIONS FOR COMPLETING THE SHARP FORM

1. The SHARP form completion depends upon meeting the eligibility requirements for either the SHARP or the Pre-Medicare/Non-Medicare Options. Refer to the Eligibility section of this document to determine which coverage is the correct one for your needs. **All Medicare-eligible** individuals may only choose from the SHARP - Ex Option and must be enrolled in Medicare
2. For each individual seeking healthcare benefits please complete the Name, Date of Birth (DOB) and Social Security Number (SSN) on the form. Use the SHARP Pre-Medicare/Non-Medicare SHARP Form, for those less than age 65 and dependent children. Enter the dollar amount for the options selected.
3. Pre-Medicare: Remember inpatient and outpatient medical benefits are separate from Dental/Vision/Hearing (DVH) and Prescription Drug (Rx) benefits. If the Pre-Medicare retiree wishes to also have SHARP DVH and SHARP Rx benefits he/she must enroll in each benefit and for each eligible individual.
4. Non-Medicare: This coverage includes medical inpatient and outpatient expenses, SHARP DVH and SHARP Rx as described within the policy. See the Pre-Medicare/Non-Medicare document entitled Schedule of Benefits.
5. Total ALL monthly selections.
6. If the retiree meets the eligibility requirements, refer to the Earned Credit Table in the Earned Credit section of this document. Enter the Earned Credit for the retiree, spouse and dependent child. Remember, only spouses who are eligible on the date the retiree has retired are eligible for the Earned Credit.
7. Add the total cost of all Options selected. Subtract the Earned Credit if eligible. The “Total” will be the monthly cost for the retiree’s elected benefits.
8. For each individual who selects SHARP Options, Step 6 should be completed.
9. **Read all conditions carefully and sign the form**. Return the form within **30** days of the retirement effective date to the SHARP Office for processing. Be sure to sign the form. Unsigned Enrollment Applications will not be processed.
10. For assistance with the enrollment process, please contact the SHARP Office at: 443-391-7338 / Monday–Thursday / 8 a.m. – 5 p.m. EST.

Pre-Medicare / Non-Medicare SHARP Form -- 2024

Retiree Name: _____ **SSN:** _____

	Retiree Name	Spouse Name
	DOB:	DOB:
	SSN:	SSN:
Pre-Medicare		
Pre-Medicare - $517/month/person		
Minus Pre-Medicare Earned Credit	-	-
Net Pre-Medicare Cost	$ 0.00	$ 0.00
Pre-Medicare Dental/Vision/Hearing- $105/month/person		
Pre-Medicare Rx - $154/month/person		
Gross Pre-Medicare DVH and/or Pre-Medicare Rx Cost	$	$
Minus PreMedicare Rx/DVH Earned Credit	-	-
Net Cost	$ -	$ -
Total Pre-Medicare/DVH/Rx:	**$ 0.00**	**$ 0.00**

Non-Medicare

	Dependent Child Name	Dependent Child Name	Dependent Child Name
	DOB:	DOB:	DOB:
	SSN:	SSN:	SSN:
Non-Medicare -- $184/month/child			
Minus Earned Credit	-	-	-
Net Non-Medicare Cost	$ 0.00	0.00	0.00

Total Cost for All Options Selected	$

Please enroll me in the SHARP coverage as requested above. I authorize SHARP to deduct monthly contributions based on the options I have selected. If the cost is greater than my pension, I will make advance monthly payments. I understand that:

- SHARP Pre-Medicare Medical and Prescription Drug options will cease at age 65 when I will be given opportunity to join an exchange option.
- My non-eligible spouse may participate in SHARP, but will receive no financial assistance towards options selected.
- SHARP's Prescription and Pre-Medicare options include calendar year deductibles and maximums, neither of which will be prorated during enrollment year.
- It is my responsibility to notify SHARP when any children enrolled above are no longer eligible to participate.
- The Pre-and Non-Medicare options are part of a PPO network. **The use of out-of-network providers without prior authorization will result in no payment by the Plan.**
- The Pre-Medicare medical option does not include Rx or DVH.
- All service credit and other information will be reviewed by the Retirement Office before finalization. A SHARP representative will contact me to review my selections. If I change my address/phone before Benefits are processed, I will notify Adventist Retirement.
- SHARP does not provide annual or three-year anniversary open enrollments.

Retiree Signature _____ **Date** _____

Effective date of Options Selected: _____

Application must be signed and returned within 30 days of retirement effective date.

Adventist Retirement
9705 Patuxent Woods Drive
Columbia, MD 21046

Phone: 443-391-7338
Fax: 443-259-4880

Authorization Agreement For Recurring Direct Payments (ACH Debits)

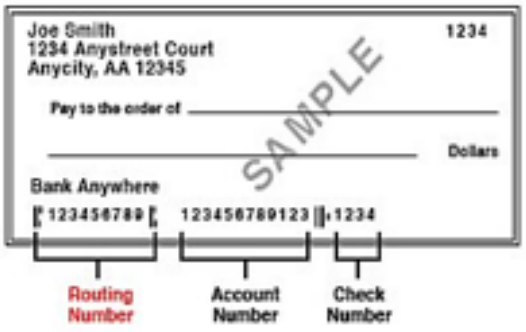
AUTHORIZATION

I hereby authorize Adventist® Retirement to electronically collect standard SHARP fees (contributions) from my bank account indicated below. Adventist Retirement will debit my bank account monthly as I have indicated below.

BANK INFORMATION **ALL FIELDS MUST BE COMPLETED**

Bank Name:	
Type of Account:	☐ Checking ☐ Savings (Please contact your bank for the correct routing number)
Routing Number:	
Account Number:	

☐ I acknowledge that my account will be debited monthly in 12 equal payments beginning on December 15 for January's fees, and then monthly on the 15th day of every month thereafter.



HOW TO CONTACT ME

My email address:			
My phone numbers	Home:		
My mailing address:		Last 4 digits of Social Security Number:	☐☐☐☐

PLEASE PRINT THE NAMES OF TWO (2) PERSONS WE CAN CONTACT IF WE CANNOT REACH YOU

Alternate Designee #1 Name:
Phone number:
Email address:

Alternate Designee #2 Name:
Phone number:
Email address:

MY SIGNATURE OF AUTHORIZATION

☐ (Check here) I have read the TERMS AND CONDITIONS on the reverse side of this form.	Date:
Print Name:	My Signature:

Return Form To: Adventist Retirement/SHARP **OR** FAX: (443) 259-4880
9705 Patuxent Woods Drive
Columbia, MD 21046

Seventh-day Adventist Church
NORTH AMERICAN DIVISION

****FOR SECURITY REASONS PLEASE DO NOT EMAIL THE COMPLETED FORM****

TERMS AND CONDITIONS

Authorization Agreement For Recurring Direct Payments (ACH Debits)

_____ Initial

Voluntary termination is only permitted per conditions outlined in the Plan document. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Adventist Retirement in writing of any changes in my account, or termination of this authorization at least 15 days prior to the next billing date.

_____ Initial

SHARP fees are required to be paid in advance of receiving coverage. Persons paying monthly will have their account debited on the 15th day of the preceding month (i.e., the fee for January 2019 coverage will be paid on December 15, 2018.)

_____ Initial

If the regularly scheduled payments fall on a weekend or holiday, I understand that the payments will be executed on the next business day.

_____ Initial

For ACH debits to my bank account, I understand that as these are electronic transactions, these funds may be withdrawn from my account as early as the regularly scheduled payment date (i.e., the 15th day of every month).

_____ Initial

In the case of an ACH transaction being rejected by my bank for Non-Sufficient Funds (NSF) or any other reason, I understand that Adventist Retirement may attempt to process the charge again within fifteen (15) days. I agree to an additional fifteen-dollar ($15.00) charge for each transaction rejected by my bank. This additional charge will also be initiated by Adventist Retirement as an ACH transaction separate from the authorized recurring payment. I understand that Adventist Retirement is not responsible for any fees charged to me by my bank for rejected ACH transactions, whether for NSF or for some other reason.

_____ Initial

If my bank rejects the first and second attempts to process a payment, I understand that my coverage will be terminated, and the termination is a lifetime termination with no opportunity for reinstatement or future coverage.

_____ Initial

I acknowledge that the origination of ACH transactions to my bank account must comply with the provisions of U.S. law. I certify that I am an authorized user of this bank account and will not dispute these scheduled transactions with my bank so long as the transactions correspond to the terms indicated on this authorization form.

AdventistRetirement
9705 Patuxent Woods Drive, Columbia, MD 21046
PHONE: (443) 391-7300 FAX: (443) 259-4880

Notes

CONTACT INFORMATION

This Plan is administered by
Adventist Risk Management, Inc.
www.adventistrisk.org

Privacy Officer
Adventist Risk Management
12501 Old Columbia Pike
Silver Spring, MD 20914-4288
privacyofficer@adventistrisk.org

Contracted Supporting Organizations

Member Services/Medical Benefit
Adventist Risk Management/WebTPA
P O Box 1928
Grapevine, TX 76099-1928
Voice (800) 447-5002

Prescription Claims Office
Express Scripts
Voice (800) 841-5396

Dental, Vision, Hearing Benefit
Adventist Risk Management, Inc.
P O Box 1928
Grapevine, TX 76099-1928
Voice (800) 447-5002