Adventist Health
Employee Health Plan (ERISA)

Summary Plan Description (SPD)

January 01, 2027

Adventist Health Administrators
ONE Adventist Health Way
Roseville, CA 95661-9031

Eligibility, Benefits and Customer Service:
1-800-441-2524
FAX: (916) 406-2301

On-line Claims and Eligibility Access:
AdventistHealth.org/EmployeeHealthPlan

4909-9196-4877

TABLE OF CONTENTS

Page

WELCOME 1

TRANSLATION SERVICES ARE AVAILABLE 1

DISCRIMINATION IS AGAINST THE LAW 1

KEY PLAN INFORMATION 3

SCHEDULE OF BENEFITS 5

DEFINITIONS 17

ELIGIBILITY, ENROLLMENT AND END OF COVERAGE 28

CONTINUATION COVERAGE RIGHTS UNDER COBRA 36

EMPLOYEE-SHARE CONTRIBUTION 44

CARE MANAGEMENT AND UTILIZATION MANAGEMENT PRIOR AUTHORIZATION PROGRAM 45

PROVIDERS AND FACILITIES AVAILABLE UNDER THE PLAN 49

SURPRISE MEDICAL BILLS NOTICE 52

BENEFITS DESCRIPTION 54

GENERAL EXCLUSIONS 67

CLAIMS PROCEDURES 76

DISCRIMINATION GRIEVANCE PROCEDURE (ACA SECTION 1557) 87

BENEFITS AVAILABLE FROM OTHER SOURCES 89

COORDINATION OF BENEFITS 93

GENERAL PLAN INFORMATION 98

STATE AND FACILITY SPECIFIC PROVISIONS 103

ADVENTIST HEALTH EMPLOYEE HEALTH PLAN NOTICE OF PRIVACY PRACTICES (HIPAA PRIVACY NOTICE) 104

STATEMENT OF ERISA RIGHTS 107

APPENDIX A – LIST OF COVERED PREVENTIVE SERVICES 109

APPENDIX B – RULE OF 80 AND SEVERANCE CONTRACT COVERAGE 120

APPENDIX C – MEDICAL RESIDENTS' EFFECTIVE DATE OF COVERAGE 121

APPENDIX D – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA PRIVACY POLICY) 122

APPENDIX E – INTERNATIONAL REGISTERED NURSES' EFFECTIVE DATE OF COVERAGE 136

APPENDIX F – WELLRITHMS SHIELD PROGRAM AND SHIELD SERVICES 137

APPENDIX G - GLP-1 DIRECT FUND

WELCOME

This Summary Plan Description (**SPD**) is designed to provide you with important information about your *Plan*'s benefits, limitations and procedures. Benefits described in this document are effective January 1, 2027. This SPD is also the *Plan* document. This is a component plan of the Adventist Health ERISA Welfare Plan.

The *Plan* is self-funded by means of *employer* and *employee* contributions. At the beginning of each year, the *employer* sets the flat amount of periodic *employee-share contributions* that are due from you, and the *employer* contributes whatever additional amounts are necessary to pay claims incurred under the *Plan* for the year. Historically, the employer has paid 80% or more of the cost of *Plan claims*. Periodic *employee-share contributions* are withheld from your paycheck and deposited into the *employer*'s general account. The *employer* is then responsible for making periodic contributions to the *Plan*-funding trust that are actuarially determined to be sufficient to cover the cost of *claims* incurred during the year.

Your benefits are affected by certain limitations and conditions, which require you to be a wise consumer of health services and to use only those services you need. Also, benefits are not provided for certain kinds of treatments or services, even if your health care provider recommends them. Rideout Memorial Hospital (doing business as Adventist Health and Rideout, hereinafter referred to as "Rideout") is the *plan administrator* and named fiduciary for this *Plan* and has contracted with *Adventist Health Administrators*, a division of Adventist Health, to provide certain plan administration and contract claims administration services.

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

We hope that you find this SPD helpful. If you have any questions about the SPD, please call the *Adventist Health Administrators* Customer Service Department toll free at **1-800-441-2524**.

Thank you for choosing us as your healthcare plan.

TRANSLATION SERVICES ARE AVAILABLE

Spanish (Español): Para obtener asistencia en Español, llame al (800) 441-2524.

For assistance in other languages, contact Benefits Administration at (800) 441-2524.

DISCRIMINATION IS AGAINST THE LAW

The *Plan* complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The *Plan* does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The *Plan*:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator, Wendi Troncao.

If you believe that the *Plan* has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Wendi Troncao (Director of Benefits Administration ONE Adventist Health Way, Roseville, CA 95661, 1-800-441-2524, Troncawc@ah.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Wendi Troncao, Director of Benefits Administration is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.

Please see the Discrimination Grievance Procedure (ACA Section 1557) section for an explanation of how to file a grievance if you believe the Plan is acting in a discriminatory manner.

KEY PLAN INFORMATION

Plan Name:
Adventist Health Employee Health Plan (ERISA), a component plan of the Adventist Health ERISA Welfare Plan.

Type of Plan: The *Plan* is a group health plan (a type of welfare benefit plan that is subject to the provisions of ERISA).

Plan Sponsor:
Rideout Memorial Hospital dba Adventist Health and Rideout
989 Plumas Street
Yuba City, CA 95991
530-749-4300

Employer Identification Number: 94-1387866

Plan Number: 503

Plan Year: January 1 to December 31

Effective Date: January 1, 2026

Plan Administrator and Named Fiduciary:
Adventist Health and Welfare ERISA Administrative Committee
ONE Adventist Health Way
Roseville, CA 95661
1-800-441-2524

Funding Medium and Type of Plan Administration: The *Plan* is self-funded by *employer* and employee contributions. Claims are paid out of a voluntary employee beneficiary association trust, for which Wells Fargo Bank is the trustee. This is not an insured plan. Claims are administered by an in-house claims administration department.

Medical Care Management/Utilization Review:
Benefits Administration
ONE Adventist Health Way
Roseville, CA 95661
1-800-441-2524

Designated Agent for Service of Legal Process:
Meredith Jobe
Vice President/General Counsel
Adventist Health
ONE Adventist Health Way
Roseville, CA 95661
916-789-4245

Service of legal process may also be made upon Rideout Memorial Hospital dba Adventist Health and Rideout (the named fiduciary and *plan administrator*).

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

This SPD may be changed or replaced at any time, by the *plan administrator*, without the consent of any *enrollee*.

SCHEDULE OF BENEFITS

The tables below summarize your medical *Plan* benefits, applicable deductibles, the annual out-of-pocket maximum, 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.

Please note that coverage for medical services which are covered under this *Plan*, other than *emergency services*, is only available when services and supplies are pre-certified per *Plan* guidelines (or when the services/supplies are required to be covered by the *No Surprises Act*). **If you do not follow the *prior authorization* procedures set forth in the Care Management and Utilization Management Prior Authorization 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 Care Management and Utilization Management Prior Authorization Program procedures will not be applied to your *deductibles* or out-of-pocket maximums**.

PLAN COVERAGE LEVELS – AH AND PPO

The *Plan* has different coverage levels for different types of services, and that differ based on the state in which the service is rendered. For "facility" services (*e.g., hospital,* mental health inpatient and outpatient, and home health care), the *Plan* generally only covers services at a *Tier 1 Facility* (Tier 1) or *PPO facility* (Tier 2), with the *Plan* paying a higher percentage of the cost of services for a *Tier 1 Facility* than it does for a *PPO facility*. Coverage for facility services at a *PPO facility* requires an approved Unavailable Service Request Form. For *provider* and other non-facility *covered services*, the *Plan* generally covers services from a *Tier 1 Providers* (Tier 1) or *PPO providers* (Tier 2), with the *Plan* paying a higher percentage of the cost of the services for a *Tier 1 Provider* than it does for the cost of services for a *PPO Provider* (see the Schedule of Benefits).

Balance Billing

Balance billing is when an *out-of-network provider/facility* bills you for the difference between the *provider/facility*'s charge and the *Plan*'s *Reasonable and Allowable Amount*. Whenever a *Tier 1 Facility*, *Tier 1 Provider, PPO provider* (or, in the limited situations when covered, a *PPO facility*) is used to provide covered services, then you will not receive a balance bill. If an *out-of-network facility/provider* is used, then you may receive a balance bill (see the Patient Advocacy Center section below for more information about the *Plan*'s advocacy services for *participants* who receive a balance bill).

If you receive a balance bill for (1) *emergency services* or *urgent care*, or (2) after receipt of an approved Unavailable Services Request Form, and you are unable to resolve a balance bill, please call the Patient Advocacy Center at (888) 837-2237 for the Level 2 services described below in the Patient Advocacy Center section.

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.)

DEDUCTIBLES AND ANNUAL OUT-OF-POCKET MAXIMUM

Deductible

A deductible is the amount of *covered service* expenses you must pay each *plan 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 Medical out-of-pocket maximum). Expenses incurred in meeting your deductible for one level of benefits apply toward your deductible for the other level of benefits. 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 an *in-network provider/facility*, do not count toward your deductible.

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the most you pay during the *plan year* (January 1 to 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 maximum:

- Your required *employee-share contributions*
- Disallowed charges
- Balance billed charges (that is, amounts above the *Reasonable and Allowable Amount* billed by an *out-of-network provider/facility* 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)

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

Covered expenses incurred in meeting your out-of-pocket maximum for one level of benefits (Tier 1, Tier 2, or *out-of-network*) apply toward your out-of-pocket maximum for the other levels of benefits.

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*.

MedImpact Assist—Copay Assistance

Copay Accumulator

Discounts, coupons, or similar financial assistance provided by drug manufacturers or pharmacies to assist you in covering the cost of your medications (including any prescription drug discount/coupons provided to pharmacies when you fill a prescription) will not count against your annual deductible or maximum out-of-pocket limits. Only the amount that you pay separate and apart from the financial assistance will be credited as true out-of-pocket payment that will apply to your annual deductible and maximum out-of-pocket limits.

Example: If your medication costs $50, and you use a $40 coupon or debit card and then pay the remaining $10 out of pocket, only the $10 will apply to your annual deductible or maximum out-of-pocket limits.

Variable Copay

In order for the *Plan* to better manage available manufacturer-funded copay assistance, copays for certain medications may vary and be set to approximate the maximum of any available manufacturer-funded copay assistance programs. However, in no case will true out-of-pocket costs to you be greater than the maximum copayment published in this *Plan*. Finally, manufacturer-funded copay assistance received will not be credited to your annual deductible or maximum out-of-pocket limits.

MedImpact Assist – Member Advocacy Program

Beginning January 1, 2026, the *Plan* has enhanced its benefit offering by partnering with MedImpact and its affiliate, Ray Savings Solutions, to provide a Member Advocacy Program for certain high-cost medicines that are classified as specialty under *Plan*. The Member Advocacy Program offers to non-Medicare eligible *Plan participants* an opportunity to help reduce or eliminate out-of-pocket costs on certain high-cost specialty

medications that are not otherwise covered by the *Plan*. You are strongly encouraged to participate in this program to determine whether you are eligible for copayment assistance. If you choose not to participate in the Member Advocacy Program the costs incurred for specialty drugs will not be considered a covered benefit under the *Plan* and any out-of-pocket costs incurred will not be counted toward your deductible or out-of-pocket maximum. If at any time you are deemed ineligible for copayment assistance, MedImpact will coordinate an appeal on your behalf to determine if the drug is eligible for coverage through your prescription drug benefit and subject to the copayment/coinsurance outlined in the plan document. If you are currently taking specialty medicine, you will receive a letter prior to January 1, 2027 with directions to contact your Member Advocate. This person will help enroll you and start looking for ways to lower the cost of your medication. You can contact your dedicated Member Advocate after January 1, 2027 at the phone number provided in your letter, or you can have all future contact made via secure email. Member Advocates are available from 6 a.m. to 6 p.m. MT, Monday through Friday.

Some examples of copayment assistance options are:

1. Patient Assistance Programs – These are drug manufacturer sponsored Patient Assistance Programs (PAP) and require members to meet certain eligibility criteria, including, but not limited to, income verification. This information will be supplied directly to the manufacturer providing the financial assistance. Under no circumstances will this information be shared with the *Plan*, nor will it be taken into consideration by the *Plan* or MedImpact when deciding your coverage.
2. Foundation Assistance Program – These are financial assistance programs offered by non-profit, or charitable organizations. Each nonprofit or charitable organization has their own criteria for financial assistance approval and plan participants may be required to meet certain eligibility criteria, including, but not limited to, income verification. This information will be supplied directly to the foundation providing the financial assistance. Under no circumstances will this information be shared with the *Plan*, nor will it be taken into consideration by the *Plan* or MedImpact when deciding your coverage.
3. Copay Assistance Programs – These are drug manufacturer sponsored copay coupons that cover most or all of the plan participants out-of-pocket costs. Copay coupon options vary based on medication and are subject to the terms and conditions set forth by the drug manufacturer.

CO-INSURANCE AND CO-PAYMENTS

The percentages the *Plan* pays apply only to *covered service* expenses that do not exceed the *Reasonable and Allowable Amount*. You are responsible for all non-*covered service* expenses and any amount that exceeds the *Reasonable and Allowable Amount* for *covered service* expenses. The table below lists the percentage of the cost of the listed services covered by the *Plan* (up to the *Reasonable and Allowable Amount*). *Co-insurance* percentages are the portions of *covered service* expenses paid by you after satisfaction of any applicable deductible. For example, if the listed *Plan* percentage in the chart below is 80%, then your *co-insurance* would be 20%.

Co-payments are fixed dollar amounts of *covered service* expenses to be paid by the *enrollee*. *Co-payments* apply per visit/admission/occurrence. Please note that fixed dollar *co-payments* do not apply toward your annual deductible.

LIFETIME MAXIMUM BENEFIT

There is no dollar limit to the amount the *Plan* will pay for essential benefits during the entire period you are enrolled in this Plan.

Generally, the following are considered to be essential benefits under the Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).The determination of which benefits provided under the *Plan* are essential benefits shall be made in accordance with the benchmark plan of the State of Utah as permitted by the Departments of Labor, Treasury, and Health and Human Services.

PATIENT ADVOCACY CENTER

It is the *Plan*'s position that an *out-of-network provider/facility* should not balance bill the *Plan participant* for amounts in excess of the *Reasonable and Allowable Amount*. It is the *Plan*'s position that these *excess charges* are clearly excessive and exorbitant. However, balance billing for such amounts can occur for *out-of-network claims* and the *Plan* has no control over the actions of the *providers/facilities* or their desire to pursue you for such amounts. (See the Surprise Medical Bills Notice for details of when you should not receive a balance bill, by law.)

In the event you receive a balance bill for an amount in excess of the *Reasonable and Allowable Amount* payable under the *Plan*, please immediately email pathwaysconcierge@wellrithms.com or call the Patient Advocacy Center toll free at (888) 423-1605.

There are two levels of Patient Advocacy Center services. The first level (Level 1), which involves providing you and the billing *provider/facility* with the facts and methodology used by the *Plan* in calculating the *Reasonable and Allowable Amount* in your case, is available for any *participant* who receives a balance bill for *covered services* under the *Plan*. The second level (Level 2), which involves direct advocacy with the treating *provider/facility* as to the *Reasonable and Allowable Amount* payable by the *Plan*, is a more aggressive service and is reserved for *enrollees* who obtain *out-of-network* services for e*mergency services*, *urgent care*, or after receipt of an approved Unavailable Services Request Form due to unavailability of a *medically necessary covered service* from an *in-network facility/provider*.

If you receive a balance bill for (1) *emergency services* or *urgent care*, or (2) after receipt of an approved Unavailable Services Request Form, please call the Level 2 Patient Advocacy Center services at (888) 423-1605 for further assistance.

Please Note: The Patient Advocacy Center provides assistance to *Plan participants* with the understanding that (i) the Patient Advocacy Center is not acting in a fiduciary capacity under this *Plan*, (ii) that the *Plan participant* must make their own independent decision with respect to any course of action in connection with any balance bill, including whether such course of action is appropriate or proper based on the *participant*'s specific circumstances and objectives, and (iii) the Patient Advocacy Center does not provide legal or tax advice.

	2027 Employee Health Plan		Comments/Explanations
	Tier 1 **Adventist Health (including LLUMC, OHSU Health Network & Medical Staff) and UC Davis**	**Tier 2** **Anthem Blue Cross and Blue Shield**	**Tier 1:** Must be either (i) medical staff of Adventist Health, Adventist Health and Rideout, Adventist Health Mendocino Coast, LLUMC, LLUMC-Murrieta, or Adventist Health Columbia Gorge, and participate in the Anthem Blue Cross and Blue Shield network; or (ii) a physician or professional provider that has contracted with UC Davis or Oregon Health & Science University to provider services under the Plan. **Tier 2:** Must participate in the Anthem Blue Cross and Blue Shield network. **(D) = Deductible Applies** *** Fixed dollar co-payments apply to annual out-of-pocket maximums. Fixed dollar co-payments apply PER visit/admission/occurrence.**
Medical Deductible	$0	$500 per individual	Common deductible and out-of-pocket. An additional deductible applies for each enrollee you cover, except as limited by the Plan's Medical out-of-pocket maximum.
Medical Out-of pocket	Individual max: $2,500 Family max: $6,000		
Pharmacy Deductible	$0		
Pharmacy Out-of-pocket	Individual max: $3,700 Family max: $4,500		
Total Out-of-pocket	Individual max: $6,200 Family max: $10,500		
Percentages listed below are the percentage the Plan pays (after any applicable deductible (D) or $ co-pay amount).			
Facility/Ambulatory Services			
Inpatient Hospital Services	100%	80% or 0%**	Preauthorization, including USRF, required for Tier 2 and out-of-network facility services. If you reside outside of CA/OR, you do not need a USRF if using the Tier 2 PPO Network, unless prior authorization is required for the service.
Outpatient Hospital Services Outpatient Surgery and Invasive Diagnostic Procedures (Facility charges) Routine Lab and Diagnostic Imaging (X-ray, Ultrasound, Mammography) Other Imaging (DEXA, MRI, MRA, CT, PET and	100%	80% or 0%**	Preauthorization, including USRF, required for Tier 2 and out-of-network facility services. If you reside outside of CA/OR, you do not need a USRF if using the Tier 2 PPO Network, unless prior authorization is required for the service.

Nuclear Medicine) Radiation Oncology Services			
Habilitation/Rehabilitation Services Inpatient (PT/OT/Speech)	100%	80% or 0%**	Preauthorization, including USRF, required for Tier 2 and out-of-network facility services. If you reside outside of CA/OR, you do not need a USRF if using the Tier 2 PPO Network, unless prior authorization is required for the service.
Habilitation/Rehabilitation Services Outpatient (PT/OT/Speech)	100% Tier Facility & AH Clinics $25 Co-pay* - Physicians	$35 Co-pay* 100%	AH Clinics = Adventist Health Physician Services entity and AH Tax IDs.
Outpatient Diabetic Instruction (Facility Based)	100%	80% or 0%**	Pre-authorization, including USRF, required for Tier 2 and out-of-network facility services. If you reside outside of CA/OR, you do not need a USRF if using the Tier 2 PPO Network, unless prior authorization is required for the service.
Maternity Hospital Care	100%	80% or 0%**	Preauthorization, including USRF, required for Tier 2 and out-of-network facility services. If you reside outside of CA/OR, you do not need a USRF if using the Tier 2 PPO Network, unless prior authorization is required for the service.
Bariatric Management Program Bariatric Surgery	100%	n/a	Covered at *Tier 1 Facilities* that are accredited by the Metabolics and Bariatric Surgery Accreditation Quality Improvement Program (MBSAQIP). The *Plan* will also cover select Adventist Health hospitals that are in the process of seeking their MBSAQIP accreditation and have met the *plan administrator*'s criteria for offering bariatric surgery to *Plan enrollees*. (Contact *Benefits Administration* for a list of such hospitals.) Coverage is subject to criteria. Benefits discussed further in the Bariatric Surgery section of the Benefits Description chapter. $500 co-payment will apply to a second bariatric surgery.
Preventive Health Care (Wellness)			
Preventive Health: Hospital Services	100%	100%	Benefits discussed further in the Preventive Health Care section of the Benefits Description chapter.
Preventive Health: Provider Services	100%	100%	
Weight Watchers	100%	100%	Lifetime maximum of 24 months. This program covers group meetings. Physician's prescription is required with the submission of the first month's claim. *Enrollee* will pay monthly program costs to Weight Watchers. Then the health plan will reimburse 100% of program fees upon completion of 80% of the sessions with proof of attendance attached to each claim submitted monthly. (This benefit excludes online and Weight Watchers for diabetes.)
Physician/Provider Services			

Physician Office Visits Primary Care Physician, Specialists	100% $25 Co-pay*	100% $35 Co-pay*	
Physician Visits Physician Visits While Hospitalized	100%	80%	
Surgeon/Assistant Surgeon	100%	80% (D)	
Outpatient Diabetic Instruction	100%	80% (D)	
Home Visit	100%	80%	
Physician Services – Inpatient/Outpatient/Hospital – Assigned per contract	100%	80%	e.g., Pathology, anesthesiology, radiology, emergency room, and hospitalist service if performed in a facility.
Physician Services - Other (non-office visits such as minor surgery, x-rays, labs, sleep labs)	100% AH Clinics 90% Non-AH Clinics	80% (D)	AH Clinics = Adventist Health Physician Services entity and AH Tax IDs. *Covered services* rendered by Myriad Genetic Laboratories will be covered at the "Tier 2" level.
Second and Third Surgical Opinion	100%	80% (D)	
Maternity Fees/Provider	100%	80% (D)	
Provider administered medications (injections, infusions, chemotherapy - office)	100%	80% (D)	
Vision Therapy	100%	100% $35 Co-pay*	12 visits annual individual maximum. Covered only for ages eighteen and younger.
E-Visits & Telehealth	$10 Co-Pay* AHOnDemand	$35 Co-Pay*	Benefits include telehealth group sessions or family therapy sessions for a *mental health condition* and/or *substance abuse*. $0 copayment for e-visit, telehealth, and telehealth group or family therapy sessions rendered by a *Thriveworks mental health provider* for a *mental health condition* and/or *substance abuse*.
Outpatient Chemotherapy (Provider's Office)	100%	80% (D)	
Emergency Care			
Emergency Care: Emergency Services	100% $200 Co-pay*	100% $200 Co-pay*	*Emergency room co-pay waived if admitted to hospital. See the Surprise Medical Bills Notice for more information about the coverage of *out-of-network emergency services*.
Emergent In-Patient Hospital Admission	75% / 100%	75% / 100% (D)	The 'Plan Pays' percentage for Emergent In-Patient Hospital Admission will be increased from **75% to 100%** if you or the health care facility/provider notify the Plan within two (2) business days of your hospital admission. Benefits discussed further in the Emergency Services section of the Benefits Description chapter. Application of deductible on Tier 2 will be waived for *emergency services* and certain post-stabilization services subject to the *No Surprises*

			Act. See the Surprise Medical Bills Notice for more information.
Ambulance (Ground)	80% after $50 Co-pay*	80% after $50 Co-pay*	
Ambulance (Air)	80% after $200 Co-pay*	80% after $200 Co-Pay*	
Urgent Care (includes out-of-network providers who will be paid under the PPO level of benefits)	100% $25 Co-pay*	100% $35 Co-Pay*	
Mental Health			All mental health and chemical dependency benefits are discussed further in the Mental Health Conditions and Substance Abuse Treatment section of the Benefits Description chapter. The terms "chemical dependency" and "substance abuse" are used interchangeably in the *Plan*.
Mental Health and Chemical Dependency (Facility) Inpatient	100%	80% or 0%**	Preauthorization, including USRF, required for Tier 2 and out-of-network facility services. If you reside outside of CA/OR, you do not need a USRF if using the Tier 2 PPO Network, unless prior authorization is required for the service.
Mental Health and Chemical Dependency (Facility) Outpatient	100%	80% or 0%**	Preauthorization, including USRF, required for Tier 2 and out-of-network facility services. If you reside outside of CA/OR, you do not need a USRF if using the Tier 2 PPO Network, unless prior authorization is required for the service.
Mental Health and Chemical Dependency (Facility) Residential	100%	80% (D)	
Mental Health and Chemical Dependency Office Visit	100% $25 Co-pay*	100% $35 Co-pay*	Benefits include telehealth group sessions or family therapy sessions for a *mental health condition* and/or *substance abuse*. $0 copayment for e-visit, telehealth, and telehealth group or family therapy sessions rendered by a *Thriveworks mental health provider* for a *mental health condition* and/or *substance abuse*.
Other Services			
Sterilization Procedures: Vasectomy/Tubal Ligation	100%	80% (D)	
Skilled Nursing Facility Care	100%	80% (D)	100 day annual maximum
Hospice Care	100%	80% (D)	Benefits include bereavement counseling for covered family members. Refer to Plan guidelines.
Home Health Care	100%	80%	
Home Infusion Therapy	100%	80% (D)	
Durable Medical Equipment	100%	80%	Benefits include purchase or rental, not to exceed the purchase price of the equipment. Requires utilization review for equipment of ≥ $2,000. Exception: CPM devices, and Dynasplints always

			require prior authorization.
Supplies and Appliances	100%	80%	
Diabetic Supplies	100%	80%	When applicable, diabetic supplies will be covered by pharmacy benefit.
Prosthetics and Orthotics	100%	80% (D)	Please refer to Durable Medical Equipment, Supplies, and Appliances section of the Benefits Description chapter.
Hearing Aid and Exam	100%	80% (D)	Limited to $5,000 for one ear and $10,000 for two ears every two years. Hearing aids may be obtained from outside vendors, such as warehouse stores, etc. UC Davis Health is not Tier 1 for this benefit.
Wigs due to Chemotherapy, Radiation therapy and Pathological Change	100%	100%	
Disposable Supplies (provided in a Physician's office)	100%	80%	
Nutritional Counseling	100% $0 Co-pay*	100% $35 Co-pay*	
Chiropractic	100% $25 Co-pay*	100% $35 Co-pay*	$1,000 individual annual maximum
Pharmacy			
Pharmacy	**See Pharmacy tables below** (Next Page)		$0 copay for select Generic Maintenance medications used to treat asthma, depression, diabetes, heart disease/high blood pressure, and high cholesterol (when filled at Adventist Health In-House pharmacies, Community Partner pharmacies, or Pharmacy Benefit Manager pharmacies)
All Other Covered Medical Expenses			
All Other Covered Medical Expenses	100%	80% (D)	Physician services only

Note:
AH =

Any *Tier 1 Facility*, which includes Adventist Health, Loma Linda University Medical Center, Loma Linda University Medical Center—Murrieta, Adventist Health Mendocino Coast, Oregon Health & Science University facilities, the health care facilities owned by Rideout Health and UC Davis Health, Adventist Health Columbia Gorge, (except that for *enrollees* whose primary worksite is the Adventist Health Corporate Offices located in Roseville, California and their *dependents,* any Anthem network facility that is not part of Adventist Health that is located within 125 miles of UC Davis Health will not be an "*Tier 1 Facility*" and will be *out-of-network*). Except for *enrollees* whose primary worksite is the Adventist Health Corporate Offices located in Roseville, California and their *dependents*, for care related to obstetrics, vaginal/caesarean deliveries and the related newborn care services only, Queen of the Valley Medical Center and Los Robles Regional Medical Center are also considered *Tier 1 Facilities*.

Any *Tier 1 Provider*, which means a *physician* or *professional provider* who is:

(i) a member of the UC Davis Medical Group, Oregon Health & Science University, or a *physician* or *professional provider* that has contracted with UC Davis Health or Oregon Health & Science University to provide *covered services* to *Plan enrollees,* or a *Thriveworks mental health provider*; **or**

(ii) both

(1) a member of the medical staff of Adventist Health, Rideout Health, Loma Linda University Medical Center—Murrieta, Loma Linda University Medical Center (Loma Linda, CA), Adventist Health Mendocino Coast, Adventist Health Columbia Gorge, Adventist Health Sierra Vista, or Adventist Health Twin Cities; **and**

(2) a member of the *Anthem PPO Network*.

** For non-emergent services, the *Plan* will pay 80% if you first obtain an Unavailable Service Request Form (USRF) and it is approved prior to scheduling services. If a USRF is not obtained and approved prior to scheduling services, services may not be covered. Members that live outside of Oregon and California do not need a USRF when using the *PPO Network* unless prior authorization is required for the service.
*** As required by law, total 2027 out-of-pocket maximum for all covered benefits will, in no case, exceed $12,000 for self-only coverage and $24,000 for other than self-only coverage. Out-of-pocket maximums apply on a per-enrollee basis, as explained in the Deductibles and Annual Out-of-Pocket Maximum section above.

PHARMACY[7]:

	No Pharmacy deductible. Pharmacy out-of-pocket maximums[6]: Individual: $3,700 Family: $4,500			
	Tier 1 Generic[1]	**Tier 2 Preferred Brand[2]**	**Tier 3 Non-preferred[2]**	**Comments**
Traditional	$17	$45	$70	• Price is per 30-day supply, up to a 90-day supply • Save $10 per 30-day supply on your copay by using an Adventist Health In-House Pharmacy • Get 3 months for the price of 2 at Adventist Health In-House Pharmacies, Community Partner Pharmacies[3] or MedImpact Direct Mail ®
Specialty[5]	$45	20%; $200 Max	20%; $225 Max	• Specialty medications are limited to a 30-day supply maximum • Specialty medications can only be filled at Adventist Health In-House (excluding OHSU) or MedImpact Direct Specialty® pharmacies. • Save $10 on generic, $20 on brand when using and Adventist Health In-House Pharmacy

[1] *Enrollees* pay $0.00 copay for select Generic Maintenance medications when filled at Adventist Health In-House pharmacies, Community Partners, or Pharmacy Benefit Manager pharmacies.

[2] If a generic version of the drug is available but you use the brand drug, you will be responsible for the cost difference between the brand and generic drug in addition to the applicable copayment for the brand drug. This "brand-over-generic fee" does not contribute to your out-of-pocket maximum. This fee may be waived when (i) you have tried and failed the generic drug option, and (ii) you have received *prior authorization* to use the brand version of the drug.

[3] The *Plan* will publish a list of Community Partner pharmacies on the *Plan*'s website at AdventistHealth.org/EmployeeHealthPlan. If a pharmacy listed as a Community Partner loses its network status with the Pharmacy Benefit Manager, it will no longer qualify as a Community Partner pharmacy under the Plan.

[4] The Pharmacy Benefit Manager is MedImpact. When using a Pharmacy Benefit Manager pharmacy, you may pay less than the above-listed copayment because the maximum you will be charged is the lesser of (1) the above-listed copayment (plus any applicable brand-over-generic fee), (2) the contractual rate the *Plan* pays for the medication, or (3) the pharmacy's retail price.

[5] Refer to the MedImpact formulary for identification of specialty medications by logging onto the MedImpact portal at medimpact.com. Participation in MedImpact Assist may be required for some specialty and brand-name traditional drugs.

[6] Pharmacy products that are *Plan* exclusions or carveouts do not contribute to the pharmacy out-of-pocket maximum. Some examples of products that are not covered by the *Plan* are cosmetic medications, hair growth agents, homeopathic medications, fertility agents, medications used to treat sexual dysfunction, vitamins, fluoride products, over-the-counter (OTC) medications, OTC equivalents, medical foods (includes infant formula), non-FDA approved medications, diagnostic supplies (non-diabetes), ostomy supplies, disposable needles and syringes (non-insulin). Please refer to the "General Exclusions" chapter for additional *Plan* exclusions. In addition, discounts, coupons, or similar financial assistance provided by drug manufacturers or pharmacies to assist you in covering the cost of your medications (including any prescription drug discount/coupons provided to pharmacies when you fill a prescription) will not count against your annual deductible or maximum out-of-pocket limits. Only the amount that you pay separate and apart from the financial assistance will be credited as true out-of-pocket payment that will apply to your annual deductible and maximum out-of-pocket limits.

[7] This table does not apply to GLP-1 medications formulated for weight loss. For out-of-pocket expenses relating to GLP-1 medications formulated for weight loss, see Appendix G.

[8] Pharmacy benefits do not cover the cost of replacement of medications that have been lost or stolen.
[9] Some generic versions of a drug may be just as expensive as the brand-name drug. If you are taking a high-cost generic medication, MedImpact will contact you and your physician about lower-cost options.

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.

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

ACA Ongoing Employee means an *employee* who has been continuously employed for at least one complete *standard measurement period*.

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

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

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

Adventist Health Administrators, a division of Adventist Health, provides claims administration services and certain plan administration services for the *Plan*. References to *Adventist Health Administrators* as paying *claims* or issuing benefits mean that *Adventist Health Administrators* processes a *claim* and then directs the *Plan* trust to pay for the *Plan*'s portion of the *covered service*. *Adventist Health Administrators* can be reached at:

Adventist Health Administrators
ONE Adventist Health Way
Roseville, CA 95661
Phone: (800) 441-2524
Fax: (916) 781-2441

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.

Anthem PPO means the *physicians* and *professional providers* contracted with Anthem Blue Cross and Blue Shield, which is the Tier 2 preferred provider network for *physicians* and *professional providers* (but not for *facilities*) in California for the Plan (referred to as the *Anthem PPO Network*). A list of *Anthem PPO Network physicians* and *professional providers* can be accessed at AdventistHealth.org/EmployeeHealthPlan.

Appeals Committee is a committee appointed by *Adventist Health Administrators* (the *plan administrator*'s delegated claims administrator). The *Appeals Committee* is responsible for hearing appeals that do not involve *medical judgment*. The contact information for the *Appeals Committee* is:

Appeals Committee
ONE Adventist Health Way
Roseville, CA 95661
Phone: (800) 441-2524
Fax: (916) 406-2301

Approved Leave means any leave of absence that is approved by your *employer*.

Approved Medical Leave means an *approved leave* that is taken for a *medical condition* you are experiencing.

Assignment of Benefits means an arrangement whereby the *Plan participant* assigns their right to seek and receive payment from the *Plan* for eligible *covered expenses* to a *provider/facility*, in strict accordance with the conditions and limitations in the Assignment of Benefits section of this SPD.

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

Child or Children means (1) a natural child; (2) a step-child (i.e., the child of an *employee*'s *spouse*); (3) a child who has been legally adopted by the *employee* or placed for adoption with the *employee* by either a court of competent jurisdiction or appropriate state agency; (4) an individual for whom an *employee* has been awarded legal guardianship by a court; (5) an eligible foster child as defined in Code Section 152(f); and (6) an individual for whom the employee is required to provide coverage pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO") as defined in applicable federal law originally enacted as part of the Child Support Performance and Incentives Act of 1998 [PL 105-200, 7/16/1998; Section 401(f)(1)].

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

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

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

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

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

Condition means a *medical condition*.

Continuation of Coverage means that coverage under this *Plan* that would otherwise terminate because of your termination of employment or otherwise, you and/or your *covered dependents* may continue coverage under this *Plan* for yourself and/or your *covered dependents* provided you request continuation of coverage as set forth in the Continuation Coverage Rights Under COBRA chapter.

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

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

Covered Employee means a *full-time employee* or a *part-time employee* of a *participating employer* who is covered by this *Plan* following acceptance by the *plan administrator* of that person's application. See the Eligibility, Enrollment and End of Coverage chapter for the rules applicable to new and ongoing *employees* beginning and maintaining coverage. For both new and ongoing *employees*, if you do not timely enroll in accordance with this

SPD, you will be required to wait until the next open enrollment period unless either the Change in Status section or the HIPAA Special Enrollment Rights section applies.

Covered Service (or *Covered Expense*) is a *medically necessary* service or supply that is specifically described as a benefit of this *Plan*. A *covered expense* does not necessarily mean the actual charge made nor the specific service or supply furnished to a *participant* by a *provider* or *facility*. Charges rendered to treat a preventable condition/cost which arises solely due to a *provider* or *facility*'s medical error are not *covered expenses*. A finding of *provider/facility* negligence and/or malpractice is not required for a service/charge to be considered not *Reasonable and Allowable* or not a *covered expense*.

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.

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

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

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

Durable Medical Equipment is equipment and related supplies which the *Plan* determines are used primarily to serve a medical purpose. Examples of *durable medical equipment* include a wheelchair, a hospital-type bed and oxygen tanks.

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

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

Emergency Services means, as provided in 26 CFR §54.9815-2719A-4T(c)(2)(i), or any successor law or regulation, with respect to an *emergency medical condition*, an appropriate medical screening examination which is within the capability of the emergency department of a *hospital* (or an independent freestanding emergency department), including *ancillary services* routinely available to the emergency department to evaluate such *emergency medical condition*, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the *hospital* (or an independent freestanding emergency department), as are required to stabilize the patient (including in-patient services). For purposes of this section, the term "to stabilize," with respect to an *emergency medical condition*, means to provide such medical treatment of the *condition* as may be necessary to assure, within reasonable medical probability, that no material deterioration of the *condition* is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman who is having contractions, to deliver (including the placenta).

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

- Individuals working for the *employer* under a lease arrangement.
- Individuals who are engaged by the *employer* to perform services for the *employer* in a relationship that the *employer* characterizes as other than an employment relationship. For

example, individuals engaged to perform services in a relationship which the *employer* characterizes as that of an "independent contractor" with respect to the *employer*.

- Any individual described in this definition as not an *employee* is not eligible to participate in the *Plan* even if a determination is made by the Internal Revenue Service, the United States Department of Labor, another governmental agency, a court or other tribunal that the individual is an employee of the *employer*. An individual who has not met the definition of *employee* shall become an *employee* eligible to participate in the *Plan* (subject the individual's meeting all other eligibility requirements of the *Plan*) effective on the date the *employer* characterizes the individual as an employee in the *employer*'s employment records.

Employee-share contribution means the contribution you must make for coverage under the *Plan*. This amount is separate from the deductible and any *co-payment*s or *co-insurance* you are required to pay for *covered services*. See the Employee-Share Contribution chapter for further discussion.

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

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

***Enrollee* (or *participant*)** means a *covered employee* or a *covered dependent* (and individuals covered under the *Plan*'s Continuation Coverage Rights Under COBRA chapter).

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Excess Charge means an amount charged by a *provider/facility* that is in excess of the *Reasonable and Allowable Amount*.

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

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

FMLA Leave means an *approved leave* during which your *employer* is required to continue to offer you health plan coverage for a statutorily specified period of time under the federal Family Medical Leave Act or any other federal or state law that requires continued health plan coverage during a leave of absence. A leave is an *FMLA leave* only during the time period during which health plan coverage is statutorily required to be maintained. See the Reinstatement of Coverage and Special Situations, Extension of Coverage sections in the Eligibility, Enrollment and End of Coverage chapter for special rules pertaining to coverage during and following an *FMLA leave.* A workers' compensation leave of absence does not meet the definition of *FMLA leave* because workers' compensation laws do not require that health plan coverage be continued for any particular amount of time while an employee is off on a workers' compensation leave. However, as required by applicable state law, an employee who is off on a workers' compensation leave is treated exactly the same as an employee who is off on a comparable non-workers' compensation leave.

Full-Time Employee means an *employee* who is regularly scheduled to work 35 hours or more per week (or for employees covered under the CNA collective bargaining agreement, 40 hours per work week or 80 hours in a 14-day period or, for CNA bargaining unit nurses working under a 12-hour shift arrangement, 36 hours per work week or 72 hours per pay period). The determination of whether an *employee* is a *full-time employee* will be made by the *plan administrator*.

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

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

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

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

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

Illness means a disease or bodily disorder.

Implant means a material inserted or grafted into tissue.

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

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

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

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

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

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

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

In-Network see the definition of *network*.

In-Network Facility means a *hospital*, *hospice facility*, *skilled nursing facility,* mental health or *substance abuse* residential facility, or home health agency that is a *Tier 1 Facility* (Tier 1) or *PPO Facility* (Tier 2).

In-Network Provider means a *physician* or *professional provider* that is either a *Tier 1 Provider* or a *PPO provider*.

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

Medical Judgment – Determinations involving *medical judgment* include, but are not limited to, those based on the *Plan*'s requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; the *Plan*'s determination that a treatment is experimental or investigational; whether an *enrollee* is entitled to a reasonable alternative standard for a reward under a wellness program; or whether the *Plan* is complying with the nonquantitative treatment limitation provisions of Code Section 9812 and Regulation Section 54.9812 (which generally require, among other things, parity in the application of medical management techniques).

Medical Necessity Prior Authorization refers to obtaining the *utilization review manager's* determination in advance that proposed medical services requiring prior authorization are medically necessary, appropriate, and neither Experimental nor Investigational Procedures as defined in the General Exclusions chapter.

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

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

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*.

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

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

(ii) Diagnosis or the treatment of any conditions 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, F52.8, F52.31, F52.32, F52.4, F52.6, F52.1, F65.0, F65.3, F65.51, F65.52, F64.1, F65.81, F66, F65.9, F98.4, F63.3, R45.1, F91.9, F63.9, F63.0, F63.2, F63.1, F63.81, F81.0, F81.2, F81.81, F81.89, F80.89, F54.

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

Network – The terms *network* and *in-network* refer to *Tier 1 Facilities, Tier 1 Providers, PPO providers*, and in the limited situations they are covered, *PPO facilities*. The *Plan* generally pays a higher percentage of the cost of services provided at *Tier 1 Facilities* and services rendered by *Tier 1 Providers*. The *Plan* generally pays a lower percentage of the cost of services provided at *PPO providers* (and in the limited situations they are covered, *PPO facilities*). See the **Schedule of Benefits** chapter.

Network Rates means the negotiated and agreed upon rates with *in-network providers* and *in-network facilities* for providing services and supplies to *enrollees*.

Non-Protected Leave means an *approved leave* that is neither an *FMLA leave* nor a *statutory leave* as required by state or federal law.

No Surprises Act means the "No Surprises Act," which was enacted 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*. Except for *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 *emergency services* (including certain post-stabilization care subject to the provisions of the *No Surprises Act*), air ambulances, *urgent care,* approved Unavailable Service Request Form services, and as required by the *No Surprises Act* for certain *out-of-network provider* services rendered in *in-network facilities*, there is no coverage for *out-of-network providers*. (See the Surprise Medical Bills Notice for more information.)

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

Part-Time Employee means an *employee* who is regularly scheduled to work 18 hours or more per week (or 20 hours for Adventist Health Mendocino Coast and Adventist Health Columbia Gorge *employees*) and who is not a *full-time employee*. The determination of whether an *employee* is a *part-time employee* will be made by the *plan administrator*.

Participant (or *enrollee*) means a *covered employee* or a *covered dependent* (and individuals covered under the *Plan*'s Continuation Coverage Rights Under COBRA chapter).

Participating Employer means Rideout Memorial Hospital, United Com-Serve, Adventist Health Mendocino Coast, and Mid-Columbia Medical Center dba Adventist Health Columbia Gorge.

Physician means a doctor of medicine or osteopathy.

Plan means this Adventist Health Employee Health Plan (ERISA), which is a component plan of the Adventist Health ERISA Welfare Plan.

Plan Administrator means Rideout or anyone appointed by Rideout. The *plan administrator* exercises all discretionary authority and control over the administration of the *Plan*. The *plan administrator* shall have the sole discretionary authority to determine eligibility for *Plan* benefits or to construe the terms of the *Plan*. The *plan administrator* has the right to amend, modify or terminate the *Plan* in any manner, at any time. The *plan administrator* may hire someone to perform claims processing and other specified services in relation to the *Plan*. Any such contractor will not replace the *plan administrator* with respect to the ultimate exercise of the authority and responsibilities described above.

Plan Sponsor is Rideout.

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

PPO Facility (or "Tier 2" facility) means a *hospital*, *hospice facility*, *skilled nursing facility*, or mental health or *substance abuse* residential facility, or home health agency that is a participating facility in the *PPO Network* and is not a *Tier 1 Facility*. A list of *Anthem PPO facilities* can be accessed at AdventistHealth.org/EmployeeHealthPlan.

PPO Network means the preferred provider network that is used for your Adventist Health worksite. The Anthem Blue Cross and Blue Shield network provides a network for *enrolled employees* (and their *covered dependents*). A list of Anthem Blue Cross and Blue Shield Network *providers/facilities* can be accessed at AdventistHealth.org/EmployeeHealthPlan.

PPO Provider (or "Tier 2" provider) means a *physician* or *professional provider* who is in the *PPO Network*, but who is not a *Tier 1 Provider*. A list of *PPO Network*, providers can be accessed at AdventistHealth.org/EmployeeHealthPlan.

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

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

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

Provider means a *physician* or *professional provider.*

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

- Marital Status: Your legal marital status changes for reasons of marriage, death of a spouse, *divorce*, legal separation, or annulment.
- Dependents: Your number of *eligible dependents* changes due to birth, adoption, placement for adoption, or death of an *eligible dependent*.
- Employment Status: You or your *eligible dependent* experience a change in employment status, including: commencement or termination of employment, a change from part-time to full-time, ineligible part-time (e.g., under the minimum hours threshold) to eligible part-time, or full-time to part-time status, a strike or lockout, commencement or return from an unpaid leave of absence, or any other change in employment status that affects benefits eligibility.
- Change in Dependent Status: Your dependent satisfies or ceases to satisfy the eligibility requirements for coverage.
- Residence: You or your *eligible dependent* change geographic residence provided that the change in residence affects your or your *eligible dependent's* eligibility for coverage under this *Plan* or another plan or policy.
- Change in Coverage Under Another Employer Plan. You or your *eligible dependent* is entitled to make a change to coverage (or the coverage of another of your *eligible dependents*) under an employer's plan due to a permitted election change or during the other employer's plan's annual enrollment period, if different from the *Plan*'s annual enrollment period.
- Overall Reduction in Benefits: You or your *eligible dependent* experience a significant overall reduction or termination of benefits under the *Plan* or under another employer's plan, as determined in the sole discretion of the *plan administrator*. In general, for a group health plan, a significant overall reduction includes a significant increase in the deductible, *co-payment*, or out-of-pocket maximum, but does not include your *physician* ceasing to be an *in-network provider*.
- Significant Reduction in Coverage: Your or your *eligible dependent's* coverage under this *Plan* or another employer's plan is significantly reduced or limited causing you or the *eligible dependent* to lose coverage, as determined at the sole discretion of the *plan administrator*. An example of a significant reduction in coverage is if there is a substantial reduction in providers available under your or your *eligible dependent*'s elected benefit option.
- Significant Change in Cost: The cost of coverage for you and/or your *eligible dependents* significantly increases or decreases under the *Plan* or another employer's plan.
- Addition of Benefit Options: A new benefit package option or coverage option is added to the *Plan* or to another employer's plan under which you or one of your *eligible dependents* is covered.
- Medicare or Medicaid Entitlement: You or your *eligible dependent* gain or lose entitlement for Medicare or Medicaid.
- Enrollment in Another Plan Due to Reduction in Hours: If you had been reasonably expected to average at least 30 hours of service per week, and your hours have been reduced so that you now are expected to average fewer than 30 hours per week.
- Enrollment in a Marketplace Plan: You become eligible mid-year to enroll in a Marketplace plan (i.e., coverage on the health insurance Exchange).
- Any other election change events permitted by Internal Revenue Code Section 125 and its underlying regulations.

Reasonable and Allowable Amount or *Reasonable and Allowed Amount* means the maximum amount payable by the *Plan* for a service, supply and/or treatment that is considered a *covered service*.

For out-of-network *providers/facilities*:

The *Reasonable and Allowable Amount* is the lesser of: 1) the charge made by the *provider/facility* that furnished the care, service, or supply; 2) the negotiated amount established by a discounting or negotiated arrangement; or 3) Usual, Customary, and Reasonable (UC&R) reimbursement" for the same treatment, service, or supply furnished in the same geographic area by a *provider/facility* of similar background, training and experience as further described below. Out-of-network claims are repriced to the Usual, Customary, and Reasonable (UC&R) Allowable Amount. The term "Usual, Customary, and Reasonable (UC&R) Allowable Amount" means the amount payable to a *Physician*, *Facility*/Institution, or supplier of services or supplies to the extent such allowable is reasonable both in amount and scope and does not exceed the general level of allowable amounts for others rendering or furnishing such services or supplies within the same geographic area in which the services are incurred for *Illnesses* or *Injuries* comparable in nature and severity to the *Illness* or *Injury* being treated.

The term "UC&R reimbursement" shall mean an amount equivalent to the lesser such other cost or quality-based reimbursement methodologies as may be available and utilized by the *Plan* from time to time.

If there is insufficient information submitted for a given procedure, the *Plan* will determine the *Reasonable and Allowable Amount* based upon reimbursement made for similar services. Determination of the "reasonable and customary reimbursement" will take into consideration the nature and severity of the condition being treated, medical complications or unusual circumstances that require more time, skill or experience, and the cost and quality data for that *provider/facility*.

The term "geographic area" as it applies to any particular service or supply means a county or such greater area as is necessary to obtain a representative cross section of charges. If the Usual, Customary, and Reasonable Allowable Amount for a service or supply cannot be easily determined because of the unusual nature of the service or supply, the determination shall be made by the *Plan Sponsor* based on information it deems pertinent. For *covered services* rendered by a *provider or facility* in a geographic area where applicable law may dictate the maximum amount that can be billed by the rendering *provider/facility*, the Usual, Customary, and Reasonable Allowable Amount shall mean the lesser of amount established by applicable law for that *covered service* or the amount determined as set forth above.

The *Plan Administrator* may determine the Usual, Customary, and Reasonable Allowable Amount based upon the average payment actually made for reasonably comparable services and/or supplies to all Providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data. The *Plan Administrator* may increase or decrease the allowable amounts based upon factors concerning the nature and severity of the condition being treated.

For purposes of *out-of-network emergency services* and any other services covered by the *No Surprises Act*, the lower of billed charges or the "recognized amount" (as defined by the *No Surprises Act*) will be the *Reasonable and Allowable Amount* unless a different amount is negotiated per the below or unless a different amount is determined at independent dispute resolution (in which case such different amount will be the *Reasonable and Allowable Amount*).

For *in-network facilities/providers*:

The *Reasonable and Allowable Amount* is the *network rate*. If no *network rate* is in place for the service or supply, the *Reasonable and Allowable Amount* will be determined as though it was provided by an *out-of-network facility/provider*.

For all *providers/facilities*:

After hours surcharges in any 24-hour facility are not *reasonable and allowable* and will not be covered by this *Plan*. This applies to both *in-network facilities* and *out-of-network facilities*.

The *plan administrator* or its designee has the ultimate discretionary authority to determine the *Reasonable and Allowable Amount*, including establishing the negotiated terms of a provider arrangement as the *Reasonable and Allowable Amount* even if such negotiated terms do not satisfy the lesser of test described

above. If a different rate is negotiated between an *out-of-network provider/facility* and the *plan administrator*, the *network,* or their delegates, then that negotiated rate will be used and will be considered the *Reasonable and Allowable Amount* for the services rendered that are subject to such different negotiated rates.

Note on alternative phraseology: In some *Plan* materials, the *Reasonable and Allowable Amount* may be referred to as the Reasonable and Allowed Amount/Charge, Reasonable and Allowable Amount/Charge, Usual and Customary Rate/Charge, the Usual, Reasonable and Customary Rate/Charge, the Reasonable and Customary Rate/Charge, the UCR, or some other, similar phrase.

Registered Domestic Partnership means a registered domestic partnership under the applicable law of the state/city in which you reside. Wherever used in the *Plan*, the terms marriage, marital status, unmarried, parent, and stepparent shall be interpreted to include reference to *registered domestic partnership* or lack thereof. The *plan administrator* may require proof of your *registered domestic partnership*.

SPD means Summary Plan Description. See the Welcome section.

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

Spouse means your lawful spouse under the applicable law of the state of your primary Adventist Health worksite. *Spouse* also includes a *covered employee*'s partner with whom the *covered employee* has entered into a *registered domestic partnership*. Some states allow common law marriage, which is a legally recognized marriage that lacks formal marriage proceedings; *spouse* does not include a spouse through common law marriage.

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

Statutory Leave means an *approved leave* that is provided for by either state or federal law and is not an *FMLA leave* (i.e., although a *statutory leave* is provided by law, the law does not require continued health plan coverage during the leave). See the Reinstatement of Coverage and Special Situations, Extension of Coverage sections in the Eligibility, Enrollment and End of Coverage chapter for special rules pertaining to coverage during and following a *statutory leave.*

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.

Tier 1 Facility means a *hospital*, *hospice facility*, *skilled nursing facility,* mental health or *substance abuse* residential facility, or home health care agency that is part of Adventist Health. *Tier 1 Facility* also includes Loma Linda University Medical Center, Loma Linda University Medical Center—Murrieta, Adventist Health Mendocino Coast, Oregon Health & Science University facilities, the health care facilities owned by Rideout Health and UC Davis Health, Adventist Health Columbia Gorge, Adventist Health Sierra Vista, Adventist Health Twin Cities. Except for *enrollees* whose primary worksite is the Adventist Health Corporate Offices located in Roseville, California and their *dependents*, for care related to obstetrics, vaginal/caesarean deliveries and the related newborn care services only, Queen of the Valley Medical Center and Los Robles Regional Medical Center are considered *Tier 1 Facilities*.

Tier 1 Provider means a *physician* or *professional provider* who is:

(i) a member of the UC Davis Medical Group, Oregon Health & Science University, or a *physician* or *professional provider* that has contracted with UC Davis Health or Oregon Health & Science University to provide *covered services* to *Plan enrollees,* or a *Thriveworks mental health provider*; **or**
(ii) both

(1) a member of the medical staff of Adventist Health, Rideout Health, Loma Linda University Medical Center—Murrieta, Loma Linda University Medical Center (Loma Linda, CA), Adventist Health

Mendocino Coast, Adventist Health Columbia Gorge, Oregon Health & Science University, Adventist Health Sierra Vista, or Adventist Health Twin Cities; **and**

(2) a member of the *Anthem PPO Network*.

A directory of Adventist Health, Rideout Health, Adventist Health Mendocino Coast, Loma Linda University, Adventist Health Columbia Gorge, Adventist Health Sierra Vista, and Adventist Health Twin Cities medical staff members can be found at AdventistHealth.org/EmployeeHealthPlan. A directory of Anthem network providers and a directory of UC Davis Health network providers can be found at AdventistHealth.org/EmployeeHealthPlan. For access to care from a *Thriveworks mental health provider*, please visit AdventistHealth.org/Thriveworks or call 916-249-9356.

Thriveworks mental health provider means a *physician* or *professional provider* that has contracted with Thriveworks through or under the name of Thriveworks and is covered by the *Plan*'s agreement with Thriveworks to provide *covered services* for *mental health conditions* and/or *substance abuse* to *Plan enrollees*. For access to care from a *Thriveworks mental health provider*, please visit AdventistHealth.org/Thriveworks or call 916-249-9356.

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

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

Utilization Review Manager/Utilization Management/Care Management means *Adventist Health Administrators*' in-house care management and utilization review department "Benefits Administration," which is responsible for determining whether requested medical care is *medically necessary*, determinations of whether an *Enrollee* requesting services at a *Tier 2 Facility* can receive those services at a *Tier 1 Facility*, authorization of services at *Tier 2 Facilities* and authorization of services from an *Out-of-Network Provider*/*Facility*. However, for all prescription drug benefits, the *utilization review manager* is the Pharmacy Benefit Manager.

ELIGIBILITY, ENROLLMENT AND END OF COVERAGE

WHO IS ELIGIBLE

Full-time employees, *part-time employees*, and any *employee* not fitting within those two categories who is an *ACA full-time employee* are eligible to participate in this *Plan*, and will have an effective date of coverage as explained in the "Waiting Period and Effective Date" section. However, except for any *ACA full-time employee*, any individual who is classified by Human Resources as either temporary or per diem is not eligible to participate in this *Plan*.

The determination of whether you are a *full-time employee, part-time employee*, or neither is determined by looking at your schedule over the prior three months. For purposes of this determination, (i) hours attributable to paid time off and paid sick leave are included, but (ii) hours worked through the in-house or an outside registry are excluded. For purposes of this paragraph, any individual who is classified by Human Resources as either temporary or per diem is neither a *full-time employee* nor a *part-time employee*. If it is determined that your status (full-time, part-time, or neither) has changed, you will be provided with a notice of the change in status and the change in status will take effect on the first of the month that follows or coincides with the 30th day after the notice was sent. Review of *employee* status (full-time, part-time, or neither) will be performed monthly.

ELIGIBLE DEPENDENTS

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

- Your *spouse* who is living with you. A *spouse* who is not living with you may continue to be covered (1) for up to six months during a trial separation, (2) if you and your *spouse* are living at separate locations because of a job, or (3) if you have a court order to provide coverage for your *spouse*.
- Your *child* from birth to attainment of age 26. This maximum *child* coverage age supersedes any inconsistent provisions in the *Plan*.
- Your unmarried *child* of any age, so long as the *child* is *totally disabled*, the *total disability* commenced before the *child* reached age 19, and the child is primarily dependent on you for support and maintenance.

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

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

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

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

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

If the *plan administrator* determines that your separated or *divorced* spouse or any state child support or Medicaid agency has obtained a qualified medical child support order ("QMCSO"), and your current plan offers dependent coverage, you will be required to provide coverage for any *child*(*ren*) named in the QMCSO directed specifically at

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

WAITING PERIOD AND EFFECTIVE DATE

New employees have an effective date for coverage to start as of the first day of the month following the first day of *active employment*, provided the employee is *actively at work* and *enrollment* is completed no later than 30 days after the first day of *active employment*. Coverage for your *eligible dependents* who are properly enrolled within those 30 days will begin when your coverage begins. *Eligible dependents* who are legally acquired after your initial *enrollment* will have an effective date of coverage of the first day of the month following the month an *eligible dependent* is properly *enrolled* (which must occur within 60 days of the *eligible dependent* being legally acquired). As explained below, your newborn or *child* who is newly adopted or placed for adoption is automatically covered for 60 days from the date of birth, adoption, or placement for adoption.

No waiting period applies for any employee who is hired within 30 days of leaving the employ of another Adventist entity. For these purposes, "Adventist entity" means any entity that is listed in either the most recent version of the Adventist Organizational Directory or the most recent version of the Seventh-day Adventist Yearbook.

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

If your status changes from neither full-time or part-time to full-time or part-time, you will be provided with a notice of the change in status and you will be offered coverage that begins on the first of the month that follows or coincides with the 30th day after the notice was sent.

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

INITIAL ENROLLMENT REQUIREMENTS

You must *enroll* within 30 days of your date of hire. If you also desire coverage for your *eligible dependent*(*s*), you must *enroll* your *eligible dependent*(*s*) at this time. When you enroll your *dependents*, you will be required to provide documentation, within the 30-day period, verifying dependent status. If you do not *enroll* within the time requirement set forth in this paragraph, you will be required to wait until the next open enrollment period unless either the Change in Status section or the HIPAA Special Enrollment Rights section applies.

If you do not have any *eligible dependents* at the time of initial *enrollment*, but acquire *eligible dependents* at a later date, you must *enroll* the *eligible dependent*(*s*) within 60 days of the date you legally acquire them. Coverage for newly-acquired *eligible dependents* (including *spouses*) will be effective on the first day of the month after the date of application for *Plan* coverage if you *enroll* them for coverage within the 60-day period and provide the required dependent verification documentation. Contact *Adventist Health Administrators* to determine what documents are required to verify dependent status. Notwithstanding the foregoing, coverage for newborns and *children* who are newly adopted or placed for adoption are subject to the below.

If you are *enrolled* for coverage under the *Plan* as a participating *employee*, your newborn *child* is automatically covered at birth for 60 days. If you would like for coverage to continue for your newborn *child* beyond 60 days, you must notify your *employer* of the birth within 60 days of the birth, pay the increased *employee-share contribution* amount, and provide the required dependent verification documentation. If notice is not provided, you do not pay your *employee-share contribution*, or you do not provide the required dependent verification documentation, coverage will terminate at the end of 60 days following your *child*'s birth. Your (or your *spouse's*) *claim* for maternity expenses is not considered as notification to your *employer* for coverage to continue beyond 60 days. Notification regarding the addition of a newborn *child* should be made to Human Resources as soon as possible.

Adopted *children* will be automatically covered for the first 60 days from the date of the court-certified adoption decree, or if a *child* is placed with you pending the completion of adoption proceedings, that *child* will be covered for the first 60 days from the date of placement. To extend coverage beyond the first 60 days, the *covered employee* must submit a complete and signed application for *Plan* coverage within 60 days from the date of adoption or placement for adoption listing the *child* as a *covered dependent* and provide the required dependent verification documentation. Placement for adoption means you have assumed and retained a legal obligation for full or partial support of the *child* in anticipation of adoption; placement for adoption is evidenced by a fully executed adoption placement agreement. Notification regarding the addition of a *child* who is newly adopted or placed for adoption should be made to Human Resources as soon as possible.

Your *employee-share contribution* will be adjusted accordingly if you add new *covered dependents*. Such adjustments will apply retroactively if your *dependents* are covered retroactively.

COORDINATION OF BENEFITS FORM

Upon your initial enrollment, the addition of *dependents*, or upon request at any time by *Adventist Health Administrators*, you will be required to complete a "Coordination of Benefits" form in which you will (i) state whether or not you or your *dependents* have other health coverage, and (ii) provide information about the other insurer/plan, if any. **You must return the form within 14 days of the date on the Coordination of Benefits form letter that you will receive upon your initial enrollment, addition of a *dependent*, and/or a subsequent request from the *plan administrator* to complete an updated form.** Failure to do so will result in any claims submitted thereafter being treated as "incomplete claims" and, if the form is not returned as part of the initial claims process, then such claims will be denied.

CHANGE IN STATUS

If you have a *qualifying change in status*, you may change your *enrollment* decision regarding yourself and/or *eligible dependents* within 30 days of the *qualifying change in status*, except that in the case of an increase in your number of *eligible dependents* due to birth, adoption, placement for adoption, or marriage, you may change your *enrollment* decision regarding yourself and/or your newly acquired *dependents* within 60 days of the *qualifying change in status*. You can only change your benefit elections if the requested change is on account of and corresponds with the permitted election change event you experience.

If application is made on a timely basis and is accepted by the *plan administrator* as a *qualifying change in status*, medical coverage will become effective on the first day of the month after the date of application, except that in the case of an *eligible dependent* who is a newborn, newly-adopted, or newly placed for adoption, coverage will be effective on the *eligible dependent*'s date of birth, adoption, or placement for adoption, as applicable. Coverage for all other newly-acquired *dependents* (including new *spouses*) is effective on the first day of the month after the date of application for *Plan* coverage. If application is not made within 30 or 60 days of the *qualifying change in status*, as applicable, you will be required to wait until the next open enrollment period unless you experience another *qualifying change in status* or the HIPAA Special Enrollment Rights section applies.

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

HIPAA SPECIAL ENROLLMENT RIGHTS

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

A. **Loss of Other Coverage:** If you decline coverage under this *Plan* for yourself or your *eligible dependents* because of other health plan coverage and such other health plan coverage is later terminated because of:

- A loss of eligibility for such coverage (loss of eligibility does not include a loss because of: failure to pay premiums when due; failure to exhaust COBRA or other group health plan continuation of coverage, if elected; or cases such as making a fraudulent *claim* or misrepresentation); or
- Termination of any company contributions for such coverage;

Then you and/or your *eligible dependents* may *enroll* in the *Plan*.

B. **New Dependents.** If you acquire a new *eligible dependent* as a result of marriage, birth, adoption or placement for adoption, you and/or your *eligible dependents* may *enroll* in this Plan.

To *enroll* under either of these special enrollment rights, you must notify *Adventist Health Administrators* and complete and return any required forms within 60 days of the underlying event, or in the case of loss of other coverage, 30 days of the underlying event, e.g., loss of other coverage, date of the marriage, birth, adoption or placement for adoption. Coverage will generally begin on the first day of the calendar month following the timely *enrollment* request. If timely *enrolled*, coverage for newborns, adopted *children* and *children* placed for adoption will begin as of the date of birth, adoption or placement for adoption.

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

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

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

To *enroll* under either of these two latter special enrollment rights, you must notify your *plan sponsor* and complete and return any required forms within 60 days of the date you lose coverage under the Medicaid or state CHIP plan, or the date you are determined to be eligible for a premium assistance program. Coverage will generally begin on the first day of the calendar month following the timely *enrollment* request.

If you elect coverage under another medical plan offered by *the plan sponsor*, that is not a declination of coverage for purposes of these HIPAA special enrollment rights.

OPEN ENROLLMENT

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

An eligible *employee* will usually be deemed to have elected to continue with his or her current-year coverage elections (including coverage elections for *covered dependents*) unless the *employee* elects to change his or her coverage elections during open enrollment.

If you do not timely enroll in accordance with this SPD, you will be required to wait until the next open enrollment period unless either the Change in Status section or the HIPAA Special Enrollment Rights section applies.

PRE-EXISTING CONDITIONS

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

REINSTATEMENT OF COVERAGE

If you are called to active duty by any of the armed forces of the United States of America, released under honorable conditions and return to employment with your *employer*: (1) on the first full business day following completion of your military service of 30 days or less, (2) within 14 days of completing military service of 31 to 180 days, or (3)

within 90 days of completing military service of more than 180 days, coverage will be reinstated. You will not be subject to any new waiting period; however, all accumulated annual and lifetime maximums will apply.

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

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

If you are laid off and return to active work within six months of being laid off, you and any previously *covered dependents* may re-*enroll* under the *Plan* on the date you are rehired. Your coverage will begin on the first of the month following your date of rehire.

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

SPECIAL SITUATIONS, EXTENSION OF COVERAGE

Coverage of Adult Children with Disabilities

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

Leaves of Absence

The following table summarizes the *Plan* coverage scenarios that apply when you have an approved absence from work.

Type of Leave	Eligibility Requirements	Medical Plan Coverage Time Limit	Employee-Share Contribution Rate	Coverage End Date
Paid time off (PTO) (including paid sick leave and paid vacation leave)	Obtain approval for PTO through the normal procedures for such requests	Up to number of hours of PTO that you have accrued	Active-employee rate	The end of the month in which you use the last of your PTO accrual.

Type of Leave	Eligibility Requirements	Medical Plan Coverage Time Limit	Employee-Share Contribution Rate	Coverage End Date
Unpaid *FMLA leave* (includes any leave during which health plan coverage is required to be continued by law)	As required by law	As required by law	Active-employee rate (see special provisions for USERRA continuation of coverage below)	The end of the month in which the statutorily required protection period ends
Unpaid *approved medical leave* that is not a leave during which health plan coverage is required to be continued by law	You must receive authorization from your local HR department to take an *approved medical leave*	18 months within the prior 60 months (including all time spent on *approved medical leave* whether *FMLA leave* or not and whether the leave is unpaid or PTO is used to continue pay)	Active-employee rate for the first six months and then the Continuation of coverage rate thereafter	The last day of the calendar month in which the last day of the 18th month of coverage occurs
Unpaid non-medical *approved leave* (either a non-medical *non-protected leave* or a non-medical *statutory leave*)	You must receive authorization from your local HR department to take an *approved leave*	Up to three months	Continuation of coverage rate	The last day of the calendar month in which the last day of the third month of coverage occurs
Continuation coverage	See Continuation Coverage Rights Under COBRA section below	Up to 36 months (18-month limit for certain qualifying events)	Continuation of coverage rate	The last day of eligibility for continuation of coverage

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

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

(ii) ***FMLA leave* (includes any leave during which health plan coverage is required to be continued by law).** If you qualify for an *FMLA leave* of absence and you are covered under the Plan on the day before the leave begins, you will be eligible to continue your coverage (and the coverage of any *covered dependents*) for the duration of the *FMLA leave* at the *employee-share contribution* rate you were paying the day before the *FMLA leave* began. You should talk to Human Resources to determine how to pay your *employee-share contribution* during your *FMLA leave.* Subject to certain exceptions, if you fail to return to work after the *FMLA leave*, your *employer* has the right to recover from you any contributions toward the cost of coverage made on your behalf during the leave. The rules for different types of *FMLA leaves* vary and are dealt with in other employer policies. Notwithstanding any other provision of the Plan, for USERRA continuation of coverage, *enrollees* can receive up to 3 months of coverage at the active-employee rate followed by up to 15 months of coverage at a higher USERRA-coverage rate and then up

to six months of regular Plan continuation of coverage at the continuation-coverage rate for a total of 24 months of USERRA continuation of coverage.

(iii) **Unpaid *approved medical leave* that is not a leave during which health plan coverage is required to be continued by law).** If you take an unpaid *approved medical leave* that is not an *FMLA leave* (or extend what started as an *FMLA leave approved medical leave* beyond the period during which continued health plan coverage is required by law) and you are covered under the *Plan* on the day before the leave begins, you (and any *covered dependents*) will be eligible to maintain coverage for a total of 18 months in the immediately prior 60-month period. All time spent on *approved medical leave*, whether *FMLA leave* or not and whether the leave is unpaid or PTO is used to continue pay, during the prior 60 months is counted for purposes of the 18-month *approved medical leave* coverage limit. While on an unpaid *approved medical leave* that is not an *FMLA leave*, you will be required to pay the active-employee rate for the first six months and then the continuation of coverage rate thereafter. You should talk to Human Resources to determine how to pay your *employee-share contribution* during your *approved leave.* If your *approved medical leave* continues beyond the 18-month limit, you will be deemed terminated for *Plan* purposes at the end of the month in which the last day of the 18th month of coverage occurs and will be subject to the provisions of the Continuation Coverage Rights Under COBRA section.

(iv) **Unpaid non-medical *approved leave* (either a non-medical *non-protected leave* or a non-medical *statutory leave*).** If you take an unpaid *approved leave* that is neither an *approved medical leave,* nor an *FMLA leave* you will be eligible to continue coverage for three months. While on an unpaid non-medical *non-FMLA leave approved leave*, you will be required to pay a higher *employee-share contribution*, which will be the continuation of coverage rate. You should talk to your Human Resources to determine how to pay your *employee-share contribution* during your *approved leave.* If your *approved leave* continues beyond the three-month limit, you will be deemed terminated for *Plan* purposes at the end of the month in which the last day of the third month of coverage occurs and will be subject to the provisions of the Continuation Coverage Rights Under COBRA section. If you use PTO, the **Paid time off** paragraph above will apply.

(v) **For all absences from work**. Unless specified elsewhere in the *Plan*, a failure to pay your *employee-share contribution* within 30 days of the due date established by your *employer* will result in termination of the coverage as of the last day of the month in which occurs the 30th day after such due date.

Should you die while employed by your *employer*, your *covered dependents* will continue to be covered by the *Plan* until the end of the month of your death, at which point the *covered dependent*(*s*) may elect continuation coverage if eligible. See the Continuation Coverage Rights Under COBRA section for more information.

WHEN COVERAGE ENDS

Your coverage ends the earliest of:

- the later of (a) the end of the month in which your employment with your *employer* ends, (b) if your termination is labeled as a "reduction in force" by your *employer*, the end of the month following the month in which your employment with your *employer* ends (unless you are eligible for and elect continuation of coverage), or (c) if your salary is continued under a severance policy, the end of the month in which your salary continuation ends;
- the end of the period for which your last contribution was made; or
- the end of the month in which you are no longer eligible to participate in this *Plan*. (See "Special Situations, Extension of Coverage" for additional information.)

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

- the date your coverage ends,
- the end of the month in which the *covered dependent* no longer meets the eligibility requirements, including, if applicable, the date you are no longer legally required to provide medical coverage for the *covered dependent*,

- the end of the month for which the last *employee-share contribution* was made,
- in the case of *covered dependents* that are spouses only, the date the *covered dependent* enters into active military service or obtains permanent residence outside the United States. (See "Special Situations, Extension of Coverage" for additional information.)

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

The *plan sponsor* intends the *Plan* to be on-going, but since future conditions affecting your *employer* cannot be anticipated or foreseen, the *plan sponsor* reserves the right to amend, modify or terminate the *Plan* in any manner, at any time, which may result in the termination or modification of your coverage. Only the *plan sponsor* has the authority to amend the *Plan*. Expenses incurred prior to the *Plan* termination will be paid as provided under the terms of the *Plan* prior to its termination.

If the *Plan* is terminated, coverage ends for you and your *covered dependents* on the date the *Plan* ends. There is one exception to this rule. If your *employer* terminates this *Plan* and a covered person is hospitalized on the day the *Plan* ends, coverage under this *Plan* (including all terms, limitations, and conditions) shall continue until the *hospital* confinement ends or *hospital* benefits under the *Plan* are exhausted, whichever is earlier.

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

NOTE: Coverage will not be continued beyond the end of the month outlined above if you choose not to pay your *employee-share contribution*.

If this SPD otherwise allows you to terminate your coverage or coverage for any *covered dependents*, you may do so by giving written notice to Human Resources. Coverage will end on the last day for which your *employee-share contribution* is paid. If you terminate your own coverage, coverage for your *covered dependents* also ends at the same time.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under the *Plan*. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. **This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health plan benefits offered under the *Plan* and not to any other benefits offered by the *plan sponsor*. .

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the *Plan*. The *Plan* provides no greater COBRA rights than what COBRA requires—nothing in this notice is intended to expand your rights beyond COBRA's requirements.

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

What Is COBRA Coverage?

COBRA coverage is a continuation of *Plan* coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event occurs and any required notice of that event is properly provided to the *plan administrator*, COBRA coverage must be offered to each person losing *Plan* coverage who is a "qualified beneficiary." You, your *spouse*, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the *Plan* is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the *Plan*, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Who Is Entitled to Elect COBRA?

If you are an employee, you will be entitled to elect COBRA if you lose your group health coverage under the *Plan* because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the *spouse* of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the *Plan* because any of the following qualifying events happens:

Your *spouse* dies;

Your *spouse*'s hours of employment are reduced;

Your *spouse*'s employment ends for any reason other than his or her gross misconduct; or

You become *divorced* or legally separated from your *spouse*. Also, if your *spouse* (the employee) reduces or eliminates your group health coverage in anticipation of a *divorce* or legal separation, and a *divorce* or legal separation later occurs, then the *divorce* or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the *divorce* or separation.

A person enrolled as the *employee*'s dependent child will be entitled to elect COBRA if he or she loses group health coverage under the *Plan* because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct; or

The child stops being eligible for coverage under the *Plan* as a "dependent child."

When Is COBRA Coverage Available?

When the qualifying event is the end of employment or reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the *plan administrator* of any of these qualifying events.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (*divorce* or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the *plan administrator* in writing within 60 days after the later of: (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the *Plan* as a result of the qualifying event. In providing this notice, you must follow the notice procedures specified at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to the *plan administrator* during the 60-day notice period, THEN ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.

Electing COBRA

Each qualified beneficiary will have an independent right to elect COBRA. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. **Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.**

How Long Does COBRA Coverage Last?

COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the covered employee's *divorce* or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage under the Plan can last for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8

months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months *before* the termination or reduction of hours.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage under the *Plan* generally can last for only up to a total of 18 months.

The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods described in this notice for several reasons, which are described in the Termination of COBRA Coverage Before the End of the Maximum Coverage Period section below.

There are two ways (described in the following paragraphs) in which the period of COBRA coverage resulting from a termination of employment or reduction of hours can be extended. (The period of COBRA coverage under the Health FSA cannot be extended under any circumstances.)

Disability extension of COBRA coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the *plan administrator* in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify the *plan administrator* in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice, you must follow the procedures specified in the box at the end of this notice entitled “Notice Procedures.” If these procedures are not followed or if the notice is not provided to the *plan administrator* during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

Second qualifying event extension of COBRA coverage

If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse and dependent children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the *Plan*. This extension may be available to the spouse and any dependent children receiving COBRA coverage if the employee or former employee dies or gets *divorced* or legally separated, or if the dependent child stops being eligible under the *Plan* as a dependent child, but only if the event would have caused the *spouse* or dependent child to lose coverage under the *Plan* had the first qualifying event not occurred. (This extension is not available under the *Plan* when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

This extension due to a second qualifying event is available only if you notify the *plan administrator* in writing of the second qualifying event within 60 days after the date of the second qualifying event. In providing this notice, you must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to the *plan administrator* during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required contribution is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- the *plan sponsor* ceases to provide any group health plan for its employees; or
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate). For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period."

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify the plan administrator if a qualified beneficiary becomes entitled to Medicare or obtains other group health plan coverage

You must notify the *plan administrator* in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. You must follow the notice procedures specified below in the section entitled "Notice Procedures." In addition, if you were already entitled to Medicare before electing COBRA, notify the *plan administrator* of the date of your Medicare entitlement at the address shown in the section below entitled "Notice Procedures."

You must notify the plan administrator if a qualified beneficiary ceases to be disabled

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the *plan administrator* of that fact within 30 days after the Social Security Administration's determination. You must follow the notice procedures specified below in the section entitled "Notice Procedures."

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated *enrollee* who is not receiving COBRA coverage. The amount of your COBRA contributions may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA contribution changes.

Payment for COBRA Coverage

How COBRA contribution payments must be made

All COBRA contributions must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the individual at the payment address specified in the election notice provided to you at the time of your qualifying event. However, if the Plan notifies you of a new address for payment, you must mail or hand-deliver all payments for COBRA coverage to the individual at the address specified in that notice of a new address.

When COBRA contribution payments are considered to be made

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

First payment for COBRA coverage

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) See the section below entitled "Notice Procedures."

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial COBRA contribution payment equals the COBRA contributions for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.) You are responsible for making sure that the amount of your first payment is correct. You may contact the *plan administrator* using the contact information provided below to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Monthly payments for COBRA coverage

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The *plan administrator* will not send periodic notices of payments due for these coverage periods (that is, **we will not send a bill to you for your COBRA coverage—it is your responsibility to pay your COBRA contributions on time).**

Grace periods for monthly COBRA contribution payments

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be

provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

More Information About Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with the covered employee during COBRA coverage period

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the *Plan*, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the *Plan*, the child must satisfy the otherwise applicable *Plan* eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A child of the covered employee who is receiving benefits under the *Plan* pursuant to a qualified medical child support order (QMCSO) received by the *plan administrator* during the covered employee's period of employment with the *plan administrator* is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a *spouse*'s plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your *Plan* or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the *plan administrator* informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the *plan administrator*.

Plan Contact Information

You may obtain information about the *Plan* and COBRA coverage on request from:

Director of Benefits Administration
Adventist Health Administrators
ONE Adventist Health Way
Roseville, CA 95661
1-800-441-2524

Notice Procedures

Warning: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).

Notices Must Be Written and Submitted on Plan Forms: Any notice that you provide must be in writing and must be submitted on the Plan's required form (you may obtain copies from the *plan administrator* without charge by calling the *Plan*'s COBRA vendor at 800-346-2126). Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.

How, When, and Where to Send Notices: You must mail your notice to:

Employee Benefits Corporation
COBRASecure
PO Box 44347
Madison, WI 53744-4347

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled "You Must Give Notice of Some Qualifying Events," "Disability extension of COBRA coverage," and "Second qualifying event extension of COBRA coverage.")

Information Required for All Notices: Any notice you provide must include: (1) the name of the *Plan* (Adventist Health Employee Health Plan; (2) the name and address of the employee who is (or was) covered under the *Plan*; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event: If the qualifying event is a *divorce* or legal separation, your notice must include a copy of the decree of *divorce* or legal separation. If your coverage is reduced or eliminated and later a *divorce* or legal separation occurs, and if you are notifying the *plan administrator* that your *Plan* coverage was reduced or eliminated in anticipation of the *divorce* or legal separation, your notice must include evidence satisfactory to the *plan administrator* that your coverage was reduced or eliminated in anticipation of the *divorce* or legal separation.

Additional Information Required for Notice of Disability: Any notice of disability that you provide must include: (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination; (5) a copy of the Social Security Administration's determination; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required for Notice of Second Qualifying Event: Any notice of a second qualifying event that you provide must include: (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a *divorce* or legal separation, a copy of the decree of *divorce* or legal separation.

Who May Provide Notices: The covered employee (that is, the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

EMPLOYEE-SHARE CONTRIBUTION

The *Plan* is self-funded by means of *employer* and employee contributions. The contribution *enrolled* employees are required to make is called the *employee-share contribution*. Your *employee-share contribution* is based on the number of *enrollees* you elect to cover.

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

Your *employee-share contribution* will be higher if you are on an unpaid leave of absence, except for an *FMLA leave* and the first six months of any other unpaid *approved medical leave*. COBRA continuation coverage requires the highest employee-share contribution.

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

Financial Aid

Each year the *plan administrator* (through its *participating employers*) may pay eligible *employees* who earn below a certain annual wage amount a taxable bonus equal to a portion of the *employee-share contributions* made by such eligible *employees*. Both the bonus and the wage threshold amount will be specified annually by the *plan administrator*, in its sole discretion, and the amounts will vary from year-to-year. The date(s) on which the bonus will be paid are not specified and will vary from year-to-year. **Any such bonus you may receive pursuant to this section will be taxable income to you.**

CARE MANAGEMENT AND UTILIZATION MANAGEMENT PRIOR AUTHORIZATION PROGRAM

The *Plan* has Care Management and Utilization Management Prior Authorization processes that are managed and administered by the Care Management department, which can be reached by calling 1-800-441-2524. The Utilization Management Prior Authorization process is mandatory for all *Plan enrollees*.

The purpose of the Care Management and Utilization Management Prior Authorization Program is to contain the cost of *Plan* benefits by encouraging prudent and reasonable use of health care and health care facilities.

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 determines whether a particular treatment or service is *medically necessary* within the meaning of the *Plan* and covered under the *Plan*.

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

CARE MANAGEMENT AND UTILIZATION MANAGEMENT PRIOR AUTHORIZATION

Medical necessity prior authorization is a process that takes place when a physician recommends hospitalization or certain other types of medical services. The *Plan* requires that *Care Management* and *Utilization Management* evaluate a proposed hospital admission or other treatment in order to verify whether the treatment or service is *medically necessary* within the meaning of the *Plan*, to determine the most appropriate *facility/provider* for that treatment or service, to determine whether a *medically necessary* treatment or service that you request to receive at a *Tier 2 Facility* is available at (and thus, only covered under the Plan at) a *Tier 1 Facility*, and/or to analyze and discuss other care options that may exist. If *Care Management and Utilization Management* determine that a treatment or service is not *medically necessary*, then the *Plan* will not cover that treatment or service. If *Care Management* and *Utilization Management* determine that a treatment or service that you have requested to receive through a *Tier 2 Facility* is available at a *Tier 1 Facility*, then the *Plan* will not cover that treatment or service even if it is otherwise *medically necessary*.

YOUR RESPONSIBILITY

You do not need to obtain *prior authorization* for routine health care performed in a provider's office, urgent care center, or emergency room.

It is your responsibility to obtain *medical necessity prior authorization* for diagnostic testing, out-patient procedures, non-emergency hospitalizations, surgeries, etc., in accordance with the below list. Your provider can request *medical necessity prior authorization* by faxing in a *prior authorization* request to 1-916-406-2301 or calling *Adventist Health Administrators* Customer Service at 1-800-441-2524.

When you know in advance that you or a *covered dependent* needs to be hospitalized, you or your provider must contact *Utilization Management* at 1-800-441-2524 prior to admission.

If you are unable to receive *medically necessary covered services in-network*, you must contact *Utilization Management* at 1-800-441-2524 to request approval to use an *out-of-network facility/provider* via an Unavailable Services Request Form in order to be eligible for Level 2 Patient Advocacy Center services in the event that you receive a balance bill from the *out-of-network facility/provider.*

In the case of *emergencies* or urgent situations that did not allow the provider to contact *Utilization Management* in advance of the treatment, the *utilization review manager* will carry out retrospective *medical necessity prior authorization*. *Utilization Management* must be contacted within two (2) business days of initial *emergency* or urgent treatment or as soon as possible thereafter. *Emergency* or urgent admissions are subject to *medical necessity*

review on a case by case basis. If you or your provider do not notify *Utilization Management* in accordance with this paragraph, then only *emergency services* (and certain post-stabilization services required to be covered by the *No Surprises Act*) will be covered.

In addition to hospital admissions, there are additional services under the *Plan* for which you will not receive benefits if you fail to obtain *prior authorization* before obtaining the service or incurring the expense. Your provider should call the *utilization review manager* at 1-800-441-2524 to start the *prior authorization* process for the following services. This list is not inclusive of all services that require *prior authorization*; the list is subject to additions or deletions at the discretion of the *plan administrator*. Please refer to the Prior Authorization Matrix in member resources on AdventistHealth.org/EmployeeHealthPlan for the most up to date information.

1. Inpatient services (including *hospital*, acute rehab and *skilled nursing facilities*): All inpatient admissions (except normal delivery unless by a non-*Tier 1 Provider* and/or in a non-*Tier 1Facility*); Acute inpatient rehab and/or *skilled nursing facility* admissions; *Gender affirming care;* Nerve grafts; Observation stays of greater than 48 hours; Any elective admission to a *hospital*, *hospice facility* or *skilled nursing facility*. Additionally, in order to increase the percentage the Plan pays for emergent inpatient hospital admission to 100%, you or your provider must call the *utilization review manager* within two (2) business days of an emergent inpatient *hospital* admission following a *hospital* emergency department visit.

2. Ambulatory care services:

    a. Imaging: Capsule endoscopy; Computed Tomography (CT) and CT angiogram; Magnetic Resonance Angiogram (MRA); PET scans; Image-Guided Minimally Invasive Lumbar Decompression for Spinal Stenosis;
    b. Laboratory services: Genetic testing (including tumor markers);
    c. Surgery/procedures: Abortion (also referred to as termination of pregnancy) will be reviewed for consistency with the coverage requirements set forth in the Benefits Description chapter which are based on Seventh-day Adventist Church teachings, and a Care Manager may be assigned to conduct a consultation; All plastic, cosmetic, or reconstructive surgery including orthognathic surgery except initial breast reconstruction following medically necessary mastectomy; Anesthesia related to a dental procedure; Artificial discs, cervical and lumbar; Autologous chondrocyte implantation; Corneal collagen cross-linking; Extracorporeal shock wave therapy (ESWT); *Gender affirming care*; Implanted devices; Lumbar kyphoplasty; Magnetic Resonance (MR) guided focused ultrasound (MRgFUS) and high intensity focused ultrasound (HIFU) ablation; Nerve stimulation; Ovarian internal iliac vein embolization, ablation, and sclerotherapy; Photodynamic & UV light therapy; Radiofrequency ablation, except for pain management; Sacroiliac joint fusion; Surgical treatment of snoring and obstructive sleep apnea; Transplants; Spinal cord stimulation; Wearable (external) cardiac defibrillator;
    d. Cancer treatment – Chemotherapy, Cryosurgical ablation of miscellaneous solid organ, pulmonary, and breast tumors; Endobronchial brachytherapy; Hyperthermia; Radioembolization for primary and metastatic liver tumors; Radiation therapy;
    e. Provider administered medications (such as infusion therapy and injections, including viscosupplements);

3. *Mental health services*: All inpatient *mental health services*, including detoxification and substance abuse treatment; All partial hospitalization programs; Applied behavioral analysis therapy; Intensive outpatient programs (that is, multi-hour per day treatment programs lasting more than two days) for psychiatric treatment or substance abuse treatment; Residential treatment centers; Transcranial magnetic stimulation (TMS);

4. Durable medical equipment, supplies, appliances, prosthetics, orthotics, wigs: All durable medical equipment or repair with billed charges of $2,000 or more (except for CPAP and BiPAP which do not require authorization); All CPM devices, and Dynasplints (regardless of cost); All orthotics/prosthetics with billed charges over $3,500 and/or custom orthotics; Cochlear implants; Enteral nutritional support (i.e., tube feeding); Insulin pumps and continuous glucose monitors; Oral appliances; Wound vacuum therapy after 30 days of use;

5. Maternity and pregnancy related care that is not preventive (as specified in Appendix A); routine pregnancy care (as specified at https://www.guideline.gov/summaries/summary/38256), or delivery with a *hospital* stay of up to 48 hours following a normal vaginal delivery or 96 hours following a cesarean delivery with a *Tier 1 Provider* at a *Tier 1 Facility*;
6. Non-emergency ambulance transportation;
7. Biofeedback;
8. Any nonspecific codes (ending in 99); and
9. Any treatment or service not listed above that would be provided at a *Tier 2 Facility*, other than routine health care performed in a provider's office, urgent care center, or emergency room.

If you are not sure whether your provider has contacted the *utilization review manager* for *prior authorization*, you should call the Customer Service Department at 1-800-441-2524 to verify that *prior authorization* has been initiated.

FAILURE TO OBTAIN UTILIZATION MANAGEMENT PRIOR AUTHORIZATION

If medical services that require *medical necessity prior authorization* are not pre-certified, the *Plan* will not reimburse you for expenses incurred. The expenses you incur due to not receiving *prior authorization* will not be applied to your deductible or out-of-pocket maximums. If medical services that require *medical necessity prior authorization* are not pre-certified, the *Plan* will also not reimburse you for any associated services. (For example, if a surgery requiring *prior authorization* 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 *utilization management prior authorization* procedure and it is your responsibility to make sure *prior authorization* is successfully obtained prior to hospital admission or other treatment.

COMPLEX 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 complex 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. If you are identified as being at risk for health issues, you will be contacted by a Care Manager.

The Care Manager will complete a comprehensive health assessment and enroll the *enrollee* in complex 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 complex 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* Care Managers 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* Care Manager determines that the transfer is safe and appropriate, benefits for subsequent services provided by *out-of-network providers/facilities* will be subject to *out-of-network* cost-sharing (e.g., higher coinsurances and copayments) and the enrollee may be subject to balance billing by the *out-of-network providers/facilities* (unless the services are subject to the *No Surprises Act*).

DETERMINATION OF WHERE NEEDED MEDICAL SERVICES ARE AVAILABLE

The *Utilization Review* Medical Director, Care Managers and Providers Relations staff are very knowledgeable about the availability of medical services from *in-network providers* and *in-network facilities*.

If you or your provider believes that needed medical services are not available from an *in-network provider* or *in-network facility*, you or your provider can call the *utilization review manager* at 1-800-441-2524. 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 *medically necessary covered services* are not available *in-network*, and you obtain an executed Unavailable Services Request Form from the *utilization review manager*, then you will be eligible for Level 2 Patient Advocacy Center services in the event that you receive a balance bill from the *out-of-network facility/provider.*

REQUIRED SECOND SURGICAL OPINION

The *utilization review manager* may determine 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.

PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS

Prior authorization is required for some prescription drugs. The Pharmacy Benefit Manager manages prior authorization for prescription drugs. The Pharmacy Benefit Manager prior authorization program monitors certain prescription drugs and their costs. Your doctor or pharmacist will request prior authorization through the Pharmacy Benefit Manager Contact Center, which is available 24 hours a day, seven days a week. Contact information is below.

MedImpact
Adventist Health *Plan enrollee* telephone number: 844-282-5331

PROVIDERS AND FACILITIES AVAILABLE UNDER THE PLAN

CHOICE OF FACILITIES

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 *Tier 1 facility*, *PPO facility*, or any *out-of-network facility*. However, you will pay a higher amount (and could be subject to balance billing) if you use an *out-of-network facility* or *PPO facility* and so using a *Tier 1 Facility* is recommended. (See the Surprise Medical Bills Notice below for details of when you should not receive a balance bill.)

When outside of California or Oregon, you may not use an *out-of-network facility* except for *emergency services* (including certain post-stabilization care) and *urgent care*.

CHOICE OF PROVIDERS

You have a choice of obtaining provider services (*physician* and other licensed *professional providers*) from any *Tier 1 provider, PPO provider,* or *out-of-network provider.* (When outside of California or Oregon, you may not use an *out-of-network provider* except for *emergency services* and *urgent care*.) You will pay the least if you use a *Tier 1 Provider*. You will pay higher *co-insurance* and *co-payments* if you use a *PPO provider* (except in the case of preventive health provider services). If you use an *out-of-network provider* you will pay even more (and you could be subject to balance billing). Therefore, using a *Tier 1 Provider* is recommended.

If you receive services at a *Tier 1 Facility* (or at a *PPO facility*) and you are not given the ability to choose your *provider* (this may occur, for example, when you receive services from a pathologist, radiologist, or anesthesiologist), the *provider*'s services may be covered by the *Plan* at the *Tier 1 Provider* level or the *PPO provider* level. The determination of coverage and the coverage level will be made at the sole discretion of the *plan administrator* (or as required by the *No Surprises Act* for services subject to that Act). Additionally, any time you receive services from an *out-of-network provider* at an *in-network facility*, you may have the rights and protections described in the Surprise Medical Bills Notice below.

A Preferred Provider Organization ("PPO") is a group of *physicians*, *hospitals*, and other health care *providers* and *facilities* that have contracted with the *PPO Network* to provide certain health care services at *network rates* to covered employees and dependents of the clients of the *PPO Network*, such as Adventist Health. Both *Tier 1 Providers* and *PPO providers* are members of the *PPO Network*.

Adventist Health contracts with Anthem Blue Cross and Blue Shield to the provide *PPO Network* for the *Plan*.

The networks provide no *claims* payment services and do not assume financial risk or obligation with respect to *claims*.

ABOUT YOUR AVAILABLE FACILITIES AND PROVIDERS

The *providers* and *facilities* have been carefully selected. The qualifications of each *provider* and each *facility* have been reviewed by the *Plan* and its networks so that you and your *eligible dependents* will be provided a wide range of medical care services at a fee significantly less than is common in the geographic area in which you live.

Out-of-pocket maximums are calculated by combining all *covered services* received through *Tier 1 Providers, Tier 1 Facilities, PPO providers, PPO facilities* (when *PPO facilities are covered*), and *out-of-network providers/facilities* (when *out-of-network providers/facilities* are covered).

PRIMARY CARE PROVIDER

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

Please see the Utilization Management Prior Authorization section for a discussion of the prior authorization requirements for consultation with certain specialists.

MEMBERSHIP CARD

After enrolling, you and your *covered dependents* will receive your **Adventist Health Employee Medical Plan Identification Cards** which will include your *employer* and identification numbers, and instructions for *medical necessity prior authorization.* You will need to present your card each time you receive services from a *physician* or *professional provider*.

If you lose your **Adventist Health Employee Medical Plan Identification Card**, we will issue a replacement. Contact *Adventist Health Administrators* at **1-800-441-2524**.

EMERGENCY CARE AND HOSPITALIZATION DUE TO AN EMERGENCY MEDICAL CONDITION

Claims for emergency care will be paid even without *medical necessity prior authorization* by the *Plan*. However, in order to increase the percentage the *Plan* pays for emergent inpatient *hospital* admission to 100%, you or your provider must notify the *Plan* of your *hospital* admission within two (2) business days of your emergent in-patient *hospital* admission following a *hospital* emergency department visit. The *utilization review manager* will work with the *hospital* and your *physician* to facilitate transfer, as appropriate, to an *in-network facility* as soon as you are stabilized and able to be transferred.

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 *Tier 1 Facility hospital* if, and after, *medical necessity prior authorization* has been granted by the *utilization review manager*. The *utilization review manager* will review elective admissions and work with the *physician* to assure that the patient avoids unnecessary time in the *hospital*.

It is your responsibility to make sure that the pre-admission process elaborated in the Care Management and Utilization Management Prior Authorization 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 their 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*.

UNAVAILABLE SERVICES

If *medically necessary covered services* cannot be rendered by a *Tier 1 Facility*, *Tier 1 Provider* or a *PPO provider* due to the unavailability of the service needed, or for any non-emergent *services* at a non-*Tier 1 Facility* (including a Tier 2 facility), a request should be made to the *utilization review manager* to use an *out-of-network facility/provider* via the Unavailable Services Request Form process. If such Unavailable Services Request Form is approved, you will be eligible for the Level 2 Patient Advocacy Center services described in the Patient Advocacy Center section.

Unless the *covered service* is *urgent care* or *emergency services*, this request should be made prior to services being rendered and you should not obtain services until you receive an executed Unavailable Services Request Form from the *utilization review manager*. For *urgent care* or *emergency services*, the Unavailable Services Request Form requirement is waived, but you must contact the *plan administrator* within two (2) business days (or sooner, if possible) and, in the case of a hospitalization, you must consent to a medically appropriate transfer to an *in-network facility* (if available) or any balance bills incurred for services rendered after refusing medical transfer will not be eligible for Level 2 Patient Advocacy Center services. (However, certain such services may nevertheless be

protected from balance bills by the *No Surprises Act*. See the Surprise Medical Bills Notice below.) The *utilization review manager* will not retroactively approve an Unavailable Services Request Form except as explicitly provided above for *urgent care* and non-*emergency services*.

For clarity, a service is not considered an *unavailable service* if a *Tier 1 Facility*, a *Tier 1 Provider* or a *PPO provider* can render a comparable service that also meets *medical necessity* standards and the Plan will only cover *unavailable services* to the extent that the Plan Administrator determines in its sole discretion that there is not a suitable service available through a *Tier 1 Facility*, a *Tier 1 Provider* or a *PPO provider*.

CONTINUITY OF CARE

You may be eligible to continue care with a facility or provider that leaves the *Plan's 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 *Plan's network* (or at the time the contract change is effective). This provision does not apply if the contract for the facility or provider is terminated for failure to meet applicable quality standards or for fraud.

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

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

Please contact *Adventist Health Administrators* at 1-800-441-2524 if you do not receive a notice, but you think you may be eligible for continued care under this section.

SURPRISE MEDICAL BILLS NOTICE

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

Your Rights and Protections

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

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

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

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

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

You are protected from balance billing for:

Emergency Services

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

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

Air Ambulance

You also have protection from balance billing for air ambulance services, but only if you meet the *Plan*'s requirements for coverage of air ambulance services.

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). The *Plan* will pay *out-of-network providers/facilities* directly.

- The *Plan* generally must:
  - Cover *emergency services* without requiring you to get approval for services in advance (*pre-certification* or prior authorization).
  - Cover *emergency services* by *out-of-network providers*.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an *in-network provider/facility* and show that amount in your explanation of benefits.
  - Count any amount you pay for *emergency services* or out-of-network services toward your deductible and out-of-pocket limit.

Contact Information

If you believe you've been wrongly billed, you may contact Customer Service at 800-441-2524 or the federal No Surprises Helpdesk at 800-985-3059.

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

BENEFITS DESCRIPTION

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

Some services require *medical necessity prior authorization* by the *utilization review manager* regardless of which provider provides the services. If *medical necessity prior authorization* for required services is not obtained from the *utilization review manager*, the *Plan* will not reimburse you for the expenses incurred unless required by the *No Surprises Act*.

Please remember to present your Adventist Health Employee Medical Plan Identification Card and make the appropriate *co-payment* before you receive care.

WHEN BENEFITS ARE AVAILABLE

This *Plan* pays claims only for *covered services* obtained when an *enrollee*'s coverage is in effect. (See the Eligibility, Enrollment and End of Coverage Chapter for information on when your coverage is in effect.) With respect to *covered services* that include a course of treatment or procedure which includes several steps or phases of treatment, *covered services* are "obtained" for the various steps or phases as the services related to each step or phase are rendered and not when services relating to the initial step or phase are rendered. More specifically, *covered services* for the entire procedure or course of treatment are not "obtained" upon commencement of the first stage of the procedure or course of treatment.

BENEFITS

The list of specific benefits under each major category heading below is not exhaustive and is intended to give you a general description of expenses for services and supplies covered by the *Plan*.

AMBULANCE

Ground or air transportation provided by a professional *ambulance* service to and from a *hospital* or *emergency services facility* equipped to treat *emergency medical conditions*. The *Plan* will directly reimburse the *provider* of the transportation services.

If you receive a balance bill from an *out-of-network* ambulance *provider*, please contact *Adventist Health Administrators* at 1-800-441-2524 for assistance.

BARIATRIC SURGERY

Covered Services and Expenses:

The *Plan* provides coverage (subject to the below eligibility criteria) for bariatric surgery at *Tier 1 Facilities* that are accredited by the Metabolics and Bariatric Surgery Accreditation Quality Improvement Program (MBSAQIP) The *Plan* will also cover select Adventist Health hospitals that are in the process of seeking their MBSAQIP accreditation and have met the *plan administrator*'s criteria for offering bariatric surgery to *Plan enrollees*. (Contact *Benefits Administration* for a list of such select hospitals.) Except for those select Adventist Health hospitals, the *Plan* requires that bariatric surgery is performed by facilities that are accredited by the MBSAQIP. (For *covered employees* of Adventist Health Corporate whose primary worksite is in Missouri and their *covered dependents* only, coverage is also available at the Bariatric Cetner of Kansas City, which is MBSAQIP-accredited). MBSAQIP participants will be required to identify a data collector, called a Bariatric Surgery Clinical Reviewer, who will participate in twice-yearly meetings with regional collaboratives. All of these criteria are designed to create a team-oriented culture focused on quality, and not necessarily quantity. *Medical necessity* review will be completed per the guidelines of the *Plan*. The items listed in this section are minimum requirements. Post-surgery, patients will have a

treatment plan developed by the bariatric coordinator for after care. Please contact your Adventist Health Employee Health Plan care manager at (800) 441-2524, option 1, if you need additional information or support.

Criteria for coverage:

1. Age 18 or older, AND
2. Has had a minimum of twelve multi-disciplinary *professional provider* visits prior to the procedure.

Coverage for a Revision or Reversal (Take Down) of Bariatric Surgery

The Plan will only cover a revision of a previously covered obesity surgery if it is due to documented surgical complication from the primary procedure that has not responded to medical treatment.

If the previous bariatric surgery was not covered by the *Plan*, the revision or reversal may be covered if the previous bariatric surgery was covered under the *enrollee's* prior group health plan or health insurance or would have been covered by the *Plan* if the *enrollee* had coverage at the time of the surgery.

Coverage for Repeat Surgery

If there is documented *medical necessity* for another bariatric surgery procedure, following a covered bariatric surgery, the *Plan* will cover the procedure if certain criteria are met and the member continues to meet the *Plan* coverage criteria. The second surgical procedure will be subject to a separate $500 *co-payment*.

Exclusions:

- Medical office visits solely for the treatment of obesity.
- Non-surgical procedures for the treatment of obesity.
- Procedures that are not authorized in advance by the Plan.
- Treatment or procedures that are deemed to be experimental or investigational.

DIAGNOSTIC X-RAY AND LABORATORY SERVICES

- Allergy testing
- Amniocentesis
- Computed tomography (CT) scans
- Developmental testing
- Genetic testing. All genetic and genomic testing require prior authorization except for those used to identify fetal aneuploidy, cystic fibrosis, or muscular atrophy.
- Infertility testing
- Diagnostic charges for laboratory services, such as urine and blood testing (including prenatal testing for elevated blood lead levels)
- Magnetic Resonance Imaging (MRI)
- Mammography 3D Tomosynthesis
- Positron emission tomography (PET) scans
- Pre-admission testing (PAT)
- Ultrasound
- Diagnostic charges for X-rays

DURABLE MEDICAL EQUIPMENT, SUPPLIES, AND APPLIANCES

- 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 Pharmacy table of the Schedule of Benefits. If not, they will be covered as provided in the Diabetic Supplies row of the Schedule of Benefits.
- Hearing aids and exams
- 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.
- Wigs and artificial hairpieces when due to a pathological change in the body.
- 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 *enrollee* has a diagnosis of diabetes and has any of the following: (1) foot deformity; (2) history of pre-ulcerative calluses; (3) history of previous ulceration; (4) peripheral neuropathy with evidence of callus formation; (5) poor circulation; or (6) previous amputation of the foot or part of the foot. Limit is 1 pair per year.
- Prior authorization required for all durable medical equipment or repair with billed charges of $2,000 or more, and all CPM devices, and Dynasplints (regardless of cost).

GENDER AFFIRMING CARE

- Treatments related to gender reassignment services, including psychotherapy, for gender dysphoria, but not including gender reassignment surgery or sex hormone therapy for individuals who are under 21 years of age.

EMERGENCY SERVICES

- *Emergency services* provided to treat an *emergency medical condition*.
- Claims for emergency care will be paid even without *medical necessity prior authorization* by the *Plan*. However, in order to increase the percentage the *Plan* pays for emergent inpatient *hospital* admission to 100%, you or your provider must notify the *Plan* of your *hospital* admission within two (2) business days of your emergent in-patient *hospital* admission following a *hospital* emergency department visit. The *utilization review manager* will work with the *hospital* and your *physician* to facilitate transfer, as appropriate, to an *in-network facility* as soon as you are stabilized and able to be transferred.

HOSPITAL CARE

- Facility fees for dental services if hospitalization is necessary to safeguard the health of the patient (for example, if the *enrollee* is under age 5, severely disabled, or has a medical or behavioral condition which requires hospitalization when dental care is provided).
- Coronary care unit, intensive care unit, medical unit, surgical unit, neonatal intensive care unit, and pediatrics unit charges.
- Nutrition counseling by a registered dietitian as part of care that is provided as a *hospital* service.
- Private room and board if *medically necessary*.
- Semi-private room and board.
- Miscellaneous *hospital* services and supplies required for treatment during a *hospital* confinement.
- *Outpatient hospital services*.
- The *Plan* will allow benefits for an unlimited number of days for acute *hospital* care.
- Inpatient Rehabilitative Hospital Care.
- Pre-admission testing is covered when ordered by the *physician*.
- Maternity and pregnancy related care in a licensed *hospital*. According to federal law, the *Plan* does 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 cesarean section. However, federal law generally does not prohibit mother's or newborn's *attending provider*, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a *provider* obtain authorization from the *Plan* or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MEDICAL SERVICES

- 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; provided that, in all instances, the Plan will only cover abortions that are permitted under applicable state law. 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 *enrollee* and her physician about these issues and to ensure that these *Plan* requirements for coverage are met in any given situation.

- Allergy injections.
- Treatment of central nervous system illness, trauma, coma, and brain injury.
- Chemotherapy.
- *Chiropractic services*.
- Clinical trial routine patient costs. If an *enrollee* is a qualified individual participating in an approved clinical trial, the *Plan* will cover the routine patient costs for items and services furnished in connection with participation in the clinical trial. "Routine patient costs" include items and services typically provided under the *Plan* for an *enrollee* not enrolled in a clinical trial, but do not include (a) the investigational item, device or service itself, (b) items and services not included in the direct clinical management of the *enrollee*, but are instead provided in connection with data collection and analysis, or (c) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. An "approved clinical trial" is a phase I, II, III, or IV trial that is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is federally funded, or is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration, or is a drug that is exempt from investigational new drug application requirements. A "qualified individual" is an *enrollee* who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other life-threatening disease or condition and either (a) the referring health care professional is an *in-network provider* and has concluded that the *enrollee's* participation in the clinical trial would be appropriate or (b) the *enrollee* provides medical and scientific information establishing that the *enrollee's* participation in the clinical trial would be appropriate. This paragraph is intended to be interpreted consistent with Public Health Services Act Section 2709 (42 USC § 300gg-8).
- Continuous passive motion devices.
- Continuous positive airway pressure therapy.
- *Dental services* received after an accidental *injury*. This includes replacement of teeth and any related X-rays. "Received after an accidental *injury*" means services that are rendered in the immediate aftermath of an accident as part of the initial treatment/procedure, including any relatively close in time follow-up service that could not be performed during the original treatment/procedure because of the *enrollee*'s condition or the nature of the treatment/procedure.
- General anesthesia for dental procedures for *enrollees* who are under age 5, severely disabled, or who have a medical or behavioral condition which requires general anesthesia when dental care is provided.
- Treatment of diabetes and self-management education programs.
- Dialysis.
- Dynasplints.
- Treatment of or related to a drug overdose.
- Routine foot care for diabetes or severe peripheral vascular disease.
- Enteral (i.e., by feeding tube) or parenteral (i.e., by intravenous administration) nutrition. The *Plan* does not cover food or formula taken by mouth except for *physician*-prescribed special medical modified formula/food products for the treatment of an *enrollee* with an inborn error of metabolism, such as phenylketonuria or an inherited disease of amino and organic acids.

- E-visits and telehealth.
- FDA approved gene and cellular therapies, based upon the drug indication and full prescribing information from the drug product package insert.
- Genetic counseling.
- Home health care provided by a home health care agency. Home health aides do qualify as a home health service provider under the *Plan*. CNAs must be under the supervision of a licensed provider and authorized by the *utilization review manager*. In-home preventative foot care may be provided for diabetic and other qualifying diagnoses once pre-certified by the *utilization review manager*.
- *Home hospice* care. Hospice care is all inclusive and includes the following: Doctor services, nursing care, durable medical equipment (like wheelchairs or walkers), medical supplies (like bandages and catheters), drugs for symptom control or pain relief, hospice aide and homemaker services, physical and occupational therapy, speech-language pathology services, social worker services, dietary counseling, bereavement counseling for you and your immediate family, short-term inpatient care (for pain and symptom management), short-term respite care (may need to pay a small copayment), any other *covered services* needed to manage your pain and other symptoms related to your terminal illness, as recommended by your hospice team. Hospice care is intended for people with 6 months or less to live if the disease runs its normal course. If you live longer than 6 months, you can still get hospice care, as long as the hospice medical director or other hospice doctor recertifies that you're terminally ill. Hospice care is given in benefit periods. You can get hospice care for two 90-day periods followed by an unlimited number of 60-day periods. At the start of each period, the hospice medical director or other hospice doctor must recertify that you're terminally ill, so you can continue to get hospice care. A benefit period starts the day you begin to get hospice care and it ends when your 90-day or 60 day period ends.
- Home infusion therapy.
- Hyperbaric oxygen treatment.
- Hyperthermia in conjunction with chemotherapy or radiotherapy for the treatment of cancer.
- Inpatient visits by the attending *physician*.
- Inpatient visits by a non-attending *physician*.
- Maternity and pregnancy related care. Child birthing is only covered in a licensed *hospital* or in emergency situations, such as in an ambulance. Doula services are not covered.
- Measurement of exhaled nitric oxide in the diagnosis and management of respiratory disorders.
- Non-custodial services of a *professional provider* nurse which are not billed by a *home health care agency*.
- Nutritional counseling.
- Outpatient infusion services.
- Outpatient rehabilitative and habilitative services, including occupational therapy, physical therapy, and speech therapy (speech therapy coverage is discussed further below).
- Pain management procedures, including epidural steroid injections, nerve blocks, and nerve destruction procedures.
- Photodynamic therapy.
- Physical therapy when performed by a *professional provider* operating within the scope of their license.
- *Physician* office visits.

- *Physician* visits to the patient's home.
- Radiation therapy.
- Radiosurgery.
- Respiratory therapy, only to the extent that the therapy is for the improvement of bodily function.
- *Second and third surgical opinions*.
- Self-inflicted *injuries*, expenses necessitated by self-inflicted *injury* that were sustained due to a *mental health condition*.
- Sleep disorder treatment, including equipment for sleep apnea. Equipment will fall under "Durable Medical Equipment."
- Speech therapy is only covered when all of the following conditions are met:

  1. Services for the treatment of communication impairment or swallowing disorders are prescribed by and under the general supervision of a physician;

  2. The patient has been evaluated by a qualified speech-language therapist who has determined that a treatable speech-language or swallowing disorder exists; and

  3. Therapy is rendered by a qualified provider of speech therapy services whose skills and expertise are necessary for the complexity and sophistication of the therapy. A qualified provider is one who is licensed where required and is performing within their scope of license; e.g., speech pathologist, speech-language pathologist, speech clinician.
- Stereotactic radiosurgery (gamma knife, cyberknife, linear accelerator).
- Therapeutic injections.
- UV light therapy.
- Temporomandibular Disorders (TMJ/TMD). Expenses incurred for jaw (mandibular) augmentation or reduction procedures or treatment for or prevention of temporomandibular joint dysfunction syndrome, including the correction of abnormal position and relationship of teeth. Coverage limited to medication management, occlusal splints or mandibular occlusal repositioning appliances and physical therapy.
- Varicose vein procedures.
- Vision therapy, but only for individuals age 18 and under.

MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE TREATMENT

- Attention Deficit Disorder (ADD), including prescribed drugs or medicines and counseling.
- Group and/or family counseling, but only for treatment of a *mental health condition* and/or *substance abuse*.
- *Inpatient* treatment of a *mental health condition*.
- *Outpatient* treatment of a *mental health condit*ion.
- *Inpatient* treatment of *substance abuse*.
- *Outpatient* treatment of *substance abus*e.

NEWBORN CARE

- Well-baby nursery, *physician* and initial exam expenses during the initial *hospital* confinement of a newborn will be considered as part of the mother's expenses. Newborns are automatically covered at birth for 60 days. Coverage will continue if the infant is properly enrolled.

PRESCRIPTION DRUGS

Your prescription drug benefit uses the Pharmacy Benefit Manager's Premier Formulary. The formulary encourages patients to use clinically appropriate medications while helping to manage increasing costs. A formulary is a list of medications in different therapy classes. Therapeutic classes are 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 three different pharmacy levels: AH In-House, Community Partner, and Pharmacy Benefit Manager (or "PBM"). Your copayments will be lowest if you use AH In-House pharmacies. Additionally, prescription drug coverage under the *Plan* is provided in two categories: Retail and Mail Order. Within each category, there are three tiers, or levels:

Tier 1 (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.

Tier 2 (preferred brand): The copayment for preferred brand drugs is higher than it is for generic drugs, but less than for non-preferred brand drugs. If a generic version of the drug is available, you will be responsible for the cost difference between the brand and generic drug in addition to the Tier 2 copayment for the preferred brand drug. This "brand-over-generic fee" does not contribute to your out-of-pocket maximum. This fee may be waived when (i) you have tried and failed the generic drug option, and (ii) you have received *prior authorization* to use the preferred brand version of the drug.

Tier 3 (non-preferred brand): Non-preferred drugs are brand name drugs that are not preferred under the Pharmacy Benefit Manager's Premium Select Standard Formulary. If a generic version of the drug is available, you will be responsible for the cost difference between the brand and generic drug in addition to the Tier 3 copayment for the non-preferred brand drug. This "brand-over-generic fee" does not contribute to your out-of-pocket maximum. This fee may be waived when (i) you have tried and failed the generic drug option, and (ii) you have received *prior authorization* to use the non-preferred brand version of the drug.

Exclusions: Excluded drugs, generally, are not covered under the *Plan*. In certain cases, excluded drugs may be covered if they are determined to be *medically necessary* after clinical review by the Pharmacy Benefit Manager.

The Pharmacy Benefit Manager's formularies are developed to be clinically sound and cost effective. Clinical appropriateness is the foremost consideration; however, the prescribing doctor has the final decision regarding a patient's drug therapy. If an *enrollee* can only take an excluded medication that is not covered, the *physician* may call the Pharmacy Benefit Manager to perform a clinical review to determine the necessity of covering the drug. If you have a drug that requires a review, please have your *physician* call the Pharmacy Benefit Manager at 800-626-0072. If approved, your medication will be covered at the Tier 3 (non-preferred brand) copayment level. If a generic version of the drug is available but you use the brand drug, you will be responsible for the cost difference between the brand and generic drug in addition to the Tier 3 copayment. If denied, the *enrollee* will need to pay out of pocket for the medication, try a Formulary alternative or file an appeal in accordance with the Pharmacy Benefit Manager's claims procedures. See the Claims Procedures chapter for more information.

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 Pharmacy table of the Schedule of Benefits. If not, they will be covered as provided in the Diabetic Supplies row of the Schedule of Benefits.

Some prescription drugs (including some preventive prescription drugs) are subject to *utilization management* by the Pharmacy Benefit Manager. Such *utilization management* may include *prior authorization*, step therapy, age limitations, and/or quantity limitations.

Compounded medications are subject to a $300 per claim maximum. When covered, compounded medications are subject to *Plan* coverage rules, including formulary restraints and clinical rules. Compounded medications, when covered, are assigned a "Tier 2 (preferred brand)" copayment. Compounded medications are only covered if determined to be *medically necessary* due to unavailability of similar or substitutable commercially-available medication(s).

Some generic versions of a drug may be just as expensiv
e as the brand-name drug. If you are taking a high-cost generic medication, MedImpact will contact you and your physician about lower-cost options.

On the other hand, if a lower cost generic version of a drug is available but you use the brand drug, you will be responsible for the cost difference between the brand and generic drug in addition to the applicable copayment for the brand drug. This "brand-over-generic fee" does not contribute to your out-of-pocket maximum. This fee may be waived when (i) you have tried and failed the generic drug option, and (ii) you have received *prior authorization* to use the brand version of the drug.

Pharmacy benefits do not cover the cost of replacement of medications that have been lost or stolen.

For any additional questions on your prescription benefit or to perform a coverage check, please call the Pharmacy Benefit Manager's customer service at 844-282-5331 or log on to the MedImpact portal at www.medimpact.com.

Preventive Prescription Drugs
Preventive prescription drugs include the prescription drugs listed in (or included in the services listed in) 26 CFR § 54.9815-2713, or any successor regulation or statute. Such preventive prescription drugs include prescription drugs included in the following:

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

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

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

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

Preventive prescription drugs will not include any items or services specified in any recommendation or guideline described in (i)-(iv) above after the recommendation or guideline is no longer described in (i)-(iv) above. See Appendix A for additional information about specific preventive care services and drugs. Preventive prescription drugs may be subject to the same *utilization management* procedures as other covered prescription drugs (described above).

Smoking cessation drugs that are prescribed by a *physician* and approved by the *plan administrator* are covered with no copay and no deductible and may be subject to the same *utilization management* procedures as other covered prescription drugs (described above).

Prescription contraceptive drugs are filled per the procedures of the Pharmacy Benefit Manager except that an Oregon *enrollee* may opt to receive a 3-month supply for an initial prescription for a specific prescription contraceptive drug and then may thereafter opt to receive 12-month supplies of the same prescription contraceptive drug, subject to all of the other limitations and coverage requirements stated elsewhere in this *Plan* or imposed by the Pharmacy Benefit Manager. (Oregon *enrollees* are *covered employees* of *participating employers* located in the State of Oregon and the *covered dependents* of *employees* of *participating employers* located in the State of Oregon.)

PREVENTIVE HEALTH CARE (WELLNESS)

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

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

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

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

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

  Preventive services include breast pump and breastfeeding materials and lactation consultations done by healthcare professionals, subject to the following:

  Limits – One breast pump per pregnancy. Post-partum period is covered an included as part of that pregnancy period in which the member is eligible for a pump.

  Cost – No cost to member

  Breast pump kit includes - Breast pump, tubing, two bottles, a supply of 600 milk storage bags, a carrying case and instructions

  Preventive services do not include any items or services specified in any recommendation or guideline described in (i)-(iv) above after the recommendation or guideline is no longer described in (i)-(iv) above. Preventive health care may be subject to the same *care management* procedures as other *Plan covered services* (see the Care Management and Utilization Management Prior Authorization Program chapter of the *Plan* for details).

  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.

The preventive services covered under this section are covered with no cost-sharing required on your part (that is, no co-payment, no co-insurance, and no deductible; this is often referred to as "first-dollar coverage"). If a preventive service is provided as part of an office visit and the office visit is not itself a preventive service covered under this section, the following rules apply: (1) if the preventive service is billed separately from the office visit, then any applicable cost-sharing requirements will apply to the office visit (such as a copayment); (2) if the preventive service is not billed separately from the office visit and the primary purpose of the office visit is the delivery of such preventive service, then no cost-sharing will be imposed; and (3) if the preventive service is not billed separately from the office visit and the primary purpose of the office visit is not the delivery of such preventive service, then any applicable cost-sharing requirements will apply to the office visit.

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

- Smoking/Tobacco Cessation. Smoking/tobacco cessation drugs prescribed by a *physician* and/or smoking/tobacco cessation programs approved by the *plan administrator*.
- Colorectal cancer screening for adults age 45 and over at the screening intervals recommended by the US Preventive Services Task Force based on test type and individual risk level: colonoscopy or sigmoidoscopy (including bowel prep kit, anesthesia, any required specialist consultation prior to the screening procedure, and any pathology exam on a polyp biopsy); or fecal occult blood testing; or fecal immunochemical testing; or multitarget stool DNA testing, e.g. Cologuard (but only if you are average risk and no more than once every three years). **Colon cancer testing for diagnostic purposes, as opposed to general screening, is not preventive care and so cost-sharing requirements will apply.**

SALES TAXES

The *Plan*'s provision of *covered services* includes payment of any applicable sales taxes.

SPECIALIZED TREATMENT FACILITIES

- An ambulatory surgery center.
- A day treatment facility.
- A *hospice facility*.
- Inpatient or outpatient psychiatric treatment facility.
- A rehabilitation facility.
- A Residential Treatment Facility.
- A skilled nursing facility.
- A *substance abuse* treatment facility.

SUPPLIES

- See the Durable Medical Equipment, Supplies, and Appliances section above.

SURGICAL SERVICES

- Anesthetic services, when performed by a licensed anesthesiologist or certified registered *nurse* anesthetist in connection with a *surgical* procedure.
- Assistant *surgeon's* expenses not to exceed 20% of the *Reasonable and Allowable Amount* of the *surgical* procedure.
- Circumcision.
- Human organ and tissue transplants, limited to: artery or vein; bone marrow (including courses of treatment involving high-dose chemotherapy or high-dose radiotherapy in conjunction with autologous bone marrow transplantation, stem cell rescue, or other hematopoietic support procedures); cornea; heart; heart/lung; heart valve replacements (except shiley valve); implantable prosthetic lenses in connection with cataracts; joint replacements (hip, knee, ankle, finger); kidney; liver; and prosthetic by-pass replacement vessels (except shiley valve). Expenses for the donor will be considered only if the recipient of the transplant is an *enrollee* and if the donor is not eligible under any other group health plan. In no case will any payment of a personal service fee be made to the donor. *Enrollees* may pursue listing at multiple sites; however, the *Plan* will only pay for one evaluation and the *enrollee* would be responsible for any additional evaluations.
- Hysterectomy.
- Joint replacement surgery.
- Maternity and pregnancy related care.
- Oral *surgery* received after an accidental *injury*. This includes replacement of teeth and any related X-rays. "Received after an accidental *injury*" means *surgery* that is rendered in the immediate aftermath of an accident as part of the initial treatment, including any relatively close in time follow-up *surgery* that could not be performed during the original treatment because of the *enrollee*'s condition or the nature of the treatment/procedure.
- Orthognathic *surgery*.
- Outpatient *surgery*.
- Podiatry services.
- Reconstructive surgery is covered when the surgery is needed to improve or restore the functioning of a body part. Coverage is also allowed for correction of the results of injury, deformity as the result of surgical treatment of malignancy (i.e., post-mastectomy breast reconstruction) and surgery needed to treat certain congenital defects such as cleft lip or cleft palate). Scar revision is limited to scars that are disfiguring and extensive or cause a functional impairment.
- Reconstructive surgery following a mastectomy. Including the following:
  - All stages of reconstruction of breast on which the mastectomy has been performed, including but not limited to, nipple reconstruction, skin grafts, and stippling of the nipple and areola.
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance.
  - Prostheses.
  - Treatment of physical complications of the mastectomy, including lymphedema.
  - Inpatient care related to the mastectomy and post-mastectomy services.
- Spine surgery.

- *Surgical* reproductive sterilization.
- Surgeon's expenses for the performance of a *surgical* procedure.
  - Two or more *surgical* procedures performed during the same session through different incisions, natural body orifices or operative fields. The amount eligible for consideration is the sum of *Reasonable and Allowable Amount* for each procedure performed.
  - Two or more *surgical* procedures performed during the same session through the same incision, natural body orifice or operative field. The amount eligible for consideration is the *Reasonable and Allowable Amount* for the largest amount billed for one procedure plus 50% of the *Reasonable and Allowable Amount* for the next largest procedure and 25% of the sum of *Reasonable and Allowable Amounts* for all other procedures performed.
- Surgical treatment of temporomandibular joint dysfunction (TMJ/TMD). Covered procedures are limited to therapeutic arthroscopy, arthrocentesis, condylotomy/eminectomy, modified condylotomy, arthroplasty, and joint reconstruction using autogenous or alloplastic materials.

URGENT CARE

- *Urgent care* services.

GENERAL 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/ facility*. Further, the *Plan* does not cover any services or procedures that are not permitted under applicable law.

Abortion

The *Plan* does not cover abortion (also referred to as termination of pregnancy) except as provided in the Medical Services section of the Benefits Description chapter.

Acupuncture

Adoption Expenses

Apolipoprotein E for Risk Assessment and Management of CV Disease

Armed Forces/War

Any *condition*, disability or expense sustained as a result of duty as a member of the armed forces of any state or country, or being engaged in a war or act of war which is declared or undeclared.

Atomic Explosion

Any *condition*, disability or expense sustained as a result of being engaged in an intentional or accidental atomic explosion, whether in peacetime or wartime.

Automobile Accidents – Limitations on Coverage: Auto Insurance
Coverage for injuries sustained in an automobile accident in which you are (or your *covered dependent* is) the driver of a vehicle involved in the accident is not provided if you (or your *covered dependent*) did not have automobile insurance, at the time of the accident that met (or exceeded) your state's minimum automobile insurance requirements.

Automobile Accidents – Limitations on Coverage: Driving Under the Influence of Alcohol

Injuries you (or your *covered dependent*) sustain while driving an automobile with a blood alcohol level above the applicable legal limit for the State in which you were driving. The presence of alcohol may be determined by tests performed by or for law enforcement authorities, by tests performed in the course of treating the person, or by other reliable means.

Automobile Accidents – Limitations on Coverage: Seat Belt Not Being Worn

Injuries caused as a result of an automobile accident in which you (or your *covered dependent*) were not wearing a seat belt to the extent required by state law.

Behavior Modification

Psychological enrichment or self-help programs for mentally healthy individuals are excluded. This includes: assertiveness training, image therapy, sensory movement groups, marathon group therapy and sensitivity training.

Benefits Not Stated

Services and supplies not specifically described in this SPD as *covered expenses* under this *Plan* are excluded.

Birth Centers that are not a part of a licensed *hospital*.

Charges Over the Reasonable and Allowable Amount

Excess charges, which are any charge over the *Reasonable and Allowable Amount* for services or supplies, will be excluded.

Comfort and First-Aid Supplies

Comfort and first-aid supplies are excluded. This includes, but is not limited to: footbaths, vaporizers, electric back massagers, footpads, heel cups, shoe inserts, band-aids, cotton balls, cotton swabs, and off-the-shelf wrist, ankle or knee braces.

Complications from Non-Covered Services

Treatment of complications from services or supplies that are not *covered services* is excluded. This exclusion applies even if the *enrollee* otherwise meets the criteria for coverage under the *Plan* but elects to self-pay or use other coverage for a service or supply rather than seek coverage under the *Plan*; in such case, any subsequent treatment of complications arising from the service or supply that was not submitted to the *Plan* for coverage is excluded. However, if all other conditions for *Plan* coverage are met, coverage will be provided for complications from a service or supply that was provided before the *enrollee* was covered under the *Plan* but the service or supply was covered under the *enrollee's* prior group health plan or health insurance or would have been covered by the *Plan* if the *enrollee* had been covered under the *Plan* at the time the service or supply was provided. The exclusion for complications from non-covered services does not apply to complications arising from a non-covered abortion.

Compounded Drugs

Compounded medications that are available in the same or equivalent form commercially are excluded. Examples of excluded compounded medications are compounded drugs that have the same active pharmaceutical ingredient(s) at the same, similar, or easily substitutable dosage strength as commercially-available drug(s), and that do not produce for the patient a significantly different treatment from the commercially-available drug(s).

Cosmetic Treatments

Cosmetic procedures (any procedure that is requested for the purpose of improving or changing appearance without restoring impaired body function) are excluded under this *Plan*. Surgery such as breast augmentation, lipectomy, liposuction and hair removal (including electrolysis and laser) are excluded. (See the Surgical Services section of the Benefits Description chapter for further information.)

Cosmetic and/or plastic surgery is defined as surgery which can be expected primarily to improve the physical appearance of a beneficiary, and/or which is performed primarily for psychological purposes, and/or which restores form, but does not correct or materially improve a bodily function. Examples include but are not limited to: rhinoplasty, breast augmentation (except as related to medically necessary mastectomy), abdominoplasty, correction of inverted nipples, hair removal by any means, liposuction, body lifts, face lifts, removal of benign skin lesions, chemical peels, otoplasty, treatment of rosacea, treatment of spider or reticular veins.

Counseling or Treatment in the Absence of Illness

Counseling or treatment in the absence of *illness*, including individual or family counseling or treatment for marital, social, behavioral, family, occupational, or religious problems or treatment of "normal" transitional response to stress.

Custodial Care

Services, routine care or hospitalization for assistance with activities of daily living, including but not limited to: bathing, dressing, feeding and administration of medications.

Dental Examinations and Treatment/Orthodontia

Except as specifically provided for under the Medical Services section of the **Benefits Description** chapter.

Dental *Implants* except for reconstructive surgery post injury.

Doulas

Duplicate Items (DME, orthotics/prosthetics)

"Duplicate" means an item of durable medical equipment or an orthotic/prosthetic that serves the same purpose that is served by another device that has already been purchased/provided. Replacement items are not duplicates if the current item is no longer functional. Technology is continuously being improved, however replacement of functioning equipment is not allowed just because of technologic improvement if the current equipment is functional.

Education-only

Court-mandated anger management classes; programs related to a DUI violation.

Educational Vocational Or Training Services And Supplies

Electrostimulation And Electromagnetic Therapy For Wounds

Endoscopic Therapies for GERD

Equipment

Equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs and any other clothing or equipment which could be used in the absence of an *illness* or *injury*.

Expenses Eligible for Consideration Under Any Other Plan of the Employer

Expenses for Education, Counseling, Job Training or Care for Learning Disorders and Developmental Delay

Expenses For Insertions Or Maintenance Of An Artificial Heart

Expenses Used to Satisfy *Plan* Deductibles

Experimental or Investigational Procedures

Services and supplies are excluded, that in our judgment:

- Are not rendered by an accredited institution, *physician* or provider within the United States, or that has not demonstrated medical proficiency in the rendering of the service or supplies, or
- Are not recognized by the medical community in the service area in which they are received, or
- Involve a treatment for which the approval of one or more government agencies is required, but has not been obtained at the time the services and supplies are rendered or are to be rendered, or
- Involve a treatment for which scientific or medical assessment has not been completed, and the effectiveness of the treatment has not been generally established as reported in peer reviewed medical literature.

Additionally, this *Plan* does not provide coverage for any expenses incidental to or incurred as a direct consequence of experimental or investigational procedures. However, see the Medical Services section of the Benefits Description chapter for a discussion of the coverage of routine patient costs in connection with approved clinical trial participation as required by Public Health Services Act Section 2709 (42 USC § 300gg-8).

Eye Examinations

Routine eye examinations, including the fitting, provision, or replacement of eyeglasses or contact lenses, and any charges for vitamin therapy or fundus photography are not covered.

Faith Healing

Family Education or Support Groups

Family Planning

Surgery to reverse voluntary sterilization procedures (vasectomy or tubal ligation) is not covered.

Financial Counseling Services

Food Services

“Meals on Wheels” and similar programs are not covered.

Foot Orthotics

Except as provided in the Durable Medical Equipment, Supplies, and Appliances section, foot orthotics are not covered.

Gender Reassignment Surgery and Sex Hormone Therapy

The *Plan* does not cover gender reassignment surgery or sex hormone therapy for individuals who are under 21 years of age. See also Sexual Disorders below.

Guest Meals in a Hospital or Skilled Nursing Facility

Habilitation/Rehabilitation Services

For limitations on habilitation and rehabilitation services see the Hospital Care and Medical Services sections in the Benefits Description chapter.

Hippotherapy and other services or supplies related to learning disabilities or developmental delay.

Homemaker or Housekeeping Services

Homeopathy

Hospice Services

The following hospice services are excluded:

- Hospice services provided to other than the terminally ill *enrollee*, except as provided in the Benefits Description chapter.
- Services and supplies not included in the hospice treatment plan or not specifically set forth as a hospice benefit.
- Services and supplies in excess of the stated limitations.

Hospital Based Billing Surcharges

Any facility fee, charge or surcharge billed on a UB04 claim form pertaining to services rendered to an *enrollee* in a *hospital* department setting.

Hypnosis

Illegal Activity

Any *condition*, disability or expense sustained as a result of *illness* or *injury* caused or contributed to by you or your *covered dependents* committing or attempting to commit any of the following or engaging in conduct which would amount to any of the following if a charge had been made, regardless, in either case, of whether a charge was filed or guilt was determined:

- A felony; or
- If the *illness* or *injury* is sustained outside of the United States, any *injury* or *illness* resulting from an act that is in violation of the criminal statutes of the country, principality, or state where the act was committed unless determined by the *plan administrator* to be a minor infraction; or
- A misdemeanor or other offense involving theft, fighting, disorderly conduct or other breach of the peace; or
- A misdemeanor or other offense involving the use of alcohol or drugs, including, but not limited to any crime or offense involving driving or being in actual physical control of a motor vehicle while under the influence of alcohol or drugs.
- A person will be presumed to be under the influence of alcohol or drugs and such influence will be presumed to be a cause of the *illness*, *condition*, accident or *injury* for purposes of this exclusion if either the person's blood alcohol level was equal to or greater than the legal limit for driving in the state where the accident occurred, or if a blood, urine, or other medically reliable test determines that there was any amount of illegal drugs in the person's system at the time of the cause or occurrence of the *illness*, *condition* or accident. The presence of alcohol or drugs may be determined by tests performed by or for law enforcement authorities, by tests performed in the course of treating the person or by other reliable means.

This exclusion does not apply if the services are provided because of an act of domestic violence and the services are provided to the victim of the domestic violence; services provided to the perpetrator of the violence are not covered by the *Plan*. This exclusion does not also apply if the conduct was caused by or due to a *medical condition* (including both physical and mental health *conditions*).

Infertility

Services and supplies for treatment of infertility are excluded. This includes, but is not limited to: artificial insemination procedures, in-vitro fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transplant (ZIFT) and Tubal Embryo Transplant (TET).

Inmates and Other Detainees

Services and supplies you or your *covered dependent* receives while in the custody of any law enforcement authorities or while in jail, prison, or any other detention facility (for example, a juvenile hall or correctional camp) are not covered. In the event that a state law or a court order requires the *Plan* to cover an inmate or any other detainee (such as in California where the *Plan* is not allowed to exclude an otherwise covered *enrollee* because he or she is confined in a city or county jail or is a juvenile detained in any facility), the *pre-authorization* requirements, the increased cost-sharing requirements for not using *Tier 1 Providers*, *Tier 1 Facilities*, or *PPO providers/facilities*, and all other *Plan* requirements will still apply to such inmate or other detainee.

In Vivo Analysis of Colorectal Polyps

Learning Disorder Services or behavioral problems or social skills training/therapy.

Legal Counseling

Magnetic Resonance Spectroscopy

Marital/Family Counseling unless for treatment of a *mental health condition* and/or *substance abuse*.

Massage or Massage Therapy

Even if related to a *condition*, which is otherwise covered by the *Plan*, massage and massage therapy are not covered.

Measurement of Exhaled Breath Condensate in the Diagnosis and Management of Respiratory Disorders

Measurement of Lipoprotein-Associated Phospholipase A2 in the Assessment of Cardiovascular Risk Lipoprotein-Associated Phospholipase A2 (Lp-PLA2)

Mental Examination and Psychological Testing and Evaluations

This *Plan* does not cover mental examinations for the purpose of adjudication of legal rights, administrative awards or benefits, corrections or social service placement, employment, or any use except as a diagnostic tool for the treatment of a *mental health condition*.

Mental Health Condition – This *Plan* does not cover any services related to the following:

(i) Diagnosis or treatment of conditions represented by V codes in the "Diagnostic and Statistical Manual of Mental Disorders Fifth Edition" (DSM-5).

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

Microwave Tumor Ablation

Missed/Broken Appointments

Expenses for missed or broken appointments or telephone calls.

Motorcycle Accidents – Limitations on Coverage: Helmet Not Being Worn

Injuries caused as a result of a motorcycle accident in which you (or your *covered dependent*) were not wearing a helmet, to the extent required by state law.

Naturopathy

Necessities of Living

Necessities of living, which include, but are not limited to: food, clothing, and household supplies are excluded (except that *physician*-prescribed special medical modified formula/food products for the treatment of an *enrollee* with an inborn error of metabolism, such as phenylketonuria or an inherited disease of amino and organic acids are not excluded). See also "Supportive Environmental Materials."

Nerve Grafts for Radical Retropubic Prostatectomy and Breast Reinnervation

Occipital Nerve Stimulation

Orthopedic Applications of Stem Cell Therapy

Orthopedic Shoes

These are not covered except as provided under the Durable Medical Equipment, Supplies, and Appliances section of the **Benefits Description** chapter.

Orthoptics/Vision Therapy [Except Vision Therapy for Age 18 and Under]

Over-the-Counter Medications and Vitamin Supplements

Drugs, medicines, supplies that do not require a physician's prescription are excluded unless they are required to be covered as a preventive service pursuant to 26 CFR §54.9815-2713, or any successor regulation (see Appendix A for details). Vitamin supplements (with the exception of provider-administered vitamin injections for the treatment of a underlying medical condition, such as vitamin B12 injections for the treatment of pernicious anemia) are excluded unless they are required to be covered as a preventive service pursuant to 26 CFR §54.9815-2713, or any successor regulation (see Appendix A for details). All other forms of vitamin supplements (including provider-prescribed vitamins, dietary supplements, foods, formula, herbs, minerals, nutritional supplements) are excluded (except that *physician*-prescribed special medical modified formula/food products for the treatment of an *enrollee* with an inborn error of metabolism, such as phenylketonuria or an inherited disease of amino and organic acids are not excluded).

Pastoral and Spiritual Counseling

Penile *Implants*

Personality Disorders

Defined as a pattern of behavior causing impairment in social or occupational functions.

Physical Examinations

Routine physical examinations for employment, licensing or health/medical coverage are excluded under the *Plan*.

Physical Exercise Programs

Even if prescribed for a specific *condition* that is otherwise covered by the *Plan*, physical exercise programs are not covered. Physical therapy is only covered if *medically necessary* and if rendered by a licensed physical therapist acting within the scope of his/her license.

Platelet-Rich Plasma

Prescription drugs, Excluded

Prescription drugs that are excluded drugs, unless they are determined to be *medically necessary* after clinical review by the Pharmacy Benefit Manager.

Private Nursing Services

Even if they relate to a *condition* that is otherwise covered by the *Plan*, private nursing services are not covered.

Psychological Enrichment or Self-Help programs for mentally healthy individuals

Removal of Breast Implants

Expenses for or related to the removal of breast or other prosthetic *implants* that were: (1) inserted in connection with cosmetic surgery, regardless of the reason for removal; or (2) not inserted in connection with cosmetic surgery, the removal of which is not currently medically necessary.

Reports and Records

This *Plan* does not cover charges for the completion of medical reports, itemized bills or *claim* forms; the cost of records; or for mailing, copying, shipping and/or handling expenses.

Riot or Civil Revolution

Any *condition*, disability or expense sustained as a result of participation in a civil revolution or riot.

Routine Foot Care

The *Plan* will not cover the following services:

- Paring or cutting of benign hyperkeratotic lesions (e.g., corn or callus).
- Trimming of dystrophic and non-dystrophic nails.
- Debridement of nail(s) by any method(s).

School Injuries

This *Plan* is secondary to any school insurance for treatment of injuries sustained on the property of a school and while participating in a school program.

Self-inflicted Injuries

Expenses necessitated by self-inflicted *injury* that were not sustained due a *mental health condition*.

Services for Learning Disabilities or Behavioral Programs or Social Skills Training/Therapy

Services Otherwise Available

This exclusion includes:

- Services and supplies for which payment could be obtained in whole or in part if you or your *covered dependent* had applied for payment under any city, county, state, or federal law, except for Medicaid or Medicare coverage.
- Charges for services and supplies for which you or your *covered dependents* cannot be held liable because of an agreement between the *physician* or provider rendering the service and another third party payer which has paid or is obligated to pay for such service or supply.
- Services and supplies for which no charge is made, or for which no charge is normally made in the absence of health coverage.
- Services or supplies you could have received in a *hospital* or program operated by a government agency or authority. This exclusion does not apply if you are a veteran of the armed forces, in which case *covered services* and supplies furnished by the Veterans' Administration of the United States and which are not service-related are eligible for payment according to the terms of this *Plan*.

Services Provided or Prescribed By You or A Member of Your Immediate Family

The *Plan* will not reimburse services provided or prescribed by you or any member of your family. Family members include, but are not limited to: a spouse and your or your spouse's *child*, brother, sister, parent, grandparent, aunt/uncle, or cousin.

Services Provided By Volunteer Workers

Services and Supplies Provided for Obesity or Weight Reduction

Except (i) as provided in the Bariatric Surgery section of the Benefits Description chapter, (ii) as may be provided in the Weight Watchers program (as discussed in the Preventive Health Care (Wellness) section of the Benefits Description chapter), (iii) as provided through the *Plan*'s nutritional counseling services (as discussed in the Medical Services section of the Benefits Description chapter), and (iv) as provided through the *Plan*'s pharmacy benefit or the GLP-1 Direct Fund as described in Appendix G, services and supplies provided for the treatment of obesity or weight reduction, services and supplies provided for the treatment of obesity or weight reduction, even if morbid obesity is present, are specifically excluded from this *Plan*. This includes, but is not limited to:

- Weight management services such as weight loss programs, exercise programs, counseling, hypnosis, neurolinguistic programming, guided imagery, relaxation training and subliminal suggestion used to modify eating behaviors.

Except as provided above, the *Plan* will cover services and supplies that are necessary for the treatment of established *medical conditions* that may be caused by or made worse by obesity, but the *Plan* will not cover services and supplies that do so by treating the obesity directly.

Sex Counseling

Sexual Disorders

This *Plan* does not cover services or supplies for the treatment of sexual dysfunction. For individuals who are under 21 years of age, this *Plan* does not cover services or supplies related to sex change procedures, sex hormone therapy or complications resulting from sex change procedures or sex hormone therapy.

Support Education

This includes the following:

- Education-only programs related to a DUI.
- Education-only, court-mandated Anger Management classes.
- Voluntary mutual support groups such as Alcoholics Anonymous.
- Family education or support groups.

Supportive Environmental Materials

These include, but are not limited to: hand rails, ramps, bath benches, humidifiers, dehumidifiers, air filters, air conditioners, heat lamps, heating pads, tanning lights, whirlpools, hot tubs, waterbeds, swimming pools, telephones and other items that are not for the treatment of a *medical condition* even if they are related to a *condition* otherwise covered by the *Plan*. See also "Necessities of Living."

Surface Electromyography (SEMG)

Surgery to Alter Refractive Character of the Eye

This *Plan* does not cover refractive surgery, laser vision correction, and any other procedure that alters the refractive character of the eye, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism. This exclusion includes, but is not limited to, radial keratotomy, corneal rings, LASIK, PRK, any procedure using the Examiner Laser or the Holmium: YAG laser, and other procedures of the refractive keratoplasty type. Reversals or revisions of any procedures which alter the refractive character of the eye and any complications of these procedures are excluded.

Surgical Deactivation of Headache Trigger Sites

Surrogate Mothers

All services related to surrogate parenting, including infertility testing and treatment, maternity care, birthing, hospitalization, professional services, etc., are not covered.

Taxes

Telephones and Televisions in a Hospital or Skilled Nursing Facility

Transportation

Except *medically necessary* ambulance transport, separate charges for transportation/travel are excluded.

Treatment for Admissions Prior to Coverage

This *Plan* does not cover services and supplies for an admission to a *hospital*, skilled nursing facility or special facility that began before the patient's coverage under this *Plan* began. Reimbursement for such admission will be the responsibility of the plan under which the individual was covered immediately preceding and extending up to the effective date of this *Plan*. If no such plan was in effect, coverage only for those *covered expenses* incurred on or after the individuals' effective date will be provided under this *Plan*.

Treatment for Services relating to the diagnosis or treatment of any mental or emotional *illness* or disorder that is not a *mental health condition*

Treatment Prior to Enrollment

This *Plan* does not cover services or supplies that you or your *covered dependent* received before you were covered by this *Plan*.

Treatment Rendered Outside of the United States

Except for medical emergencies.

Voluntary Mutual Support Groups, such as Alcoholics Anonymous

Wigs, Toupees, and Hair Transplants

These services and supplies are not covered except as otherwise provided in this *Plan*. (See the Durable Medical Equipment, Supplies, and Appliances section of the Benefits Description chapter.)

Work-Related Conditions

This *Plan* does not cover services or supplies for treatment of *illness* or *injury* arising out of or in the course of employment or self-employment for wages or profit so long as the covered patient is not exempt from state and federal workers' compensation law. This exclusion applies whether or not the expense for the service or supply is paid under workers' compensation.

CLAIMS PROCEDURES

Article 1 General Claim Filing Procedures

Section 1.01 *Introduction*

There usually will be no need for you to submit *claims* under the *Plan* because, as described below, your *facility/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*.

Adventist Health Administrators (on behalf of the *plan administrator*) reserves the right to decide whether to pay benefits to you, the *facility/provider* who rendered the service, or to you and the *facility/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 Employee Medical Plan Identification 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 *Adventist Health Administrators*, and be sure it includes the information listed in Section 3.03.

For any 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 *Adventist Health Administrators*, and be sure it includes the information listed in Section 3.03.

Section 1.03 *Physician and Professional Provider Benefits*

In most cases, your *in-network provider* will bill charges directly to the *Plan*. 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* and you are billed, you may forward the bills directly to *Adventist Health Administrators*. Be sure the provider uses his or her billing form and that the information required under Section 3.03 is provided.

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 a prior authorization. The prior authorization process for prescription drug benefits is administered by the Pharmacy Benefit Manager. Your doctor or doctor's office will need to call the Pharmacy Benefit Manager to perform a clinical review. To begin the prior authorization process, your doctor should call 844-282-5331 or fax 858-549-1569. Prior authorization 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 the Pharmacy Benefit Manager or visit medimpact.com to determine coverage of your medication. *Enrollees* can reach the Pharmacy Benefit Manager with any questions or comments at 844-282-5331.

You should use your ID card at point of service to obtain medications. If you have not received your physical ID card, please contact the *Plan* or MedImpact in order to obtain an electronic temporary ID card or your pharmacy benefit processing information. If you need to submit a manual *claim* for prescription drug benefits, you should call the Pharmacy Benefit Manager 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 the Pharmacy Benefit Manager at:

MedImpact Healthcare Systems, Inc.
PO Box 509098
San Diego, CA 92150-9108

In order to receive full prescription drug benefits, you must use your ID card or MedImpact pharmacy benefit processing information at the point of service to obtain medications. Manual claims are reimbursed based on the *Plan*'s negotiated rate for the medication, not the cash price paid for the medication.

Please note that, when used in regard to prescription drug benefits, the term *utilization review manager* refers to the Pharmacy Benefit Manager. The Pharmacy Benefit Manager 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 the Pharmacy Benefit Manager 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*, you may access this information on-line at AdventistHealth.org/EmployeeHealthPlan or call *Adventist Health Administrators* at 1-800-441-2524. We will respond to your inquiry within 30 days of receipt.

Section 1.07 *Appointment of Authorized Representative*

A *claimant* may appoint an *authorized representative* 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 on-line at AdventistHealth.org/EmployeeHealthPlan or from *Adventist Health Administrators*. Completed forms must be submitted to *Adventist Health Administrators*. 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 (or in the case of a *Tier 1 Facility* or *Tier 1 Provider*, even without an Appointment of Authorized Representative), 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 *facility/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-Authorization Claim*

A *claim* is a "*pre-authorization 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*, *pre-authorization claims* include the following: You or your *facility/provider* must obtain *prior authorization* 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 prior authorization* you must contact the *utilization review manager* (phone number on your ID card) before you receive the medical care (or prescription drugs).

Such *prior authorization* 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-Authorization Claim*

An "*urgent pre-authorization claim*" is a special type of *pre-authorization claim* that involves *urgent care*. A *pre-authorization claim* involves *urgent care* if application of the time periods that otherwise apply to *pre-authorization 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-authorization 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-authorization claim*.

Throughout these Claims Procedures, when the terms "*pre-authorization*" and "*pre-authorization claim*" are used without the term "urgent," they are used to describe non-urgent *pre-authorization 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 *facility/provider* will file *post-service claims*. If your *facility/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-authorization claim*. If the urgency subsides, it may be re-characterized as a *pre-authorization 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 the *utilization review manager* (phone number on your ID card) or *Adventist Health Administrators*.

Article 3 How to File a Claim for Benefits

Section 3.01 *General Filing Rules*

Claims for all medical services must be submitted in accordance with these procedures. See Section 1.04 for instructions on filing a *claim* for prescription drug benefits.

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

To file a *pre-authorization claim* or an *urgent pre-authorization claim* (usually to obtain prior authorization of *medical necessity*), you, your *authorized representative*, or your *facility/provider* must contact the *utilization review manager* (phone number on your ID card) before you receive the medical care.

If you fail to obtain required prior authorization 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 for your failure to receive *prior authorization*. If the *utilization review manager* determines you had reasonable cause for your failure to receive *prior authorization*, 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 *facility/provider* within 12 months or such later date as required by applicable law (except that an *out-of-network facility/provider* may file within 12 months) following receipt of the medical service, treatment or product to which the *claim* relates unless (a) it was not reasonably possible to file the *claim* within such time; and (b) the *claim* is filed as soon as possible and in no event (except in the case of legal incapacity of the *claimant*) later than 12 months after the date of receipt of the service, treatment or product to which the *claim* relates.

Your *facility/provider* will, generally, file required *post-service claims*. However, sometimes an *out-of-network facility/provider* may not file a *post-service claim* on your behalf. If you receive services for which your *facility/provider* does not file a *post-service claim* on your behalf, you should submit a *post-service claim* to *Adventist Health Administrators*. The appropriate *claim* forms and identification cards may be obtained online at AdventistHealth.org/EmployeeHealthPlan or directly from *Adventist Health Administrators*.

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

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

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

- The name of the covered person who was treated;
- The date(s) of service;
- The *facility/provider's* name, address, phone number and degree;
- The federal tax identification number of the *facility/provider*;
- The diagnosis;
- A description of services or supplies provided, detailing the charge for each supply or service.

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

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

Post-service claims should be submitted in writing to *Adventist Health Administrators*.

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-authorization 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-authorization 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 notification of the *Plan*'s decision on appeal described in Article 9 or, if your *claim* is eligible for external review, upon notification of final external review decision as described in Section 11.07.

Article 4 Timeframe for Deciding Initial Benefit Claims

Section 4.01 *Pre-Authorization Claim*

The *Plan* shall decide an initial *pre-authorization 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-Authorization Claims*

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

Section 4.03 *Concurrent Care Extension Request*

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

If an *urgent pre-authorization 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-authorization 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-Authorization and Urgent Pre-Authorization Claims*

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

Section 5.02 *Notification of Adverse Benefit Determination*

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

- information sufficient to identify the *claim* involved, including, if applicable: (i) the date of service, (ii) the health care *provider*, (iii) the *claim* amount, and (iv) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a statement of the specific reason(s) for the decision, including (i) the *Plan*'s denial code and its corresponding meaning (ii) the *Plan*'s standard, if any, that was used in denying the appeal; and (iii), for *final internal adverse benefit determinations*, a discussion of the decision;
- a reference to the specific *Plan* provision(s) on which the decision is based;
- a description of any additional material or information necessary for the *claimant* to perfect the *claim*/appeal and an explanation of why such material or information is necessary;
- a description of the *Plan*'s review procedures and the time limits applicable to such procedures;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- for *adverse benefit determinations* (including *final internal adverse benefit determinations*) of appeals, a statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination;
- if the decision is based on a *medical necessity* or experimental treatment or similar exclusion or limit, disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the *Plan* to the *claimant*'s medical circumstances, or (b) a statement that such explanation will be provided at no charge on request.
- in the case of an *urgent pre-authorization claim*, an explanation of the expedited review methods available for such *claims*/appeals;
- a statement describing any remaining mandatory appeal and information regarding how to initiate any such remaining appeal;
- a statement of the right to sue in federal court under ERISA Section 502(a); and
- the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Services Act Section 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-authorization claim* may be provided orally, but written notification shall be furnished not 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*, a *Tier 1 Facility,* or a *Tier 1 Provider* on the *claimant*'s behalf) has a right to appeal an *adverse benefit determination* under these Claims Procedures.

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

In light of the expedited timeframes for decision of *urgent pre-authorization claims*, an urgent pre-authorization appeal may be submitted to the *utilization review manager* by phone (the phone number can be found on your ID card). The *utilization review manager* will decide your appeal if it requires a determination involving *medical judgment*. If it does not require a determination involving *medical judgment*, the *utilization review manager* will send your appeal to the *Appeals Committee*. All necessary information in connection with an *urgent pre-authorization* appeal shall be transmitted between the *Plan* and the *claimant* by telephone, fax, or e-mail.

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

An appeal of an *adverse benefit determination* involving a *pre-authorization claim* and requiring a determination involving *medical judgment* should be submitted to the *utilization review manager*. To appeal an *adverse benefit determination* involving a *pre-authorization claim* that does not require a determination involving *medical judgment*, submit a written Request for Review form to the *Appeals Committee.* Details on how to submit an appeal will be provided by the *utilization review manager* upon an *adverse benefit determination*. You may call the *utilization review manager* (phone number on your ID card) or *Adventist Health Administrators* for more information regarding how and to whom to submit your appeal.

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

A post-service appeal of an *adverse benefit determination* requiring a determination involving *medical judgment* should be submitted to the *utilization review manager*. Details on how to submit an appeal to the *utilization review manager* will be provided by the *utilization review manager* upon an *adverse benefit determination*. You may call the *utilization review manager* (phone number on your ID card) for more information.

A post-service appeal of an *adverse benefit determination* that does not require a determination involving *medical judgment* should be filed by submitting a written Request for Review form to the *Appeals Committee*. 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 *Adventist Health Administrators*.

Section 6.05 *How to File Your Appeal: Prescription Drug Appeals*

To appeal a denied prescription drug benefit claim, follow the instructions on the adverse benefit determination you received from the Pharmacy Benefit Manager. (See Section 1.04 for contact information for the Pharmacy Benefit Manager.)

Section 6.06 *Important Appeal Deadline*

The appeal of an *adverse benefit determination* in all of the above-listed situations in this Article 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 take into account all information submitted by the *claimant*, whether or not presented or available at the initial benefit decision. Additionally, the *claimant* will be entitled to present evidence and testimony pertaining to the *claim*.

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

Section 7.02 *Consultation with Expert*

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

Section 7.03 *Access to Relevant Information*

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

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

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

Article 8 Timeframes for Deciding Benefits Appeals

Section 8.01 *Pre-Authorization Claims*

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

Section 8.02 *Urgent Pre-Authorization Claims*

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

Section 8.03 *Post-Service Claims*

The appeal of an *adverse benefit determination* relating to a *post-service claim* shall be decided within a reasonable period but no later than thirty (30) days after receipt of the appeal.

Section 8.04 *Concurrent Care Claims*

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

Article 9 Notification of Decision on Appeal

Written notification of the decision on appeal shall be provided to the *claimant* whether or not the decision is an *adverse benefit determination*. If the decision is an *adverse benefit determination*, the written notification shall include the information in Section 5.02, written in a manner calculated to be understood by the *claimant*.

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

The *Plan* will not consider you to have exhausted the administrative remedies available under the *Plan* until you have properly filed and received a decision on your appeal. If the decision received on appeal is an *adverse benefit determination*, it is the *Plan*'s *final internal adverse benefit determination* on your *claim*.

Article 10 Exhaustion and Deemed Exhaustion of Internal Claims and Appeals Processes

If you fail to follow these Claims Procedures, if you miss any of the above-stated deadlines for filing a *claim* or an appeal, or if you otherwise fail to exhaust all of the administrative remedies under the *Plan*, then (i) you will not be eligible for external review unless the completion of an *urgent pre-authorization* appeal would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant*'s ability to regain maximum function, and (ii) you will forfeit any right to pursue any remedies under State or federal law. This means that if you do not comply with the deadlines and fully exhaust these Claims Procedures, you may not sue the *Plan*.

If the *Plan* fails to strictly adhere to these Claims Procedures when reviewing your *claim* or appeal, you will be deemed to have exhausted the *Plan*'s internal claims and appeals process, unless the violation is de minimis, non-prejudicial, is attributable to good cause or matters beyond the *Plan*'s control, occurred in the context of an ongoing, good faith exchange of information between you and the *Plan*, and is not reflective of a pattern or practice of non-compliance. If the *Plan* claims that a violation occurred that meets the above exception, you may request a written explanation of the violation; the *Plan* will reply within 10 days to such a request and will include a description of the reasons for asserting that the violation did not cause the Claims Procedures to be deemed exhausted. If you have been deemed to have exhausted the *Plan*'s internal claims and appeals process, you may (i) initiate an external review, or (ii) pursue any remedies available under ERISA Section 502(a) 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 11 External Review

Section 11.01 *In General*

You are eligible to have certain *final internal adverse benefit determinations* and certain non-final *adverse benefit determinations* reviewed by an *independent review organization* and the decision reached through the external review will be binding on the *Plan*.

Section 11.02 *Eligibility for External Review*

All *final internal adverse benefit determinations* that involve (a) rescission of coverage, (b) application of the *No Surprises Act*, or (c) *medical judgment* are eligible for external review. For a non-final *adverse benefit determination* to be eligible for external review, it must involve a *medical condition* of the *claimant* for which the timeframe for completion of an *urgent pre-authorization* appeal would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant*'s ability to regain maximum function.

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

Section 11.03 *Request for External Review*

A *claimant* who is eligible for an external review (or the *claimant*'s *authorized representative*, or a *Tier 1 Facility* or a *Tier 1 Provider* on behalf of the *claimant*) 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 next day that is not a Saturday, Sunday, or Federal holiday.

Section 11.04 *Preliminary Review*

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

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

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

(iii) The *claimant* has exhausted the *Plan*'s internal appeal process or if the *claimant* is deemed to have exhausted the internal appeals process under Article 10; and

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

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

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

Section 11.05 *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-authorization* 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 make the determinations described in Section 11.04 and will then send any requests that are complete and eligible for external review to an *independent review organization*.

Section 11.06 *Assignment To and Consideration By Independent Review Organization*

Upon a determination that a request for external review is complete and is eligible for external review, the *Plan* will assign an *independent review organization* pursuant to Section 11.04 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 11.07 *Notification of Final External Review Decision*

The assigned *independent review organization* will provide written notice of the final external review decision to the *Plan* and the *claimant* within 45 days of the *independent review organization*'s receipt of the request for external review. In the case of expedited external review, the *independent review organization* will provide notice of the final external review decision as expeditiously as the *claimant's medical condition* or circumstances require, but in no event more than 72 hours after the *independent review organization* receives the request for an expedited external

review; if the initial notice is not in writing, the *independent review organization* will provide written confirmation of the decision to the *claimant* and *Plan* within 48 hours of providing the initial notice.

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

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

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

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

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

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

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

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

Section 11.08 *Reversal of Plan's Decision*

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

Article 12 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 *Adventist Health Administrators*.

DISCRIMINATION GRIEVANCE PROCEDURE (ACA SECTION 1557)

It is the policy of the *Plan* to not to discriminate on the basis of race, color, national origin, sex, age or disability. The *Plan* has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the Section 1557 Coordinator, Wendi Troncao (Director of Benefits Administration, ONE Adventist Health Way, Roseville, CA 95661, 1-800-441-2524, Troncawc@ah.org), who has been designated to coordinate the efforts of the *Plan* to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for the *Plan* to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of the *Plan* relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Chief Business Officer of Adventist Health at ONE Adventist Health Way, Roseville, CA 95661 within 15 days of receiving the Section 1557 Coordinator's decision. The Chief Business Officer of Adventist Health shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at: https://www.hhs.gov/civil-rights/filing-a-complaint/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

The *Plan* will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

BENEFITS AVAILABLE FROM OTHER SOURCES

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

A. **Coordination of Benefits (COB)**

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

B. **Third-Party Liability**

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

If a covered individual, as defined below, has a right to recover benefits or healthcare costs from a third party, we will pay the covered individuals' expenses subject to an automatic lien in the *plan sponsor'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 sponsor's* to perfect the lien and the amount paid by the *plan sponsor's* 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 *Medi-Cal* 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 an *enrollee*. "Covered individual" also includes the estate, heirs, guardian or conservator of the individual for whom benefits have been paid or may be paid by us, and includes any trust established for the purpose of receiving "Recovery Funds" and paying for the future income, care or medical expenses of such individual.
- **Benefits** means any amount paid by us, or submitted to us for payment to or on behalf of the covered individual. Bills, statements or invoices submitted to us by a provider of services, supplies or facilities to or on behalf of a covered individual are considered requests for payment of "benefits" by the covered individual.
- **Third Party Claim** means any claim, settlement, award, lawsuit, verdict, judgment, arbitration decision or other action against a third party (or any right to assert the foregoing) by or on behalf

of a covered individual, regardless of the characterization of the claims or damages of the covered individual, and regardless of the characterization of the recovery funds. (For example, a covered individual who has received payment of medical expenses from us, may file a third party claim against the party responsible for the covered individual's injuries, but only seek the recovery of non-economic damages. In that case, we are still entitled to recover benefits as described herein.)

- **Third Party** means any individual or entity responsible for the *injury* or *illness*, or the aggravation of an *injury* or *illness*, of the covered individual. Third party includes any insurer of such individual or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the covered individual including uninsured motorist coverage, under-insured motorist coverage, and workers' compensation insurance.
- **Recovery Funds** means any amount recovered from a third party.

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

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

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

(iii) In order to receive payment of benefits pursuant to this Section, we require that any covered individual seeking payment of benefits by us, and if the covered individual is a minor or legally incapable of contracting, then the covered person's parent or guardian, must fill out, sign and return to 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.

(iv) If the covered individual makes a demand upon a third party, enters into settlement negotiations or commences litigation, the covered individual must not prejudice, in any way, our recovery rights under this Section. If a suit is filed by the covered individual, the covered individual agrees that we may cause to be recorded a notice of payment of benefits, and such notice will constitute a lien on any judgment or settlement. We may provide notice to the third party or its insurer. In the event of settlement, the covered individual must obtain our consent prior to releasing any third party from liability for payment of any expenses covered, paid or pending for payment by us. The covered individual will hold the rights of and to recovery funds in trust for our benefit, up to the amount of benefits we have paid or which are pending payment at the time of resolution of the third party claim.

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

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

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

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

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.

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

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

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

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

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

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

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

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

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

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

C. **Motor Vehicle Insurance**

We will not pay benefits for healthcare costs to the extent that a covered individual including a *covered dependent* is covered by motor vehicle insurance. But we will advance payment of benefits over the amount covered by the motor vehicle insurance, subject to the third party recovery Section above. If we have paid benefits first, we are entitled to any reimbursement from the motor vehicle insurer, under the third party recovery Section above.

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

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

COORDINATION OF BENEFITS

COORDINATION OF THIS PLAN'S BENEFITS WITH OTHER BENEFITS

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

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the "**Primary Plan**." The Primary Plan must pay benefits in accordance with its terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the "**Secondary Plan**." When this *Plan* is the Secondary Plan it will reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense, as defined below. When Plan is italicized in this section, this term is referencing the Adventist Health Employee Health Plan (ERISA).

I. DEFINITIONS

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

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

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

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

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.

The order of benefit determination rules determine whether this *Plan* is a Primary Plan or Secondary Plan when you and/or your dependent has health care coverage under more than one Plan. When this *Plan* is the Primary Plan, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this *Plan* is the Secondary Plan, 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.

B. An "**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 facility/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 (or reasonable and allowable) 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 (or reasonable and allowable) 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 payment arrangement yielding the lowest fees shall be the Allowable Expense for all Plans. However, if the facility/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 facility/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, prior authorization of admissions, and preferred facility/provider arrangements.

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

D. "**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.

II. ORDER OF BENEFIT DETERMINATION RULES

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

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

B.

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

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

connection with a Closed Panel Plan to provide out-of-network benefits.

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

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

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

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

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

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan (i.e., the "Birthday Rule"); 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

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

- 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.

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

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

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

(4) *COBRA or State continuation of 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 of coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

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

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

III. 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 facility/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*.

REQUEST FOR INFORMATION

When necessary to process *claims*, we may require that you submit information concerning benefits to which you or your *covered dependents* are entitled. Such information may include, but is not limited to, medical records pertaining to requested benefits. We may also require that you authorize any *physician* or provider to provide us with information about a *condition* for which you claim benefits.

CONFIDENTIALITY OF ENROLLEE INFORMATION

The confidentiality of your protected health information is of extreme importance to the *plan sponsor*, *plan administrator,* and *Adventist Health Administrators*. Your protected health information includes, but is not limited to, enrollment, *claims*, and medical information. Your information is used for *claims* payment, prior authorization of services, business operations such as care management, preventive care and quality management programs. We may reach out to your providers to request your health information in an effort to determine whether you would benefit from early intervention due to a health factor, such as high blood pressure or high blood sugar. For more complete detail about how your *plan sponsor* uses your information, please refer to the HIPAA Privacy Notice. *Adventist Health Administrators*, as the delegate of the *plan administrator*, is required to adhere to these same practices. If you have additional questions about the privacy of your information beyond that provided in the HIPAA Privacy Notice, please contact Human Resources.

ASSIGNMENT OF BENEFITS

The term "Assignment of Benefits" shall mean an arrangement whereby the *Plan participant* assigns their right to seek and receive payment from the *Plan* for eligible *covered expenses* to a *provider/facility*, in strict accordance with the conditions and limitations of such rights provided under the terms of this summary plan description.

Conditions and Limitations of an Assignment of Benefits:

(a) The validity of an Assignment of Benefits by a *Plan participant* to a *provider/facility* is limited by the terms of this summary plan description. An Assignment of Benefits is considered valid on the condition that the *provider/facility* accepts the payment received from the *Plan* as consideration, in full, for *covered expenses* for services, supplies and/or treatment rendered. This amount does not include any cost sharing amounts (i.e. copayments, deductibles, or coinsurance), or charges for non-covered services; the *provider/facility* may bill the *Plan participant* directly for these amounts.

(b) An Assignment of Benefits cannot be inferred, implied or transferred. An Assignment of Benefits must be made by the *Plan participant* to the *provider/facility* directly through a valid written instrument that is signed and dated by the *Plan participant*.

(c) Unless specifically prohibited by a *participant*, a *provider/facility* with a valid Assignment of Benefits may file a claim on behalf of a *Plan participant*. If that *provider/facility* also has an Appointment of Authorized Representative, then that *provider/facility* may also exhaust, on behalf of the *Plan participant*, any administrative remedies available under the terms of the summary plan description, including initiating an internal or external appeal of an adverse benefit determination in accordance with the terms of the Claims Procedures chapter. (An Appointment of Authorized Representative is not required for a *Tier 1 Facility* or *Tier 1 Provider* to file an internal or external appeal on behalf of a *claimant*.) Notwithstanding the foregoing, the *Plan participant* does not, under any circumstances, have the right to assign to any *provider/facility* (or their representative) through an Assignment of Benefits any right to initiate any cause of action (or lawsuit) against the *Plan* that the *Plan participant* them self may be afforded under applicable law, nor may the *Plan participant* assign any future benefits or amounts paid as a result of a lawsuit or settlement. The assignment of any right to initiate suit against the *Plan* (and the assignment of any benefits paid as a result of any suit/settlement) to a *provider/facility* is strictly prohibited.

(d) An Assignment of Benefits does not grant the *provider/facility* any rights other than those specifically set forth herein.

(e) The *plan administrator* may disregard an Assignment of Benefits at its discretion and continue to treat the *Plan participant* as the sole recipient of the benefits available under the terms of the *Plan*.

(f) An Assignment of Benefits by a *participant* to a *provider/facility* will not constitute the appointment of an *authorized representative*. An Appointment of Authorized Representative will be required in order for a *provider/facility* to file an internal appeal or to request external review on behalf of the *participant* under the Claims Procedures (except that an Appointment of Authorized Representative will not be required for a *Tier 1 Facility* or a *Tier 1 Provider* to file an internal or external appeal on behalf of a *claimant*). Neither an Assignment of Benefits, nor an Appointment of Authorized Representative, will assign to a *provider/facility* the right to initiate any cause of action (or lawsuit) or will assign any future benefits or amounts paid as a result of a lawsuit or settlement (such assignments are strictly prohibited).

By submitting a *claim* to the *Plan* and accepting payment by the *Plan*, the *provider/facility* is expressly agreeing to the foregoing conditions and limitations of an Assignment of Benefits in addition to the other terms of this summary plan description. The *provider/facility* further agrees that the payments received constitute an 'accord and satisfaction' and consideration, in full, for the *covered expenses* for services, supplies and/or treatment rendered. The *provider/facility* agrees that the conditions and limitations of an Assignment of Benefits as set forth herein shall supersede any previous terms and/or agreements. The *provider/facility* agrees to the specific condition that the patient not be balance billed for any amount beyond applicable cost sharing amounts (i.e. copayments, deductibles, or coinsurance), or charges for non-covered services; the *provider/facility* may bill the *Plan participant* directly for these amounts.

If a *provider/facility* refuses to accept an Assignment of Benefits under the conditions and limitations as set forth herein, any *covered expenses* payable under the terms of the summary plan description will be payable directly to the *Plan participant*, and the *Plan* will be deemed to have fulfilled its obligations with respect to such *covered expense*.

RECOVERY OF EXCESS OR MISTAKEN PAYMENTS

Whenever payments for services rendered to you or any of your *covered dependents* have been made in excess of the amount necessary to satisfy the provisions of this *Plan* (including payments made by mistake or due to fraud), the Plan has the right to (i) recover these payments from any individual (including yourself), insurance company, facility, provider, payer, or other organization to whom the excess payments were made or (ii) withhold payment on your or your *covered dependent*'s future benefits until the amount withheld equals the amount of the overpayment. The *Plan* will not request a refund from a *facility/provider* (or offset against a *claim* paid to a *facility/provider*) more than 12 months after the *claim* has been paid except in cases of fraud or misrepresentation by the *facility/provider.*

RESPONSIBILITY FOR QUALITY OF MEDICAL CARE

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

GOVERNING LAW

To the extent state law is not preempted by ERISA, this *Plan* is governed by and construed in accordance with the laws of the State of the *Tier 1 Facility* (or other Adventist Health worksite) at which you are based. If you are not based at a *Tier 1 Facility* (or other Adventist Health worksite), the *Plan* shall be governed by and construed in accordance with the laws of the State of California.

STATUTE OF LIMITATIONS: VENUE/FORUM

Before filing a lawsuit, the *claimant* must exhaust all available levels of review as described in the Claims Procedures chapter, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one (1) year of the date of the notice of *adverse benefit determination* on the final level of internal or external review, whichever is applicable. Further, any legal action arising out of this *Plan* must be filed in the county of the *Tier 1 Facility* (or other Adventist Health worksite) at which you are primarily based. The *participant*, any *authorized representative* of the *participant*, or any *Tier 1 Facility* or *Tier 1 Provider* pursuing benefits on behalf of a *participant*, submits to and accepts the exclusive jurisdiction of such courts for the purpose of such legal action. To the fullest extent permitted by law, *participant*, and any *authorized representative*, *Tier 1 Facility,* or *Tier 1 Provider* pursing benefits on behalf of a *participant* irrevocably waive any objection which they may now or in the future have as to venue, as well as any claim that any legal action or proceeding brought in such court has been brought in an inconvenient forum.

AMENDMENT AND TERMINATION

While the *plan sponsor* intends to continue the *Plan* for an indefinite period of time, the *plan sponsor* reserves the right, at any time, to amend or terminate the *Plan*, in whole or in part, by written instrument without prior notice. Any amendment to modify, amend or terminate the *Plan* shall be affected by the Chief Business Officer of Adventist Health. Such amendments may be made retroactively.

If the *plan administrator* determines that a person is *totally disabled* on the date coverage would otherwise end due to *Plan* termination (including *Plan* termination only for the *employer* from whom the disabled person's coverage is received), expenses directly related to the disabling condition will continue to be eligible for consideration, subject to the *Plan*'s usual limitations and restrictions, until the earliest of the date *total disability* ends, the date the disabled person becomes covered under any other group health plan, or the earlier of the date following 12 months of extended benefits or the period of time equal to the number of months the disabled person was covered under this *Plan* prior to the beginning of the disability-condition coverage began. The coverage will be subject to the same *employee-share contribution* rate as COBRA continuation coverage.

EFFECTIVE DATE OF AMENDMENT OR TERMINATION

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

APPLICABLE TO ACTIVE EMPLOYEES AND THEIR SPOUSES AGE 65 AND OVER

A *Plan participant* that is an *active employee* and his or her *spouse* (ages 65 and over) may, at the option of such *employee*, elect or decline coverage under this *Plan* at open enrollment or some other specified special enrollment period. If such *employee* elects coverage under this *Plan*, the benefits of this *Plan* shall be determined before any benefits provided by Medicare. If coverage under this *Plan* is declined by such *employee*, benefits listed herein will not be payable even as secondary coverage to Medicare. The *Plan* will at all times, when applicable, adhere to the requirements set forth in the Medicare Secondary Payer regulations.

APPLICABLE TO ALL OTHER PLAN PARTICIPANTS ELIGIBLE FOR MEDICARE BENEFITS

To the extent required by Federal regulations, this *Plan* will pay *covered expenses* at the *Reasonable and Allowable Amount* before Medicare makes any secondary payment for benefits.

If any *Plan participant* is eligible for Medicare benefits because of end stage renal disease, the benefits of the *Plan* will be determined before Medicare benefits for the first 30 months of Medicare entitlement. After the first 30 months, the *Plan participant* will be assumed to have full Medicare coverage whether or not the *Plan participant* has actually enrolled in the full coverage, and this *Plan* will calculate the *participant*'s benefits as though the *Plan* is secondary to Medicare, unless applicable Federal law provides to the contrary, in which event the benefits of the *Plan* will be determined in accordance with such law.

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.

ALTERNATIVE PAYEE PROVISION

Under normal conditions, all *in-network* benefits are automatically assigned to the provider of services or supplies. All other benefits are payable to you and can only be paid directly to another party upon signed authorization from you. If conditions exist under which a valid release or assignment cannot be obtained, the *Plan* may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment. The *Plan* must 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 also honor benefit assignments made prior to your death in relation to remaining benefits payable by the *Plan*.

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

HEALTH CARE FRAUD AND ABUSE

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

The most common types of fraud, waste or abuse are misrepresentation of services with incorrect Current Procedural Terminology (CPT) codes; billing for services not rendered; altering claim forms for higher payments; falsification of information in medical record documents, such as International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-10-CM) codes and treatment histories; billing for services that were not performed or misrepresenting the types of services that were provided; billing for supplies not provided; and providing medical services that are unnecessary based on the patient's condition.

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

HEALTH CARE CLAIMS AUDITS

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

1. Coding & Billing Audits which may encompass accurate application of many different items such as the following:
    A. Diagnosis coding,
    B. Procedure coding,
    C. Units or keystroke errors,
    D. Diagnosis Related Grouping (DRG),
    E. Ambulatory Payment Classification (APC),
    F. Ambulatory surgery payment groupings (ASC),

G. Discharge disposition,
H. Present on Admission (POA) indicators,
I. HAC, Medical/Surgical Misadventure or Medical Never Event,
J. National Correct Coding Initiative (NCCI) edits,
K. Outpatient Code Editor (OCE) edits,
L. Modifiers, etc.

2. Charge Audits may encompass not only accuracy of the charges but appropriateness of the charges when items may not be consistent with uniform billing practices (for example, unbundling of items from the room rate such as venipuncture, pulse oximetry, oxygen, floor stock supplies, etc).
3. Assessing if services provided were reasonable and necessary (for example, level of care or setting, experimental and investigational usage of drugs or devices).
4. Covered Services.
5. Readmissions up to 30 days.

STATE AND FACILITY SPECIFIC PROVISIONS

PROVISIONS APPLICABLE TO OREGON ENROLLEES ONLY

If you are an employee of an Adventist Health entity in Oregon, the following provisions apply to you:

- For employees of Adventist Health entities in Oregon, a person whose coverage under the *Plan* has terminated may be eligible to secure major medical coverage on a self-pay basis through the Oregon Medical Insurance Pool (OMIP). The available coverage through OMIP is known as "portability." OMIP is not part of the *Plan*, nor is it sponsored or endorsed in any way by the *Plan*. OMIP is provided through the Oregon Department of Consumer and Business Services (DCBS). If you have questions about available coverage under OMIP, you can visit their website at www.omip.state.or.us or telephone **1-800-848-7280**.
- An Oregon *enrollee* may opt to receive a 3-month supply for an initial prescription for a specific prescription contraceptive drug and then may thereafter opt to receive 12-month supplies of the same prescription contraceptive drug, subject to all of the other limitations and coverage requirements stated elsewhere in this *Plan* or imposed by the Pharmacy Benefit Manager. (Oregon *enrollees* are *covered employees* of *participating employers* located in the State of Oregon and the *covered dependents* of *employees* of *participating employers* located in the State of Oregon.)

ADVENTIST HEALTH EMPLOYEE HEALTH PLAN NOTICE OF PRIVACY PRACTICES (HIPAA PRIVACY NOTICE)

This notice applies to the Adventist Health Employee Health Plan. For further information regarding this notice, contact the Privacy Official at ONE Adventist Health Way, Roseville, CA 95661 or by phone at (916) 781-2000.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights
You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

See the following pages of this notice for more information on these rights and how to exercise them.

Your Choices
You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

See the following pages of this notice for more information on these choices and how to exercise them.

Our Uses and Disclosures
We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

See the following pages of this notice for more information on these uses and disclosures.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the beginning of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes

- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways:

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration. We may disclose your health information to the medical plan administration staff that are listed in the privacy policy.
Example: We may provide information to your employer to explain the employee-share contributions.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: https://www.hhs.gov/hipaa/for-individuals/faq/index.html**.**

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. State and federal law may impose more restrictive requirements on certain uses and disclosures of protected health information than those listed in this notice. The Plan will comply with all such applicable requirements. There are special laws regarding information about HIV/AIDS status, STD status, mental health, developmental disabilities, reportable conditions, genetic information, and drug and alcohol abuse. The Plan follows these laws.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: https://www.hhs.gov/hipaa/for-individuals/faq/index.html**.**

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date
This notice is effective January 1, 2027.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits
Examine, without charge, at the *plan administrator's* principal office and at other specified locations, such as worksites, all documents governing the *Plan*, including a copy of the latest annual report (Form 5500 Series), if any, filed by the *Plan* with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to Human Resources, copies of documents governing the operation of the *Plan*, including copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The *plan administrator* may make a reasonable charge for the copies.

Receive a summary of the *Plan*'s annual Form 5500, if any is required by ERISA to be prepared, in which case the *plan administrator* is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the *Plan* as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the *Plan* on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for *Plan* participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your *Plan*, called "fiduciaries" of the *Plan*, have a duty to do so prudently and in the interest of you and other *Plan* participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a *Plan* benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of *Plan* documents or the latest annual report (Form 5500), if any, from the *Plan* and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the *plan administrator* to provide the materials and pay you up to $110 per day (plus as adjusted for inflation) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the *plan administrator*. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the *Plan* (discussed in the Claims Procedures Chapter), you may file suit in a state or federal court.

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

Assistance With Your Questions
If you have any questions about your *Plan*, you should contact *Adventist Health Administrators*. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the *plan administrator*, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory), or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX A – LIST OF COVERED PREVENTIVE SERVICES

Preventive care benefits for adults –
See below (printed on 8-31-2023) or, for the most current information, go to
https://www.healthcare.gov/preventive-care-adults/

Preventive care benefits for women –
See below (printed on 8-31-2023) or, for the most current information, go to
https://www.healthcare.gov/preventive-care-women/

Preventive care benefits for children –
See below (printed on 8-31-2023) or, for the most current information, go to
https://www.healthcare.gov/preventive-care-children/

Preventive care benefits for adul

All Marketplace health plans and many other plans must cove preventive services without charging you a copayment or coir you haven't met your yearly deductible.

> **IMPORTANT**
> These services are free only when delivered by a doctor or plan's network.

1. Abdominal aortic aneurysm one-time screening (http://health visits/screening-tests/talk-to-your-doctor-about-abdominal-aortic-aneurysm) for have ever smoked
2. Alcohol misuse screening and counseling (http://healthfinder.go conditions-and-diseases/heart-health/drink-alcohol-only-in-moderation)
3. Aspirin use (http://healthfinder.gov/HealthTopics/Category/health-conditions- doctor-about-taking-aspirin-every-day) to prevent cardiovascular dise adults 50 to 59 years with a high cardiovascular risk
4. Blood pressure screening (http://healthfinder.gov/HealthTopics/Catego blood-pressure-checked)
5. Cholesterol screening (http://healthfinder.gov/HealthTopics/Category/do cholesterol-checked) for adults of certain ages or at higher risk

11. Hepatitis B screening for people at high risk, including pe
or more Hepatitis B prevalence, and U.S.-born people no
with at least one parent born in a region with 8% or more
12. Hepatitis C screening (http://healthfinder.gov/HealthTopics/Category/doc
c-screening) for adults age 18 to 79 years
13. HIV screening (http://healthfinder.gov/HealthTopics/Category/health-conditi
tested-for-hiv) for everyone age 15 to 65, and other ages at ir
14. PrEP (pre-exposure prophylaxis) HIV prevention medicati
high risk for getting HIV through sex or injection drug use
15. Immunizations (http://healthfinder.gov/HealthTopics/Category/doctor-visits
adults — doses, recommended ages, and recommended
    - Chickenpox (Varicella) (http://www.vaccines.gov/diseases/chickenp
    - Diphtheria
    - Flu (influenza)
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus (HPV)
    - Measles
    - Meningococcal
    - Mumps
    - Whooping Cough (Pertussis)

19. Statin preventive medication for adults 40 to 75 at high
20. Syphilis screening (http://healthfinder.gov/HealthTopics/Category/healt stds/syphilis-testing-questions-for-the-doctor) for adults at higher ris
21. Tobacco use screening (http://healthfinder.gov/HealthTopics/Categor diseases/diabetes/quit-smoking) for all adults and cessation inte
22. Tuberculosis screening for certain adults without symp

More on prevention

Preventive care benefits for wom

All Marketplace health plans and many other plans must cove preventive services for women without charging a copayment even if you haven't met your yearly deductible.

> **IMPORTANT**
> These services are free only when delivered by a doctor or plan's network.

Services for pregnant women or wome become pregnant

1. Breastfeeding support and counseling (http://healthfinder.gov/He ready-for-your-baby/breastfeed-your-baby) from trained providers, an supplies, for pregnant and nursing women
2. Birth control (http://healthfinder.gov/HealthTopics/Category/health-condition the-right-birth-control): Food and Drug Administration-approvec sterilization procedures, and patient education and couns health care provider for women with reproductive capaci drugs). This does not apply to health plans sponsored by employers." Learn more about contraceptive coverage.
3. Folic acid (http://healthfinder.gov/HealthTopics/Category/nutrition-and-physica

9. Rh incompatibility screening (http://healthfinder.gov/HealthTopics/C visits/have-a-healthy-pregnancy) for all pregnant women and follo higher risk
10. Syphilis screening (http://healthfinder.gov/HealthTopics/Category/health stds/syphilis-testing-questions-for-the-doctor)
11. Expanded tobacco intervention and counseling (http://healt conditions-and-diseases/diabetes/quit-smoking) for pregnant tobacco
12. Urinary tract or other infection screening (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-v

Get more information about services for pregnant women fi (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/h

Other covered preventive services for

1. Bone density screening (http://healthfinder.gov/HealthTopics/Categor density-test) for all women over age 65 or women age 64 ar through menopause
2. Breast cancer genetic test counseling (BRCA) (http://healthfir conditions-and-diseases/cancer/talk-with-a-doctor-if-breast-or-ovarian-cancer-ru higher risk
3. Breast cancer mammography screenings (http://healthfinder.g visits/screening-tests/get-tested-for-breast-cancer)
    - Every 2 years for women 50 and over

7. Diabetes screening for women with a history of gestatio
currently pregnant and who haven't been diagnosed wit
8. Domestic and interpersonal violence screening and cou
9. Gonorrhea screening (http://healthfinder.gov/HealthTopics/Category/he
stds/get-tested-for-chlamydia-and-gonorrhea) for all women at higher
10. HIV screening and counseling (http://healthfinder.gov/HealthTopics/
diseases/hiv-and-other-stds/get-tested-for-hiv) for everyone age 15 to
increased risk
11. PrEP (pre-exposure prophylaxis) HIV prevention medica
at high risk for getting HIV through sex or injection drug
12. Sexually transmitted infections counseling (http://healthfinder
conditions-and-diseases/hiv-and-other-stds) for sexually active wome
13. Tobacco use screening and interventions (http://healthfinder.g
conditions-and-diseases/diabetes/quit-smoking)
14. Urinary incontinence screening for women yearly

Preventive care benefits for child

Most health plans must cover a set of preventive health servic
This includes Marketplace and Medicaid coverage.

> **IMPORTANT**
> These services are free only when delivered by a doctor or
> plan's network.

Coverage for children's preventive hea

All Marketplace health plans and many other plans must cove
preventive services for children without charging you a copay
true even if you haven't met your yearly deductible.

1. Alcohol, tobacco, and drug use assessments (http://www.healthfinder.gov/HealthTopics/Category/parenting/healthy-communica about-tobacco-alcohol-and-drugs) for adolescents
2. Autism screening (http://healthfinder.gov/HealthTopics/Category/parenting/ childs-visit-to-the-doctor-ages-1-to-4) for children at 18 and 24 mont
3. Behavioral assessments for children: Age 0 to 11 months (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-m 0-to-11-months), 1 to 4 years (http://healthfinder.gov/HealthTopics/Category/ your-childs-visit-to-the-doctor-ages-1-to-4), 5 to 10 years

your-childs-visit-to-the-doctor-ages-11-to-14), 15 to 17 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-m 15-to-17)

6. Blood screening for newborns
7. Depression screening (http://healthfinder.gov/HealthTopics/Category/doc screened-for-depression) for adolescents beginning routinely at a
8. Developmental screening (http://healthfinder.gov/HealthTopics/Categor of-speech-or-language-delay) for children under age 3
9. Dyslipidemia screening (PDF, 609 MB) for all children o and once between 17 and 21 years, and for children at hi
10. Fluoride supplements (http://healthfinder.gov/HealthTopics/Category/par childs-teeth) for children without fluoride in their water sour
11. Fluoride varnish for all infants and children as soon as tee
12. Gonorrhea preventive medication (http://healthfinder.gov/HealthTo midwife-visits/talk-with-your-doctor-about-newborn-screening) for the eyes
13. Hearing screening for all newborns (http://healthfinder.gov/HealthT midwife-visits/talk-with-your-doctor-about-newborn-screening); and regular for children and adolescents as recommended by their pr
14. Height, weight and body mass index (BMI) measurements regularly for all children
15. Hematocrit or hemoglobin screening (http://healthfinder.gov/Healt visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4) for all chil
16. Hemoglobinopathies or sickle cell screening

- Chickenpox (Varicella)
- Diphtheria, tetanus, and pertussis (DTaP)
- Haemophilus influenza type b
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Inactivated Poliovirus
- Influenza (flu shot)
- Measles
- Meningococcal
- Mumps
- Pneumococcal
- Rubella
- Rotavirus

22. Lead screening for children at risk of exposure
23. Obesity screening and counseling (http://healthfinder.gov/HealthTop physical-activity/help-your-child-stay-at-a-healthy-weight)
24. Oral health risk assessment (PDF, 609 KB) for young chi years
25. Phenylketonuria (PKU) screening (http://healthfinder.gov/HealthTopic

28. Vision screening (http://healthfinder.gov/HealthTopics/Category/doctor-visits checked) for all children

29. Well-baby and well-child visits

More information about preventive ser

- Preventive services for children age 0 to 11 months (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-mo 0-to-11-months)
- Preventive services for children age 1 to 4 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-mo 1-to-4)
- Preventive services for children age 5 to 10 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-mo 5-to-10)
- Preventive services for children age 11 to 14 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-mo 11-to-14)
- Preventive services for children age 15 to 17 years

APPENDIX B – RULE OF 80 AND SEVERANCE CONTRACT COVERAGE

The following provisions are part of the *Plan*, but are maintained separately in this Appendix B. As with all provisions of the Plan, the *plan administrator* has the discretionary authority to interpret this Appendix B and make eligibility and benefit determinations as the *plan administrator* may determine in the *plan administrator's* sole discretion.

For purposes of this Appendix B, the term "executive" means Adventist Health employees who are at the assistant vice president level or above.

Rule of 80. For any Adventist Health executive who is at least 55 years old and has a combination of age and years of Adventist Health service that equals at least 80 when he/she retires, if the executive is unable to obtain comparable (benefits and costs) health insurance, the executive will be granted the opportunity to purchase continuation of coverage for himself/herself and his/her *eligible dependents* at the full, unsubsidized continuation of coverage rate. The executive will be allowed to continue purchasing continuation of coverage until he/she is able to purchase comparable insurance or is eligible to purchase coverage under the Medicare program. The *spouse* of an eligible executive has the same right to stay on continuation of coverage as the executive. That is, the *spouse's* coverage may continue (as long as all contributions are timely paid) until the *spouse* is eligible for comparable insurance or is eligible to purchase coverage under the Medicare program—even if the executive reaches this status first.

Severance Contract Coverage. When an executive terminates employment with Adventist Health, the executive's *Plan* coverage (including coverage for *covered dependents*) will be continued by Adventist Health until the earlier of the end of the salary continuation period or three months after the executive secures alternate employment or any other remunerable position. At that time, if the executive is unable to obtain comparable (benefits and cost) health coverage, and is at least 55 years old, with at least 15 years of Adventist Health executive service at the level of vice president or above, the executive will be granted the opportunity to purchase continuation of coverage for himself/herself and his/her *eligible dependents* at the full, unsubsidized continuation of coverage rate. The executive will be allowed to continue purchasing continuation of coverage until he/she is able to purchase comparable insurance or is eligible to purchase coverage under the Medicare program.

APPENDIX C – MEDICAL RESIDENTS' EFFECTIVE DATE OF COVERAGE

The following provisions are part of the *Plan*, but are maintained separately in this Appendix C. As with all provisions of the *Plan*, the *plan administrator* has the discretionary authority to interpret this Appendix C and make eligibility and benefit determinations as the *plan administrator* may determine in the *plan administrator's* sole discretion.

For individuals employed by Adventist Health as medical residents, rather than having an effective date for coverage as specified in the Waiting Period and Effective Date section of this Summary Plan Description, each medical resident's effective date for coverage will be dictated by the terms of his or her employment contract with Adventist Health.

APPENDIX D – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA PRIVACY POLICY)

I. Introduction

In this Privacy Policy, your *employer* is referred to as the "Company." The Company sponsors this Plan, which is a self-insured group health plan.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act, and their respective implementing regulations, are collectively referred to as "HIPAA" for purposes of this Privacy Policy. HIPAA restricts the Plan's and the Company's ability to use and disclose protected health information.

Members of the Company's workforce may have access to protected health information of Plan participants (1) on behalf of the Plan itself; or (2) on behalf of the Company, for administrative functions of the Plan performed by the Company and other purposes permitted by the HIPAA privacy and security rules. This Privacy Policy sets forth the Plan's policies and procedures for HIPAA compliance by the Plan and the Company when it receives protected health information from the Plan.

> *Participant*. For purposes of this Privacy Policy, participant means any individual who is or has been enrolled in the Plan, including current and former employees and their dependents.
>
> *Protected Health Information.* Protected health information means information (including electronic information) that is created, received, transmitted or maintained by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

For purposes of this Policy, protected health information does not include the following, referred to in this Policy as "Exempt Information":

1. summary health information, as defined by HIPAA's privacy rules, that is disclosed to the Company solely for purposes of obtaining premium bids, or modifying, amending, or terminating the Plan;

2. enrollment and disenrollment information concerning the Plan that does not include any substantial clinical information;

3. protected health information disclosed to the Plan or the Company under a signed authorization that meets the requirements of the HIPAA privacy rules;

4. health information related to a person who has been deceased for more than 50 years;

5. information disclosed to the Company by an individual for functions that the Company performs in its role as an employer and not as sponsor of the Plan or in providing administrative services to the Plan.

The Company also sponsors other plans in addition to its health plans which are not subject to this Privacy Policy. This Privacy Policy will govern the circumstances, if any, that protected health information may be shared with any such plans.

It is the Company's policy that the Plan shall comply with HIPAA's requirements for the privacy and security of protected health information. To that end, all members of the Company's workforce who have access to protected health information must comply with this Privacy Policy. For purposes of this Policy and the Plan's Privacy Use and Disclosure Procedures (which are set forth in a separate document), the Company's workforce includes individuals who would be considered part of the workforce under HIPAA, such as employees, volunteers, contractors, trainees, and other persons whose work performance is under the direct control of the Company, whether or not they are paid by the Company. The term "workforce member" includes all of these types of workers.

No third-party rights (including but not limited to rights of Plan participants, beneficiaries, covered dependents, or Business Associates) are intended to be created by this Policy. The Company reserves the right to amend or change this Policy at any time (and even retroactively) without notice. To the extent this Policy establishes requirements and obligations above and beyond those required by HIPAA, the Policy shall be aspirational and shall not be binding upon the Plan or the Company. This Policy does not address requirements under other federal laws or under state laws. To the extent this Policy is in conflict with the HIPAA privacy rules, the HIPAA privacy rules shall govern.

II. Plan's Responsibilities as Covered Entity

II.A. Privacy Official and Contact Person

The Company's designated Privacy Official is the privacy officer and security officer for the Plan. The Privacy Official will be responsible for the development and implementation of policies and procedures relating to privacy of the Plan's protected health information, including but not limited to this Privacy Policy and the Plan's Privacy Use and Disclosure Procedures. The Privacy Official will also serve as the contact person for participants who have questions, concerns, or complaints about the privacy of their protected health information.

The Privacy Official is responsible for ensuring that the Plan complies with all provisions of the HIPAA privacy and security rules, including the requirement that the Plan have a HIPAA-compliant Business Associate Contract in place with all Business Associates. The Privacy Official shall also be responsible for monitoring compliance by all Business Associates with the HIPAA privacy and security rules and the terms of their Business Associate Contracts.

II.B. Workforce Training

It is the Company's policy to train all members of its workforce who have access to protected health information for familiarity and compliance with the Plan's Policy and its Privacy Use and Disclosure Procedures. The Privacy Official is charged with developing training schedules and programs so that all workforce members receive the necessary and appropriate training to permit them to carry out their Plan functions in compliance with HIPAA. Workforce training will be updated as necessary to reflect any changes in policies or procedures and to ensure that workforce members are appropriately aware of their obligations.

II.C. Safeguards and Firewall

The Company will establish on behalf of the Plan appropriate administrative, technical, and physical safeguards to prevent protected health information from intentionally or unintentionally being used or disclosed in violation of HIPAA's requirements. Administrative safeguards include implementing procedures for use and disclosure of protected health information, including identifying workforce members who need access to protected health information to do their jobs. See the Plan's Privacy Use and Disclosure Procedures. Technical safeguards include limiting access to information by creating computer firewalls and tracking workforce members' access to protected health information. Physical safeguards include locking doors or filing cabinets.

Firewalls will ensure that only authorized workforce members will have access to protected health information, that they will have access to only the minimum amount of protected health information necessary for the plan administrative functions they perform, and that they will not further use or disclose protected health information in violation of HIPAA's privacy rules.

II.D. Privacy Notice

The Privacy Official is responsible for developing and maintaining a notice of the Plan's privacy practices that complies with the HIPAA privacy rules and describes:

- the uses and disclosures of protected health information that may be made by the Plan;
- the rights of individuals under HIPAA privacy rules;
- the Plan's legal duties with respect to the protected health information; and
- other information as required by the HIPAA privacy rules.

The privacy notice will inform participants that the Company will have access to protected health information in connection with its plan administrative functions. The privacy notice will also provide a description of the Plan's complaint procedures, the name and telephone number of the contact person for further information, and the effective date of the notice. The effective date will not be earlier than the date the notice is published.

The notice of privacy practices shall be placed on the Plan's or the Company's website. The notice also will be individually delivered:

- at the time of an individual's enrollment in the Plan;
- to a person requesting the notice; and
- to participants within 60 days after a material change to the notice. However, if the Plan posts its notice on the Plan's website and there is a material change to the notice, the Plan will prominently post the change or the revised notice on its website by the effective date of the change, and provide the change or information about the change and how to obtain the revised notice, in its next annual mailing to individuals covered by the Plan.

The Plan will also provide notice of availability of the privacy notice (or a copy of the privacy notice) at least once every three years in compliance with the HIPAA privacy regulations.

II.E. Complaints

Complaints regarding this Privacy Policy can be submitted to Human Resources, to the Privacy Official, or to *Adventist Health Administrators*.

The Privacy Official is responsible for creating a process for individuals to lodge complaints about the Plan's privacy procedures and for creating a system for handling such complaints. A copy of the complaint procedure shall be provided to any participant upon request.

II.F. Sanctions for Violations of Privacy Policy

Sanctions against workforce members for using or disclosing protected health information in violation of HIPAA or this HIPAA Privacy Policy will be imposed in accordance with the Company’s discipline policies and procedures, up to and including termination of employment.

II.G. Mitigation of Inadvertent Disclosures of Protected Health Information

The Plan shall mitigate, to the extent possible, any harmful effects that become known to it from a use or disclosure of an individual's protected health information in violation of HIPAA or the policies and procedures set forth in this Policy. As a result, if a workforce member or Business Associate becomes aware of an unauthorized use or disclosure of protected health information, either by a workforce member or a Business Associate, the workforce member or Business Associate must immediately contact the Privacy Official so that appropriate steps to mitigate harm to the participant can be taken.

II.H. No Intimidating or Retaliatory Acts; No Waiver of HIPAA Privacy

No workforce member may intimidate, threaten, coerce, discriminate against, or take other retaliatory action against individuals for exercising their rights, filing a complaint, participating in an investigation, or opposing any improper practice under HIPAA. No individual shall be required to waive his or her privacy rights under HIPAA as a condition of treatment, payment, enrollment, or eligibility under the Plan.

II.I. Documentation

The Plan's privacy policies and procedures shall be documented and maintained for at least six years from the date last in effect. Policies and procedures must be changed as necessary or appropriate to comply with changes in the law, standards, requirements and implementation specifications (including changes and modifications in regulations), and the Plan's practices and processes. Any changes to policies or procedures must be promptly documented.

The Plan shall document certain events and actions (including authorizations, requests for information, sanctions, and complaints) relating to an individual's privacy rights. The Plan shall also document the dates, content, and

attendance of workforce members at training sessions.

The documentation of any policies and procedures, actions, activities, and designations may be maintained in either written or electronic form. The Plan will maintain such documentation for at least six years.

III. Policies on Use and Disclosure of Protected Health Information

III.A. Use and Disclosure Defined

The Plan will use and disclose protected health information only as permitted under HIPAA. The terms "use" and "disclosure" are defined as follows:

- *Use.* The sharing, employment, application, utilization, examination, or analysis of protected health information by any Company workforce member with access, as defined in Section III.C of this Policy, or by a Business Associate of the Plan.

- *Disclosure.* The release, transfer, provision of access to, or divulging in any other manner of protected health information to persons who are not Company workforce members with access, as defined in section III.C of this Policy, or to a person or entity who is not a Business Associate of the Plan.

III.B. Workforce Must Comply With Plan's Policy and Procedures

All members of the Company's workforce who have access to Plan protected health information must comply with this Policy and with the Plan's Privacy Use and Disclosure Procedures, which are set forth in a separate document.

III.C. Permitted Uses and Disclosures for Plan Administration Purposes

The Plan may disclose Exempt Information to the Company. Exempt Information is not governed by this Policy, and the Company may use and disclose it for any lawful purpose.

The Plan may disclose protected health information to the following Company workforce members to perform Plan administrative functions ("workforce members with access"):

- Employees under the control of the Company and who are employed in the following job categories: employees in Adventist Health Benefits Administration or the Adventist Health Risk Management department who are responsible for Plan administration, members of the Adventist Health information technology department who need access as a part of their job duties to keep the Plan administration information technology infrastructure of the Plans operational, and plan sponsor officials who are responsible for enrollee advocacy/facilitation functions in connection with the Plan.

- Patient Financial Services Department employees who need to view enrollment status under the Plan in connection with confirming a source of payment for the provision of healthcare services to a Plan enrollee by a Company health facility.

- **No one else at Rideout or Adventist Health is allowed access to Protected Health Information.**

Workforce members with access may disclose protected health information to other workforce members with access for plan administrative functions (but the protected health information disclosed must be limited to the minimum amount necessary to perform the plan administrative function). Workforce members with access may not disclose protected health information to workforce members (other than workforce members with access) unless a valid, signed authorization is in place or the disclosure otherwise is in compliance with this Policy and the Plan's Privacy Use and Disclosure Procedures. Workforce members with access must take all appropriate steps to ensure that the protected health information is not disclosed, available, or used for employment purposes. For purposes of this Policy, "plan administrative functions" include the payment and health care operation activities described in section III.D of this Policy.

III.D. Permitted Uses and Disclosures: Payment and Health Care Operations

Protected health information may be disclosed for the Plan's own payment purposes, and protected health information may be disclosed to another covered entity for the payment purposes of that covered entity.

Payment. Payment includes activities undertaken to obtain Plan contributions or to determine or fulfill the Plan's responsibility for provision of benefits, or to obtain or provide reimbursement for health care. Payment also includes:

- eligibility and coverage determinations including coordination of benefits and adjudication or subrogation of health benefit claims;
- risk-adjusting based on enrollee status and demographic characteristics;
- billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess loss insurance) and related health care data processing; and
- any other payment activity permitted by the HIPAA privacy regulations.

Protected health information may be disclosed for purposes of the Plan's own health care operations. Protected health information may be disclosed to another covered entity for purposes of the other covered entity's quality assessment and improvement, care management or health care fraud and abuse detection programs, if the other covered entity has (or had) a relationship with the participant and the protected health information requested pertains to that relationship.

Health Care Operations. Health care operations means any of the following activities:

- conducting quality assessment and improvement activities;
- reviewing health plan performance;
- underwriting and premium rating;
- conducting or arranging for medical review, legal services, and auditing functions;
- business planning and development;
- business management and general administrative activities; and
- other health care operations permitted by the HIPAA privacy regulations.

III.E. No Disclosure of Protected Health Information for Non-Health Plan Purposes

Protected health information may not be used or disclosed for the payment or operations of the Company's "non-health" benefits (e.g., disability, workers' compensation, life insurance), unless the participant has provided an authorization for such use or disclosure (as discussed in "Disclosures of Protected Health Information Pursuant to an Authorization") or such use or disclosure is required or allowed by applicable state law and all applicable requirements under HIPAA are met.

III.F. Mandatory Disclosures of Protected Health Information

A participant's protected health information must be disclosed in the following situations:

- The disclosure is to the individual who is the subject of the information (see the policy for "Access to Protected Information and Request for Amendment" that follows);
- The disclosure is required by law; or
- The disclosure is made to HHS for purposes of enforcing HIPAA.

III.G. Other Permitted Disclosures of Protected Health Information

Protected health information may be disclosed in the following situations without a participant's authorization, when specific requirements are satisfied. The Plan's Privacy Use and Disclosure Procedures describe specific requirements that must be met before these types of disclosures may be made. The requirements include prior approval of the Plan's Privacy Official. Permitted are disclosures-

- about victims of abuse, neglect, or domestic violence;
- to a health care facility/provider for treatment purposes;
- for judicial and administrative proceedings;
- for law-enforcement purposes;
- for public health activities;
- for health oversight activities;
- about decedents;
- for cadaveric organ-, eye-, or tissue-donation purposes;
- for certain limited research purposes;
- to avert a serious threat to health or safety;
- for specialized government functions; and
- that relate to workers' compensation programs.

III.H. Disclosures of Protected Health Information Pursuant to an Authorization

Protected health information may be disclosed for any purpose if an authorization that satisfies all of HIPAA's requirements for a valid authorization is provided by the participant. All uses and disclosures made pursuant to a signed authorization must be consistent with the terms and conditions of the authorization.

III.I. Complying With the "Minimum-Necessary" Standard

HIPAA requires that when protected health information is used, disclosed, or requested, the amount disclosed generally must be limited to the "minimum necessary" to accomplish the purpose of the use, disclosure, or request.

The "minimum-necessary" standard does not apply to any of the following:

- uses or disclosures made to the individual;
- uses or disclosures made pursuant to a valid authorization;
- disclosures made to HHS;
- uses or disclosures required by law; and
- uses or disclosures required to comply with HIPAA.

Minimum Necessary When Disclosing Protected Health Information. The Plan, when disclosing protected health information subject to the minimum-necessary standard, shall take reasonable and appropriate steps to ensure that

only the minimum amount of protected health information that is necessary for the requestor is disclosed. More details on the requirements are found in the Plan's Privacy Use and Disclosure Procedures. All disclosures not discussed in the Plan's Privacy Use and Disclosure Procedures must be reviewed on an individual basis with the Privacy Official to ensure that the amount of information disclosed is the minimum necessary to accomplish the purpose of the disclosure.

Minimum Necessary When Requesting Protected Health Information. The Plan, when requesting protected health information subject to the minimum-necessary standard, shall take reasonable and appropriate steps to ensure that only the minimum amount of protected health information necessary for the Plan is requested. More details on the requirements are found in the Plan's Privacy Use and Disclosure Procedures. All requests not discussed in the Plan's Privacy Use and Disclosure Procedures must be reviewed on an individual basis with the Privacy Official to ensure that the amount of information requested is the minimum necessary to accomplish the purpose of the disclosure.

III.J. Disclosures of Protected Health Information to Business Associates

Workforce members may disclose protected health information to the Plan's Business Associates and allow the Plan's Business Associates to create, receive, maintain, or transmit protected health information on its behalf. However, prior to doing so, the Plan must first obtain assurances from the Business Associate, in the form of a business associate contract, that it will appropriately safeguard the information. The Privacy Official shall maintain a log of all Business Associates and shall maintain all Business Associate Contracts in a readily accessible and retrievable form and format. Before sharing protected health information with outside consultants or contractors who meet the definition of a "Business Associate," workforce members must contact the Privacy Official and verify that a Business Associate contract is in place.

A Business Associate is an entity that:

- creates, receives, maintains, or transmits protected health information on behalf of the Plan (including for claims processing or administration, data analysis, underwriting, etc.); or

- provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services to or for the Plan, where the performance of such services involves giving the service provider access to protected health information.

III.K. Disclosures of De-Identified Information

The Plan may use and disclose information that has been "de-identified" in accordance with the HIPAA privacy regulations. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

III.L. Breach Notification Requirements

The Plan will comply with the Reportable Breach Notification Policy set forth in section V of this Policy.

IV. Policies on Individual Rights

IV.A. Right to Access Protected Health Information

HIPAA gives participants the right to access and obtain copies of their protected health information that the Plan (or its Business Associates) maintains in Designated Record Sets. A participant's personal representative may request access to protected health information on behalf of the participant. The Plan will provide access to protected health information in accordance with HIPAA.

A Designated Record Set is a group of records maintained by or for the Plan that includes:

- the enrollment, payment, and claims adjudication record of an individual maintained by or for the Plan; or

- other protected health information used, in whole or in part, by or for the Plan to make coverage decisions about an individual.

Participants will be instructed to send their requests for access to the Plan's Privacy Official. The Plan will make reasonable efforts to verify the identity of the requesting participant following procedures approved by the Privacy Official. The Plan will attempt to provide participants with access to their protected health information as soon as possible, and within 30 days, after receiving a written request. If the Plan is unable to provide access within 30 days, it may extend the response by up to 30 additional days so long as it communicates the reason for the extension to the participant and the estimated response date within the initial 30-day period.

The Plan will send requested information in a Designated Record Set to a third party identified by the participant, so long as the request is signed and in writing, and clearly identifies the third party and where to send the information.

Generally, the Plan will not deny participants access to their own protected health information. However, if an exception to the right to access set forth in 45 CFR §164.524 exists, the Privacy Official will review the request for access and will respond within the timeframe and with the information required by the privacy rule.

If information in one or more Designated Record Sets is maintained electronically, and an individual requests an electronic copy of such information, the Plan will provide the individual with access to the requested information in the electronic form and format requested by the individual, if it is readily producible in such form and format. If the requested information is not readily producible in such form and format, the requested information will be produced in a readable electronic form and format as agreed by the Plan and the individual. If the Plan and the individual are unable to agree on the form and format, the Plan will provide a paper copy of the information to the individual.

The Plan will send information to the participant by mail or email, as requested by the participant. However, if a participant asks to receive a copy of protected health information by unencrypted email, the Plan will provide a brief warning to the participant that there is some level of risk that the participant's protected health information could be read or otherwise accessed by a third party while in transit, and confirm that the participant still wants to receive protected health information by unencrypted email. If the participant says yes, the Plan will comply with the request. Because of the security risk, the Plan will not copy information onto participant-supplied storage media.

IV.B. Right to Amend Protected Health Information

If a participant believes that protected health information about the participant in a Designated Record Set is incorrect or incomplete, the participant may ask the Plan to amend the protected health information. The participant has the right to request an amendment for as long as the information is kept by or for the Plan. The request for amendment must be made in writing and submitted to the Plan's Privacy Official. In addition, the participant must provide a reason that supports the request. The Plan may deny the request for an amendment if it is not in writing or does not include a reason to support the request.

The Plan will act on the request as soon as possible, and within 60 days, after receiving the request. If the Plan is unable to act on the request within 60 days, it may extend the period for up to 30- additional days, provided that the Plan notifies the participant of the reason for the delay and the date it will act on the request during the original 60-day period.

In addition, the Plan may deny the request if the request is to amend information that—

- Was not created by the Plan, unless the participant provides a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
- Is not part of a Designated Record Set;
- Is not subject to the right of access described above; or
- Is accurate and complete.

If the Plan denies the request, it will provide the participant with a written explanation of the basis for the denial, the participant's right to file a statement of disagreement with the Plan, and the Plan's compliant procedures. Any future disclosures of the disputed information will include that statement.

IV.C. Right to Accounting of Disclosures

A Participant has the right to obtain an accounting of certain disclosures of his or her own protected health information. This right to an accounting extends to disclosures made in the last six years, other than disclosures:

- to carry out treatment, payment, or health care operations;
- to individuals about their own protected health information;
- incident to an otherwise permitted use or disclosure;
- pursuant to an authorization;
- to persons involved in the individual's care or payment for the individual's care or for certain other notification purposes;
- to correctional institutions or law enforcement when the disclosure was permitted without authorization;
- as part of a limited data set;
- for specific national security or law-enforcement purposes; or
- disclosures that occurred prior to the compliance date.

Participants shall be instructed to send their requests for an accounting to the Plan's Privacy Official. The Plan shall respond to an accounting request within 60 days. If the Plan is unable to provide the accounting within 60 days, it may extend the period by 30 days, provided that it gives the participant notice (including the reason for the delay and the date the information will be provided) within the original 60-day period.

The accounting must include the date of the disclosure, the name of the receiving party, a brief description of the information disclosed, and a brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure (or a copy of the written request for disclosure, if any). If a brief purpose statement is included in the accounting, it must be sufficient to reasonably inform the individual of the basis of the disclosure.

The first accounting in any 12-month period shall be provided free of charge. The Privacy Official may impose reasonable production and mailing costs for subsequent accountings.

IV.D. Requests for Alternative Communication Means or Locations

Participants may ask to receive communications regarding their protected health information by alternative means or at alternative locations. For example, participants may ask to be called only at work rather than at home. Participants shall be instructed to send their requests for alternative communication means or locations to the Plan's Privacy Official. The Plan may, but need not, honor such requests. The decision to honor such a request shall be made by the Privacy Official.

However, the Plan must accommodate such a request if the participant clearly states that the disclosure of all or part of the information could endanger the participant. The Privacy Official has responsibility for administering requests for confidential communications.

IV.E. Requests for Restrictions on Use and Disclosure of Protected Health Information

A participant may request restrictions on the use and disclosure of the participant's protected health information. Participants shall be instructed to send their requests for restrictions on uses and disclosures to the Plan's Privacy Official. The Plan may, but need not, honor such requests. However, the Plan will comply with a restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care facility/provider involved has been paid in full by the individual or another person, other than the Plan. The decision to honor restriction requests shall be made by the Privacy Official.

V. Reportable Breach Notification Policy

V.A. Introduction

This Reportable Breach Notification Policy is adopted by the Plan as part of the Plan's Privacy Policy and is intended to comply with the final HITECH regulations at 45 CFR §164.400 et seq. for breaches occurring on or after September 23, 2013 ("Breach Regulations").

Under the Breach Regulations, if a Reportable Breach of unsecured protected health information has occurred, the Plan must comply with certain notice requirements with respect to the affected individuals, HHS, and, in certain instances, the media.

V.B. Identifying a Reportable Breach

The first step is to determine whether a Reportable Breach has occurred. If a Reportable Breach has not occurred, the notice requirements do not apply.

The Privacy Official is responsible for reviewing the circumstances of possible breaches brought to his or her attention and determining whether a Reportable Breach has occurred in accordance with this Reportable Breach Notification Policy and the Breach Regulations. All Business Associates, and all workforce members who have access to protected health information, are required to report to the Privacy Official any incidents involving possible breaches.

Acquisition, access, use, or disclosure of unsecured protected health information in a manner not permitted under the privacy rules is presumed to be a Reportable Breach, unless the Privacy Official determines that there is a low probability that the privacy or security of the protected health information has been or will be compromised.

The Privacy Official's determination of whether a Reportable Breach has occurred must include the following considerations:

- *Was there a violation of HIPAA Privacy Rules?* There must be an impermissible use or disclosure resulting from or in connection with a violation of the HIPAA Privacy Rules by the Plan or a Business Associate of the Plan. If not, then the notice requirements do not apply.

- *Was protected health information involved?* If not, then the notice requirements do not apply.

- *Was the protected health information secured?* For electronic protected health information to be "secured," it must have been encrypted to NIST standards or destroyed. For paper protected health information to be "secured," it must have been destroyed. If yes, then the notice requirements do not apply.

- *Was there unauthorized access, use, acquisition, or disclosure of protected health information?* The violation of HIPAA Privacy Rules must have involved one of these. If it did not, then the notice requirements do not apply.

- *Does an exception apply?* The regulations contain three narrow exceptions to breach notification (described below).

- *Is there a low probability that privacy or security was compromised?* If the Privacy Official determines that there is only a low probability of compromise, then the notice requirements do not apply.

To determine whether there is only a low probability that the privacy or security of the protected health information was compromised, the Privacy Official must perform a risk assessment that considers at least the following factors:

- *The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification.* For example, did the disclosure involve financial information, such as credit card numbers, Social Security numbers, or other information that increases the risk of identity theft or financial fraud; did the disclosure involve clinical information such as a treatment plan, diagnosis, medication, medical history, or test results that could be used in a manner adverse to the individual or otherwise to further the unauthorized recipient's own interests.

- *The unauthorized person who used the protected health information or to whom the disclosure was made.* For example, does the unauthorized recipient of the protected health information have obligations to protect the

privacy and security of the protected health information, such as another entity subject to the HIPAA privacy and security rules or an entity required to comply with the Privacy Act of 1974 or the Federal Information Security Management Act of 2002, and would those obligations lower the probability that the recipient would use or further disclose the protected health information inappropriately? Also, was the protected health information impermissibly used within a covered entity or business associate, or was it disclosed outside a covered entity or business associate?

- *Whether the protected health information was actually acquired or viewed.* If there was only an opportunity to actually view the information, but the Privacy Official determines that the information was not, in fact, viewed, there may be a lower (or no) probability of compromise. For example, if a laptop computer with was lost or stolen and subsequently recovered, and the Privacy Official is able to determine (based on a forensic examination of the computer) that none of the information was actually viewed, there may be no probability of compromise.

- *The extent to which the risk to the protected health information has been mitigated.* For example, if the Plan can obtain satisfactory assurances (in the form of a confidentiality agreement or similar documentation) from the unauthorized recipient of that the information will not be further used or disclosed or will be destroyed, the probability that the privacy or security of the information has been compromised may be lowered. The identity of the recipient (e.g., another covered entity) may be relevant in determining what assurances are satisfactory.

If the Privacy Official determines that there is only a low probability that the privacy or security of the information was compromised, then the Plan will document the determination in writing, keep the documentation on file, and not provide notifications. On the other hand, if the Privacy Official is not able to determine that there is only a low probability that the privacy or security of the information was compromised, the Plan will provide notifications.

If an exception applies, then a Reportable Breach has not occurred, and the notice requirements are not applicable.

- *Exception 1:* A Reportable Breach does not occur if the breach involved an unintentional access, use, or acquisition of protected health information by a workforce member or Business Associate, if the unauthorized access, use, acquisition, or disclosure (a) was in good faith; (b) was within the scope of authority of the workforce member or Business Associate; and (c) does not involve further use or disclosure in violation of the HIPAA privacy rules. For example, the exception might apply if an employee providing administrative services to the Plan were to access the claim file of a participant whose name is similar to the name of the intended participant; but if the same employee intentionally looks up protected health information of his neighbor, the exception does not apply.

- *Exception 2:* A Reportable Breach has not occurred if the breach involved an inadvertent disclosure from one person authorized by the Plan to have access to protected health information to another person at the same covered entity or Business Associate also authorized to have access to the protected health information, provided that there is no further use or disclosure in violation of the HIPAA privacy rules. For example, the exception might apply if an employee providing administrative services to the Plan inadvertently emailed protected health information to the wrong co-worker; but if the same employee emailed the information to an unrelated third party, the exception likely does not apply.

- *Exception 3:* A Reportable Breach has not occurred if the breach involved a disclosure where there is a good faith belief that the unauthorized person to whom the disclosure was made would not reasonably have been able to retain the protected health information. For example, the exception may apply to an EOB mailed to the wrong person and returned to the Plan unopened, or if a report containing protected health information is handed to the wrong person, but is immediately retrieved before the person can read it. However, the exception does not apply if an EOB was mailed to the wrong person and the unintended recipient opened the envelope before realizing the mistake.

V.C. If a Reportable Breach Has Occurred: Notice Timing and Responsibilities

If the Privacy Official determines that a Reportable Breach has occurred, the Privacy Official will determine (in accordance with the Breach Regulations) the date the breach was discovered in order to determine the time periods

for giving notice of the Reportable Breach. The Plan has reasonable systems and procedures in place to discover the existence of possible breaches, and workforce members are trained to notify the Privacy Official or other responsible person immediately so the Plan can act within the applicable time periods.

The Privacy Official is responsible for the content of notices and for the timely delivery of notices in accordance with the Breach Regulations. However, the Privacy Official may, on behalf of the Plan, engage a third party (including a Business Associate) to assist with preparation and delivery of any required notices.

The Breach Regulations may require a breach to be treated as discovered on a date that is earlier than the date the Plan had actual knowledge of the breach. The Privacy Official will determine the date of discovery as the earlier of- (1) the date that a workforce member (other than a workforce member who committed the breach) knows of the events giving rise to the breach; and (2) the date that a workforce member or agent of the Plan, such as a Business Associate (other than the person who committed the breach) would have known of the events giving rise to the breach by exercising reasonable diligence.

Except as otherwise specified in the notice sections that follow, notices must be given "without unreasonable delay" and in no event later than 60 calendar days after the discovery date of the breach. Accordingly, the investigation of a possible breach, to determine whether it is a Reportable Breach and the individuals who are affected, must be undertaken in a timely manner that does not impede the notice deadline.

There is an exception to the timing requirements if a law-enforcement official asks the Plan to delay giving notices.

V.D. Business Associates

If a Business Associate commits or identifies a possible Reportable Breach relating to Plan participants, the Business Associate must give notice to the Plan. The Plan is responsible for providing any required notices of a Reportable Breach to individuals, HHS, and (if necessary) the media.

Unless otherwise required under the Breach Regulations, the discovery date for purposes of the Plan's notice obligations is the date that the Plan receives notice from the Business Associate.

In its Business Associate contracts, the Plan will require Business Associates to-

- report incidents involving breaches or possible breaches to the Privacy Official in a timely manner;
- provide to the Plan any and all information requested by the Plan regarding the breach or possible breach, including, but not limited to, the information required to be included in notices (as described below); and
- establish and maintain procedures and policies to comply with the Breach Regulations, including workforce training.

V.E. Notice to Individuals

Notice to the affected individual(s) is always required in the event of a Reportable Breach. Notice will be given without unreasonable delay and in no event later than 60 calendar days after the date of discovery (as determined above).

V.E.1. Content of Notice to Individuals

Notices to individuals will be written in plain language and contain all of the following, in accordance with the Breach Regulations:

- A brief description of the incident.
- If known, the date of the Reportable Breach and the Discovery Date.
- A description of the types of unsecured protected health information involved in the Reportable Breach (for

example, full name, Social Security numbers, address, diagnosis, date of birth, account number, disability code, or other).

- The steps individuals should take to protect themselves (such as contacting credit card companies and credit monitoring services).

- A description of what the Plan is doing to investigate the Reportable Breach, such as filing a police report or reviewing security logs or tapes.

- A description of what the Plan is doing to mitigate harm to individuals.

- A description of what measures the Plan is taking to protect against further breaches (such as sanctions imposed on workforce members involved in the Reportable Breach, encryption, installation of new firewalls).

- Contact information for individuals to learn more about the Reportable Breach or ask other questions, which must include at least one of the following: Toll-free phone number, email address, website, or postal address.

V.E.2. Types of Notice to Individuals

The Plan will deliver individual notices using the following methods, depending on the circumstances of the breach and the Plan's contact information for affected individuals.

Actual Notice will be given in all cases, unless the Plan has insufficient or out-of-date addresses for the affected individuals. Actual written notice-

- will be sent via first-class mail to last known address of the individual(s);

- may be sent via email instead, if the individual has agreed to receive electronic notices;

- will be sent to the parent on behalf of a minor child; and

- will be sent to the next-of-kin or personal representative of a deceased person, if the Plan knows the individual is deceased and has the address of the next-of-kin or personal representative.

Substitute Notice will be given if the Plan has insufficient or out-of-date addresses for the affected individuals.

- If addresses of fewer than ten living affected individuals are insufficient or out-of-date, substitute notice may be given by telephone, an alternate written notice, or other means.

- If addresses of ten or more living affected individuals are insufficient or out-of-date, substitute notice must be given via either website or media.

  - *Substitute notice via website.* Conspicuous posting on home page of the website of the Plan or Plan Sponsor for 90 days, including a toll-free number that remains active for at least 90 days where individuals can learn whether the individual's unsecured information may have been included in the breach. Contents of the notice can be provided directly on the website or via hyperlink.

  - *Substitute notice via media.* Conspicuous notice in major print or broadcast media in the geographic areas where the affected individuals likely reside, including a toll-free number that remains active for at least 90 days where individuals can learn whether the individual's unsecured information may have been included in the breach. It may be necessary to give the substitute notice in both local media outlet(s) and statewide media outlet(s) and in more than one state.

- Substitute Notice is not required if the individual is deceased and the Plan has insufficient or out-of-date information that precludes written notice to the next-of-kin or personal representative of the individual.

Urgent Notice will be given, in addition to other required notice, in circumstances where imminent misuse of unsecured protected health information may occur. Urgent notice must be given by telephone or other appropriate means.

- Example: Urgent notice is given to an individual by telephone. The Plan must also send an individual notice via first-class mail.

V.F. Notice to HHS

Notice of all Reportable Breaches will be given to HHS. The time and manner of the notice depends on the number of individuals affected. The Privacy Official is responsible for both types of notice to HHS.

Immediate Notice to HHS. If the Reportable Breach involves 500 or more affected individuals, regardless of where the individuals reside, notice will be given to HHS without unreasonable delay, and in no event later than 60 calendar days after the date of discovery (as determined above). Notice will be given in the manner directed on the HHS website.

Annual Report to HHS. The Privacy Official will maintain a log of Reportable Breaches that involve fewer than 500 affected individuals, and will report to HHS the Reportable Breaches that were discovered in the preceding calendar year. The reports are due within 60 days after the end of the calendar year. The reports will be submitted as directed on the HHS website.

V.G. Notice to Media (Press Release)

Notice to media (generally in the form of a press release) will be given if a Reportable Breach affects more than 500 residents of any one state or jurisdiction. For example:

- If a Reportable Breach affects 600 individuals who are residents of Oregon, notice to media is required.

- If a Reportable Breach affects 450 individuals who are residents of Oregon and 60 individuals who are residents of Idaho, notice to media is not required.

If notice to media is required, notice will be given to prominent media outlets serving the state or jurisdiction. For example:

- If a Reportable Breach involves residents of one city, the prominent media outlet would be the city's newspaper or TV station.

- If a Reportable Breach involves residents of various parts of the state, the prominent media outlet would be a statewide newspaper or TV station.

- If a Reportable Breach affects 600 individuals who are residents of Oregon, and 510 individuals who are residents of Washington, notice to media in both states is required.

If notice to media is required, it will be given without unreasonable delay, and in no event more than 60 calendar days after the date of discovery (as determined above). The content requirements for a notice to media are the same as the requirements for a notice to individuals. The Privacy Official is responsible for giving notice to media.

APPENDIX E – INTERNATIONAL REGISTERED NURSES' EFFECTIVE DATE OF COVERAGE

The following provisions are part of the *Plan*, but are maintained separately in this Appendix C. As with all provisions of the *Plan*, the *plan administrator* has the discretionary authority to interpret this Appendix C and to make eligibility and benefit determinations as the *plan administrator* may determine in the *plan administrator*'s sole discretion.

For newly-hired international registered nurses who will enter the United States on a work visa or green card to work for a *participating employer*, the *Plan*'s waiting period will be waived and, rather than having an effective date for coverage as specified in the Waiting Period and Effective Date section of this Summary Plan Description, each such international nurse (and the *eligible dependents* of such nurse) will have an effective date of coverage that is his/her first day of *active employment*, as long as such international nurse completes enrollment in the *Plan* in accordance with the provisions of this Summary Plan Description no later than 30 days after the first day of *active employment*. Coverage for the nurse's *eligible dependents* who are properly enrolled within those 30 days will also begin effective as of the nurse's first day of *active employment*.

APPENDIX F – WELLRITHMS SHIELD PROGRAM AND SHIELD SERVICES

The *Plan* has partnered with WellRithms, Inc. to provide Shield Services (as defined below) and act as the Subject Medical Claim Administrator ("SMBA") on behalf of the *Plan Administrator* for certain Assigned Claims (as defined below). The SMBA will assist *Enrollees* who receive a balance bill for an Assigned Claim(s). As the SMBA, WellRithms is a limited co-fiduciary of the *Plan* and has ultimate discretionary authority to reprice and resolve a balance bill on behalf of the *Plan* and/or *Enrollee*. If the *Plan* assigns a claim to WellRithms, the member will receive communication from WellRithms explaining the process. In the event an *Enrollee* receives a balance bill for an Assigned Claim, please immediately email WellRithms at smba@wellrithms.com or call 971-213-4209.

Responsibilities of the Plan Administrator and Subject Medical Claim Administrator related to Shield Services

Notwithstanding any provision of the *Plan* to the contrary, the *Plan Administrator* has assigned limited co-fiduciary authority to WellRithms, Inc. to act as the SMBA. The limited co-fiduciary authority allocated to the SMBA is limited to claims that are assigned to the SMBA by the *Plan Administrator* and accepted by the SMBA ("Assigned Claims"). This limited fiduciary authority involves the repricing of Assigned Claims. The SMBA has ultimate authority to review, reprice, and resolve Assigned Claims based on the Sustainable Claims Pricing ("SCP") methodology.

For Assigned Claims that are appealed under the *Plan's* claim filing procedure, the SMBA has the limited co-fiduciary authority, assigned to it by the *Plan Administrator*, to respond to all such internal appeals of adverse benefit determinations. The SMBA, or its designee, will review and respond to all appeals in accordance with the applicable *Plan* provisions and applicable law.

Claim Filing Procedure – Assigned Claims for Shield Services

For all Assigned Claims submitted to the SMBA, either directly by the *Plan Administrator* or through the claims administrator, the SMBA is granted limited co-fiduciary authority to review and respond to internal appeals of adverse benefit determination(s) that are received by the SMBA. The SMBA, or its designee, will review and respond to all such claims in accordance with the applicable *Plan* provisions and applicable law.

Exclusions

The following is a list of exclusions added to the *Plan* to the extent necessary to administer this Appendix G and the Wellrithms Shield Program and Shield Services.

1. Charges in excess of the *Reasonable and Allowable Amount*, which means charges that are considered Errors, Invalid Charges, Excess Charges, or Unbundling, each as defined by this Appendix G.
2. Charges that are not included in the Sustainable Claims Pricing (SCP) methodology.

Definitions

This section contains defined terms that are only applicable for the purposes of this Appendix G or to the extent necessary to administer the Wellrithms Shield Program and Shield Services.

Assigned Claim means a medical claim that has been submitted by the *Plan* and accepted by WellRithms and meets all of the requirements as set forth by WellRithms for Shield Services.

Balance Bill means a medical provider's invoice for a *Covered Service* which was found to be in excess of the *Reasonable and Allowable Amount*.

Bill Review means a review of claiming documentation and related medical records undertaken to uncover any Invalid Charges or Excess Charges, as necessary and sufficient to allow the *Plan Administrator* to reasonably assess the accuracy and validity of billed charges submitted in connection with a claim and to make determinations as to whether any such charges exceed the *Reasonable and Allowable Amount*.

Errors means charges based on claiming mistakes, improprieties or illegitimate claiming entries, including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or services not actually rendered or performed, or charges otherwise determined to be invalid, impermissible or improper based on any applicable law, regulation, guidelines, rule or professional standard; it is in the *Plan Administrator's* sole discretion to determine what constitutes an Error under the terms of the *Plan*.

Excess Charge(s) means a charge or portion thereof billed for care and treatment of an *Illness* or *Injury* that is not payable under the *Plan* because it exceeds the *Reasonable and Allowable Amount*, or is determined by the *Plan Administrator* to be based on Invalid Charges or Errors in accordance with the terms of the *Plan*.

Invalid Charge(s) means charges (a) that are found to be based on Errors, Unbundling, misidentification or unclear description; (b) charges for fees or services determined not to have been *Medically Necessary* or reasonable; (c) charges found by the *Plan Administrator* to be in excess of the *Reasonable and Allowable Amount*, or (d) charges that are otherwise determined by the *Plan Administrator*, or its designee, to be invalid or impermissible based on any applicable law, regulation, guideline, rule or professional standard.

Subject Medical Claim Administrator ("SMBA") means WellRithms, Inc. is the Subject Medical Claim Administrator, and has the limited co-fiduciary authority to review, repricing, and resolve certain Assigned Claims.

Sustainable Claims Pricing ("SCP") means a method of repricing utilized by WellRithms, Inc. for claims, grounded in English common law principles of quantum meruit, which takes into consideration reasonable industry standards and local market realities.

Unbundling means charges for any items billed separately that are customarily included in a global claiming procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) the Healthcare Common Procedure Coding System (HCPCS), and/or the National Correct Coding Initiative (NCCI) codes used by CMS.

WellRithms Shield Services ("Shield Services") means the review, repricing, and resolution services provided by WellRithms, Inc. for Assigned Claims.

APPENDIX G – GLP-1 DIRECT FUND

Effective August 1, 2026, the *Plan* provides coverage for certain GLP-1 medications formulated for weight loss exclusively through the GLP-1 Direct Fund program provided by Ray Savings Solutions. The GLP-1 Direct Fund allows you to access your medication at a low cost through manufacturer-supported self-pay channels, rather than through the pharmacy benefit at your regular retail or mail-order pharmacy.

As of August 1, 2026, GLP-1 medications formulated for weight management will no longer be available through the *Plan's* pharmacy benefit. Instead, you will obtain your medication directly from the drug manufacturer's self-pay program. This means your medication may be shipped directly to you, or you may pick it up at a pharmacy that participates in the manufacturer's self-pay program. If you choose to fill your prescription at a retail or mail-order pharmacy instead, you will be responsible for the full cost of the medication.

If your physician prescribes a GLP-1 medication to treat a condition other than weight loss, but the specific medication prescribed is formulated primarily for weight loss, you must still obtain it through the GLP-1 Direct Fund.

To participate in the GLP-1 Direct Fund, you must enroll with the manufacturer and apply for a pre-funded Visa card through our payment vendor, Paytient. Each month, the Plan will load your Visa card with funds sufficient to cover the cost of your medication. You will pay no more than $45 per monthly medication fill, and the Plan will pay for the remaining cost of the medication. To receive next month's funding on your card, you must pay your $45 copayment.

Please note that your $45 monthly copayment under the GLP-1 Direct Fund does not count toward your annual pharmacy deductible or out-of-pocket maximum.

If your pre-funded debit card is not used for 100 consecutive days, the card will become inactive.

To enroll in the GLP-1 Direct Fund, visit beam.raysavings.com/Adventist. If you have any questions about your account or if you need to reactivate your card, contact Ray Savings Solutions Member Services at 800-472-2635.