RESHARP

REGIONAL CONFERENCE SUPPLEMENTAL HEALTHCARE ADVENTIST RETIREMENT PLAN

PLAN DOCUMENT
AND SUMMARY PLAN DOCUMENT

EFFECTIVE JANUARY 1, 2024

7000 Adventist Boulevard
Huntsville, AL 35896

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Introduction

The Seventh-day Adventist® Regional Conferences of the North American Division (Regional Conference) offers a healthcare assistance plan for certain retirees and their eligible spouses and eligible dependent children through the Regional Conference Supplemental Healthcare Adventist Retirement Plan (the Plan or RESHARP). The Regional Conference (the plan administrator of this Plan), its delegate Adventist Risk Management, Inc. ("ARM"), and ARM's representatives and delegates administer the Plan. When the term "plan administrator" is used in this Plan, it generally refers to ARM as the delegate of the Regional Retirement Office.

This document describes the Plan for the 2024 Plan Year. Capitalized terms used in this document are defined in the Glossary.

Under RESHARP, retirees will automatically participate in the following Plan Options, once enrolled:

- **MCx Option** (Medicare Extension),
- **DVH Optio**n (Dental, Vision and Hearing), and
- **Rx Option** (Prescription Drugs Enhancement).

Eligible Spouses may participate in RESHARP as described in the Spouse Eligibility section below. Dependent children are not eligible to participate in the Plan Options, but Eligible Retirees may be eligible to receive a payment to assist in paying for health coverage for dependent children through another medical plan. Dependent healthcare assistance payments are available as described in the Dependent Children Eligibility section below.

Coordination with Medicare

The Plan requires eligibility for and enrollment in original Medicare (Parts A and B). Medicare requires U.S. residency. The Plan is not a qualified 'Medicare supplemental coverage' plan as administered by various insurance companies (Medicare Advantage and MediGap plans) and regulated by states, generally designated as plans A–N of Medicare.

The Plan Options are described later in this booklet. The Plan prohibits concurrent enrollment in a Medicare Part D program.

Medicare health insurance is available to individuals who are age 65 even if their "normal" retirement age is at a later date.

Information about Medicare enrollment, service and benefits can be obtained at the Medicare website, www.medicare.gov or by calling Medicare at **1-800-633-4227**.

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

Retirees Share in Plan Costs

The Regional Retirement Office pays part of the cost for Plan coverage. This is based primarily on years of

qualifying church service credit and the policies in place at retirement as described in the Earned Credit section. Eligible Retirees pay the remainder of the cost.

Enrollment is Important

There is no automatic enrollment in the Plan. Retirees who do not complete the enrollment form will not be eligible for assistance with health care costs as sent by the Regional Retirement Office. A sample enrollment form is included at the end of this booklet.

It is important to read this document carefully to fully understand the limits of coverage under the Plan and then determine if enrollment in RESHARP makes sense for the Eligible Retiree and the Eligible Spouse.

Eligibility

Retiree Eligibility

To be an Eligible Retiree, a retiree must:

1. Be enrolled in Medicare Parts A and B;
2. Have at least 15 years of Retirement Plan Service (as defined in the Glossary); and
3. Be a beneficiary of the Regional Retirement Plan.

An Eligible Retiree who is:

1. Less than age 65 may not select coverage under the Plan.
2. Less than age 65 but is enrolled for Medicare Parts A and B because of a disability or other reason, may enroll in the Plan.
3. Age 65 or older may enroll in the Plan.

Spouse Eligibility

To be an Eligible Spouse under the Plan, an individual must:

1. Be married to the Eligible Retiree at least one year prior to the Eligible Retiree's retirement date and on the retirement date;
2. Be enrolled in Medicare Parts A and B; and
3. Be covered for a joint and survivor (J&S) annuitant spouse benefit by the Eligible Retiree under the Regional Retirement Plan, or be eligible under the special rules described in the section on Special Enrollment Rights—Family Status Cha.

An Eligible Spouse who is:

1. Less than age 65 may not select coverage under the Plan.
2. Less than age 65, but enrolled for Medicare Parts A and B because of disability or other reason, may enroll in the Plan.
3. Age 65 or older may enroll in the Plan.

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

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

The Plan reserves the right to review and approve a spouse's eligibility upon receiving a request to enroll a spouse in the Plan.

Dependent Children Eligibility

An Eligible Retiree may receive dependent healthcare assistance payments to use to pay for other medical coverage for his or her Eligible Dependent children, but dependent children are not eligible to participate in the Plan Options. An Eligible Dependent is:

1. The child (including a child born to you and/or your spouse, adopted child or child under legal guardianship) of an Eligible Retiree or Eligible Spouse prior to the date of the Eligible Retiree's retirement, or a child who becomes eligible under the special rules described in the section on Special Enrollment Rights – Family Status Changes;
2. Under age 26, or a disabled child, if that child is determined to be disabled prior to attaining age 26; and
3. Covered by the Regional Conference active employee medical insurance plan for at least five years prior to the retirement of the Eligible Retiree; and
4. The child of an Eligible Retiree with or the child of the Eligible Spouse of an Eligible Retiree with at least fifteen years of Retirement Plan Service.

An Eligible Dependent described above shall remain an Eligible Dependent for 60 days following the death of the Eligible Retiree (or the second to die of both the Eligible Retiree and Eligible Spouse) and shall continue to receive dependent healthcare assistance payments until the end of such 60 days (unless such Eligible Dependent otherwise ceases to meet the requirements to be an Eligible Dependent during such time period). An Eligible Dependent described above shall cease to be eligible for dependent healthcare assistance payments when he/she attains age 26, except in circumstances where the child over age 26 is disabled and was determined to be disabled prior to attaining age 26. A dependent child of an Eligible Retiree or Eligible Spouse who is not covered under Medicare is generally eligible for dependent healthcare assistance payments while under age 26 (without regard to disability status).

The amount of dependent healthcare assistance payments is determined as described in the Earned Credit section below.
The Eligible Retiree (or Eligible Spouse) is responsible for independently obtaining and paying for health insurance coverage for their Eligible Dependent(s) through the federal healthcare Marketplace. The Eligible Retiree (or Eligible Spouse) must submit proof of coverage and payment to the Regional Retirement Office to receive their monthly dependent healthcare assistance payments. Proof of coverage and payment must be submitted at least once every six months, but may be submitted monthly or quarterly.

Eligibility Exclusions

1. Beneficiaries of the Supplemental Healthcare Adventist Retirement Plan (SHARP) are not eligible to participate in this Plan.
2. The Plan is not available to individuals who reside outside of the United States.

Enrollment and Enrollment Changes

The effective date for Plan coverage is generally the first day of the month in which the Eligible Retiree completes the enrollment form for themselves and any Eligible Spouse. Enrollment in the Plan requires eligibility for and enrollment in original Medicare (Parts A and B). An Eligible Retiree who wishes to claim dependent healthcare assistance payments must also provide the Regional Retirement Office with proof that the Eligible Retiree has obtained coverage for Eligible Dependents through the federal healthcare Marketplace. Visit HealthCare.gov for information on how to enroll your dependent children in Marketplace coverage.

Without completed and signed enrollment form from the Eligible Retiree or timely submitted proof of marketplace coverage for Eligible Dependents, as applicable, healthcare assistance will not be provided under the Plan.

Enrollment Changes

Each Eligible Retiree and Eligible Spouse may choose to enroll in the Plan at any time once the Eligible Retiree has retired and the Eligible Retiree or Eligible Spouse who is seeking to enroll has attained age 65 (or otherwise become eligible for Medicare). The effective date for Plan coverage is generally the first day of the month in which the enrollment form has been completed and submitted to the Regional Retirement Office.

An enrolled Eligible Retiree or Eligible Spouse may choose to cancel their enrollment in the Plan at any time by notifying the Regional Retirement Office prior to the date the Eligible Retiree or Eligible Spouse wishes to disenroll in the Plan. Coverage under the Plan will end on the date the Eligible Retiree or Eligible Spouse identifies as their final day of coverage in their request to the Regional Retirement Office to disenroll. If an Eligible Retiree or Eligible Spouse fails to notify the Regional Retirement Office prior to the date they wish to disenroll in the Plan, the cancellation date may be delayed.

> **IMPORTANT NOTE:** If no action is taken to cancel enrollment in the Plan, an Eligible Retiree's and Eligible Spouse's coverage will generally remain in effect during the life of the Eligible Retiree and the Eligible Spouse.

Loss of Other Coverage

For the purposes of the Plan, a "loss of other coverage" means an involuntary loss of other coverage in any one of the following events:

(i) loss of eligibility for coverage due to termination of employment (such as an Eligible Spouse's termination of employment),

(ii) a significant premium increase (over 25% per current plan year) by the sponsor of the other coverage,

(iii) a move by the Eligible Retiree or Eligible Spouse from the covered territory of the other coverage, or

(iv) the company providing the other coverage withdraws from the market.

"Loss of other coverage" does not include the voluntary decision of an Eligible Spouse to terminate other healthcare coverage except for a reason described in (iii) above.

The Eligible Retiree must notify the Regional Retirement Office of a "loss of other coverage" within 30 days.

In the case of an Eligible Retiree who is currently working within Retirement Plan guidelines for an employer that is participating in the Regional Retirement Plan, a "loss of other coverage" also includes a loss of

eligibility for coverage as a result of legal separation, divorce, death or reduction in the number of hours of employment.

Special Enrollment Rights—Changes in Family Status

An Eligible Retiree may enroll his/her newly married Eligible Spouse in the Plan or seek dependent healthcare assistance payments for an Eligible Dependent as a "special enrollee" if any one of the qualifying events happens:

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

If any one of these events happens, the Eligible Retiree should enroll the newly acquired non-Eligible Spouse and/or notify the Regional Retirement Office of the Eligible Dependent promptly after the qualifying event..

*If an Eligible Retiree has enrolled an ex-spouse in the Plan as described under "Impact of Divorce" below, then the Eligible Retiree may not enroll a new spouse upon marriage.

Discretionary Special Enrollment

The Board may find it necessary to make significant changes to the Plan. Should this occur, the Plan may provide an opportunity to change enrollment under the Plan.

High Inflation Special Enrollment

Healthcare costs can increase significantly. The Board reserves the right to increase contributions with appropriate notice. If the three-year average percentage increase of the retiree contributions exceeds the percentage increase in the Consumer Price Index (CPI-U) for the previous year, the Plan may allow a special enrollment period in which Eligible Retirees are permitted to disenroll from the Plan.

Impact of Divorce

If an Eligible Retiree divorces prior to retirement, then the Eligible Retiree's former spouse is not eligible for enrollment in the Plan unless there is a court order requiring coverage for the ex-spouse. If an Eligible Retiree and Eligible Spouse divorce following the Eligible Retiree's retirement and at a time that the Eligible Spouse is enrolled in the Plan, then the Eligible Spouse may continue to participate in the Plan. In either situation, the Earned Credit for the former spouse will be based on the Retiree's years of Retirement Plan Service.

Medicare Part D

his Plan prohibits concurrent enrollment in a Medicare Part D plan. If the Plan discovers that an enrollee is also enrolled in a Medicare Part D prescription drug plan, that enrollee will be terminated from the Plan.

Re-Employment

If an Eligible Retiree or Eligible Spouse returns to full-time employment subsequent to enrollment in the Plan and becomes eligible for employer sponsored healthcare coverage, the Plan requires the Eligible Retiree and/or Eligible Spouse to terminate benefits in the Plan, and dependent healthcare assistance payments will cease. To be reinstated into the Plan, a written request, with documentation of loss of coverage, must be submitted to the Regional Retirement Office within 30 days of the loss of other coverage.

Surviving Retiree or Eligible Spouse

pon the death of either the covered Eligible Retiree or Eligible Spouse/Eligible Dependent, the Plan will stop taking deductions and/or making dependent healthcare assistance payments for the deceased beneficiary.

Your Responsibility to Report Family Changes

Since the Regional Retirement Office may be unaware of family changes that might affect you and your family member's eligibility for the Plan or the proper administration of the Plan, it is your responsibility to report change in eligibility of general family or other status to the Regional Retirement Office within 30 days of the change. Failure to do so may hamper the Regional Retirement Office's ability to effectively administer benefits under the Plan. Examples of the types of changes that you must report are: marital status changes such as divorce, full time employment, loss of disability status of a dependent child, change in address/ telephone number, eligibility for Medicaid assistance.

Earned Credit

Earned Credit—In General

An Earned Credit is calculated for Eligible Retirees based on years of Retirement Plan Service. The Earned Credit is the monthly amount that is made available to assist an Eligible Retiree with the costs of the Plan Options or as dependent healthcare assistance payments.

For coverage under the Plan, each Eligible Retiree (and each Eligible Spouse) will receive his/her own Earned Credit. That means that if both the Eligible Retiree and Eligible Spouse are covered under the Plan, they will each receive an Earned Credit for the Plan.

The Earned Credit is applied to the total cost of the Plan Options in which the Eligible Retiree (and each Eligible Spouse) is enrolled. For the portion of the Plan Options that exceed the Earned Credit, the balance will be withheld from the Eligible Retiree's monthly retirement benefits (or direct billing arrangements are made if no retirement benefit is available). Earned Credit under the Plan may only be used for the Plan.

For dependent healthcare assistance payments, Earned Credits are based on the Eligible Retiree's years of Retirement Plan Service.

An Eligible Spouse will qualify for an Earned Credit only when the Eligible Retiree qualifies for an Earned Credit. Dependent healthcare assistance payments will only be made if the Eligible Retiree qualifies for an Earned Credit.

Determining the Earned Credit Category

The category in the Earned Credit Table is determined based on the sum of years of Retirement Plan Service.

If a retiree was with the Regional Conference as of January 1, 2000 and signed a Regional Conference Employee Acknowledgement and Release to have all of their years of service count towards the Regional Retirement Plan, then their eligible NAD and/or Bermuda years of service are counted towards their overall years of service with the Regional Retirement Plan.

Earned Credit Table for 2024

Retirement Plan Service Credit	30+ Yrs.	26–29 Yrs.	22–25 Yrs.	18–21 Yrs.	15–17 Yrs.
CATEGORY	A	B	C	D	E
Plan Coverage (Eligible Retiree and Eligible Spouse)	$225	$205	$184	$164	$144
Retirement Plan Service Credit	**30+ Yrs.**	**26–29 Yrs.**	**22–25 Yrs.**	**18–21 Yrs.**	**15–17 Yrs.**
CATEGORY	A	B	C	D	E
Dependent healthcare assistance payments (Eligible Dependents)	$225	$205	$184	$164	$144

Claiming Dependent Healthcare Assistance Payments

If you qualify for dependent healthcare assistance payments and timely enrolled your Eligible Dependent or Dependents in Marketplace coverage, then you are eligible for dependent care reimbursement payments up to the amount determined under the Earned Credit Table above. To claim the dependent healthcare assistance payments, you must submit proof of Marketplace coverage premium payments to the Regional Retirement Office. We prefer that you submit reimbursement requests every six months but will accept reimbursement as often as monthly. In all events, you must submit a request for reimbursement no later than twelve months from the date of the expense.

Schedule of Plan Benefits

JANUARY 1, 2024 TO DECEMBER 31, 2024

Medicare will pay amounts per Medicare guidelines for the current year.		
SERVICE	**MCx Option**	
	RESHARP Pays	**You Pay**
Deductibles	Balance of Medicare approved expenses	$0
Hospital Expenses	Days 1–150: Balance of Medicare approved expenses	$0 (For Medicare approved days)
Semi-Private Room & Board, General Nursing & Miscellaneous Services & supplies[1]	Over 150 days: $0	All costs
Skilled Nursing Facility[2]	Days 1–100: Balance of Medicare approved expenses	$0 (For Medicare approved days)
Semi-Private Room & Board, General Nursing & Miscellaneous Services & supplies	Days over 100: $0	All costs
Outpatient Medical Services		
Outpatient services	Balance of Medicare approved expenses	$0
Blood (first 3 pints)	Balance of Medicare approved expenses	$0
Colostomy/Ileostomy Supplies	80%	20%
Medical Supplies	80% up to $500/yr	20%
Mental Health	$0	20%
Hospice Care[3]	Balance of Medicare approved expenses	$0
Home IV Therapy	Balance of Medicare approved expenses	20%
Foreign Travel Emergency $1000 deductible	80% up to $50,000/yr	20%
Orthotics/Orthopedic Shoes	80% up to $600/yr	20%

[1] Services not approved by Medicare will be denied by the Plan.
[2] Custodial Care and Nursing Home expenses are not covered.
[3] Physician must certify as a terminal illness.

Dental, Vision, Hearing

SERVICE	DVH — Dental, Vision, Hearing Options		
	Annual Plan Payment Limit	**RESHARP Pays**	**You Pay**
Dental	$2,200 person/year	80%	20%
Vision	$400 person/year	80%	20%
Hearing	$2,200 person/year	80%	20%

Prescription

	RX Option (Prescription Drug)		
	RESHARP Pays	**You Pay**	
Deductible	$0	$200	
		Retail 30-day Copay[1]	**Mail 90-day Copay[1]**
Generic Drugs	After Deductible is met, cost of the medication less your copay, unless the drug costs less than your copay	$12	$29
Preferred Brand Drugs		$29	$70
Non-Preferred Brand Drugs		$45	$110
Preventive Vaccinations	100%	$0	N/A
[1] Plus costs resulting from non-compliance with plan rules			

The prescription drug benefit only covers formulary supplies/services received from Express Scripts, Inc. (ESI) or from a pharmacy contracted with ESI.

Maintenance prescriptions up to a 90-day supply are available only via Walgreen's smart 90 program, Express Scripts home delivery, or Accredo specialty pharmacy.

Preventive prescriptions drugs are 100% covered by the plan (and Eligible Retiree or Eligible spouse pay $0) when provided by ESI or a pharmacy contracted with ESI (as described under Preventive Care Services —Prescription Drugs in Appendix A).

Specialty drugs can only be filled via mail order through Accredo Specialty Pharmacy (see **www.accredo.com** for details). The co-payment for specialty drugs is the same as other traditional prescription drugs as listed in the chart above, with the exception for drugs available through the SaveonSP specialty drugs program.

SaveonSP Specialty Drug list may be found at **www.saveonsp.com/adventistrisk**

Coinsurance for Saveon SP drugs is set at 30%. However, if an Eligible Retiree or Eligible Spouse signs up for the SaveonSP Program, their out-of-pocket cost will be set by the Plan at $0 and they will not be required to pay anything for the drug. If an Eligible Retiree or Eligible Spouse does not sign up for the SaveonSP Program, then they will not have their out-of-pocket cost set by the Plan at $0 and will have to pay a high coinsurance (30%) for the drug (which is eligible for assistance from the drug manufacturer).

Standard Plan Options and Costs

As noted above, an Eligible Retiree who elects to participate in the Plan will automatically be enrolled in the MCx Option, DVH Option and Rx Option.

The deductibles, payment percentages and other limits for each Plan Option are illustrated on the Schedule of Plan Benefits on the preceding page.

The **MCx Option** has ***no*** annual deductible. The provisions of the Plan do not restrict members to seeking services within a provider network.

Plan Options are provided at **$355/month/perso**n in 2024.

The Plan requires enrollment in original Medicare Part A and Part B. A retiree who does not enroll in Medicare Part B will not be reimbursed on Part B claims. Except in the case of certain preventive care services described in Appendix A, Medicare must first approve the medical service and the amounts charged and pay its portion before Plan reimbursement will be made. **If Medicare does not approve an expense, the Plan does not cover the expense.** Current information about Medicare can be obtained at the Medicare website; www.medicare.gov or by calling Medicare at 1-800-633-4227.

Medical Benefits: MCx Option

Covered Expenses

The MCx Option generally supplements Medicare Parts A and B to provide protection from catastrophic medical expenses. Although the nature and amount of covered expenses are generally determined by Medicare, the Plan pays a few items differently from Medicare. (see the Schedule of Benefits)

The Plan generally provides reimbursement for Medicare Part A (hospital) deductible and the Medicare Part B (medical/outpatient) deductible and co-insurance for Medicare-approved medical expenses, including:

1. Medicare hospitalization deductible
2. Medicare outpatient annual deductible
3. Medicare co-insurance for hospital days 61– 90
4. Medicare co-insurance for hospital days 91–150
5. Skilled nursing facility days 21–100
6. Preventive Services described in Appendix A on page 41

Excluded Expenses

Expenses not covered under the MCx Option include:

1. Expenses not approved by Medicare,
2. Expenses that exceed Medicare limits and maximums,
3. Expenses for nursing home care and custodial care, and
4. Expenses for skilled nursing facility charges for stays exceeding Medicare limits.

MCx Option—Coverage Exceptions:

1. **Blood:** Medicare will usually deny the first 3 pints of blood each calendar year. The MCx Option covers this expense.
2. **Medical Supplies**: The MCx Option provides limited assistance for medical supplies not covered by Medicare such as blood pressure monitors, but only if accompanied by a letter of medical necessity from the treating physician. Reimbursement for these medical supplies (not including colostomy/ileostomy supplies described below) is 80% of the expense with a maximum of $500 per calendar year.
3. **Colostomy/ileostomy Supplies:** The MCx Option provides assistance for colostomy and ileostomy supplies at 80% reimbursement, but only if denied by Medicare.
4. **Incontinence Supplies:** not covered.
5. **Orthopedic Shoes:** Medicare may deny assistance for orthopedic shoes, shoe inserts or similar devices. Under the MCx Option, a covered member can submit such Medicare-denied expenses

for reimbursement at 80% of the reasonable and customary cost with a maximum of $600 per calendar year. The claim must include a doctor's written statement of medical necessity, shoe-fitting documentation and a copy of the Medicare denial.

6. **Support stockings:** not covered.
7. **Wigs:** not covered.
8. **Preventive Care:** The Plan will cover certain preventive care services not otherwise covered by Medicare as described in Appendix A.

Claims submitted for reimbursement as an exception for blood, orthopedic shoes, and colostomy/ileostomy supplies as described above must include a copy of the Medicare denial. However, if the Medicare denial is because the services were provided by a provider that does not participate in Medicare, the Plan will not provide reimbursement.

One Annual Dental Cleaning/Exam

One annual dental exam including bite wing X-rays and cleaning is covered and reimbursed at 100% of the reasonable and customary cost. Additional dental benefit is available under the DVH Option.

Maximum Out of Pocket Limit for Medical Benefits

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

Foreign Travel Emergency Medical Benefit

Foreign travel emergency medical benefit is provided under the MCx Option. All claims must be translated into English and be submitted to the ARM claims office address found on the back of the Plan ID card.

Reimbursement is limited to unexpected or emergency medical expenses incurred during a personal trip lasting less than 60 days. This benefit has a separate $1,000 per person/year deductible. Covered expenses are reimbursed at 80% with a $50,000 maximum benefit per calendar year. Reimbursement is subject to the following terms and limitations:

- Travel due to an invitation of a church entity or volunteer mission is **not** covered.
- Coverage includes $1,000 to assist with the transport or preparation of remains, not subject to the deductible.
- Coverage includes a companion coach rate airfare if the covered member establishes a medical need for assistance in returning to the United States.
- The covered member must pay for all medical services out of pocket in the country of travel and submit claims to the ARM claims office, along with the appropriate supporting documentation and receipts upon return to the United States. Reimbursement will follow the routine claims process.

Reimbursement is secondary to any other travel policy purchased by the covered member.
For information regarding short-term medical coverage that can be purchased for denominationally and volunteer sponsored trips or personal trips, please contact ARM:

- by phone at 1-888-951-4276;
- by fax at 1-888-353-6848;
- by email at **sttservice@adventistrisk.org;** or
- go to their website at **www.adventistrisk.org**.

Dental, Vision, Hearing (DVH) Option

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

The Dental benefit provides coverage for dental services based upon reasonable and customary fees for the geographical area in which the services are rendered. The Plan will pay 80% of reasonable and customary fees subject to a calendar year Plan maximum paid amount of $2,200. Any expenses above this maximum amount are not eligible expenses under the Plan. The covered member is responsible for the 20% coinsurance, charges above the annual maximum paid amount and any charges above reasonable and customary fees. The Dental benefit has a **one year "look-back" provision** which allows the payment of any unused benefits from the previous calendar year to be used in the current calendar year. Services that begin in one calendar year will have a date of service in that calendar year. Pre-certification is not required.

Covered Dental Benefits

- Two cleanings per calendar year
- One set of bite wing x-rays per calendar year
- Extractions and periodontal treatment
- Full mouth/panorex x-ray every 3 calendar years
- Implants (Caution: one implant may take your full annual limit)
- Application of fluoride twice per calendar year
- Fillings
- Root canal therapy
- Crowns/bridges/partials/dentures
- Anesthesia, if medically necessary

Dental Exclusions

- Orthodontic treatment
- TMJ/TMD treatment
- Jaw surgery
- Temporary crowns or bridges
- Experimental treatments/procedures
- Cosmetic services
- Toothbrushes

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

The Hearing benefit provides coverage for services including hearing tests, hearing aids and the repair of hearing aids. The Plan will pay 80% of the costs subject to a calendar year Plan maximum paid amount of

$2,200. Any expenses above this maximum amount are not eligible expenses under the Plan. The covered member is responsible for the 20% coinsurance and charges above the calendar year maximum paid amount. The Hearing benefit has a one year "look-back" provision which allows the payment of any unused benefits from the previous calendar year to be used in the current calendar year

Prescription Drug (Rx) Option

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

This section describes the prescription benefits provided by the Rx Option. Please refer to the Schedule of Benefits for the specific payment percentages, maximum amounts payable, and requirements. Express Scripts, Inc. (ESI) is the pharmacy benefit manager (PBM) for the Rx Option. The Rx Option is considered Creditable Coverage for purposes of Medicare.

The following benefits are covered under the Rx Option:

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

Formulary, Pharmacy Levels and Drug Tiers

ESI uses a national preferred formulary. The formulary encourages Eligible Retiree (or Eligible Spouse) to use clinically appropriate drugs while helping to manage costs. A formulary is a list of drugs covered through the pharmacy benefit and presented in different therapy classes used to categorize or group the drugs on the formulary. The classes group drugs which are considered similar by the disease they treat or by the effect they have on the body. Prescription drug coverage under the Plan is offered through two different pharmacy levels: 30-day for short term drugs; and 90-day Mail Order and Walgreens Smart90 retail program for long term maintenance drugs. Copayments will be lowest if an Eligible Retiree (or Eligible Spouse) uses 90-day Mail Order or the Walgreens Smart90 retail program.

If an Eligible Retiree (or Eligible Spouse) chooses to purchase long-term maintenance medication at other retail pharmacies for 30-day supply at a time rather than via mail order or Walgreens Smart 90 program, after three purchases of the drug, they will have to pay the difference in the cost between the price of the drug at the retail pharmacy and the price of the drug charged by the mail order home delivery program. For a list of long-term maintenance drugs that are subject to this rule, please contact the ESI Member Services Department at 800-841-5396.

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

Generic (Tier 1):	A generic drug is a safe, effective drug approved by the U.S. Food and Drug Administration (FDA) that also costs less. Eligible Retirees (or Eligible Spouse) pay the lowest copayment for generic drugs.

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

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

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

Prescription Drug Pre-Certification Requirement

Some drugs require pre-certification through the PBM (ESI) before a prescription can be filled. The Plan participates in ESI's utilization management program which manages the list of drugs with pre-certification requirements. The select drugs with pre-certification requirements are subject to a review for medical necessity pre-certification criteria, and/or any Plan restrictions set by ESI or the plan administrator.

If an Eligible Retiree or Eligible Spouse is prescribed a drug that requires pre-certification, their pharmacy will be notified when processing their prescription. Eligible Retirees and Eligible Spouses should work with their providers to submit the additional clinical information requested by the pre-certification request to ESI for review.

The list of drugs that require pre-certification is subject to change at any time. Please call Express Scripts' Member Services, (800) 841-5396, or visit ESI's website **www.express-scripts.com** for further details.

Step Therapy Program

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

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

If an Eligible Retiree or Eligible Spouse is taking a Step-Therapy Drug, they or their doctor will receive a letter explaining this program. After receiving a letter an Eligible Retiree or Eligible Spouse should consult

with their doctor immediately concerning their use of Step-Therapy Drugs. **Do not stop taking any medication prescribed by a doctor without first consulting such doctor.**

Please call Express Scripts' Member Services, (800) 841-5396, or visit ESI's website **www.express-scripts.com** for further details.

Coordination of Benefits

As an employer-sponsored plan for retirees, the Standard Plan benefits (MCx, DVH and Rx Options) are paid secondary to *all other healthcare plans available to the member,* including:

- other coverage that is secondary to Medicare, and
- other coverage from current employment of an Eligible Spouse.

Medicare is primary for all medical services for a covered member who has reached age 65, regardless of whether or not the member has applied for and /or obtained Medicare Part A and B coverage. Each medical service must first be approved and its portion paid by Medicare before it is considered for payment by the Plan.

Except for certain preventive services described in Appendix A, services not approved and paid for by Medicare are generally not covered by the MCx Option.

A member who enrolls in the Plan mid- Plan year will have access to full limits and will be subject to full deductibles without pro-ration.

Coordination Rules

The Plan is ***not*** insurance. It is a retirement medical benefit available to those who have met certain requirements described in this document. Thus it cannot be required to be primary by any insurance plan whether it is an employer insurance plan, a retiree supplemental insurance plan, a Medicare Advantage or HMO plan, a retiree supplemental reimbursement program for Medicare Part B premium, an auto policy or Worker's Compensation, etc. The Plan will coordinate with all other plans where it has secondary or tertiary responsibility by paying up to 100% of otherwise approved or covered amounts. Total Payments between the Plan and another plan will not exceed the Plan's payment responsibility as if the Plan had been primary.

Medicaid

Covered members who are receiving Medicaid benefits should consult with the appropriate state agency to determine whether the Plan should be retained. The Medicaid program may be dual-eligible with the Medicare program. The Plan will abide by state rules and regulations to determine primary responsibility and may terminate Plan benefits.

Filing Claims

Timely Filing Requirements

All medical, dental, vision and hearing claims must be filed within one year of the date of service. Claims that are first submitted to Medicare and are delayed by Medicare claims processing will be considered to have been filed on a timely basis if they are received within one year from the date that Medicare pays the claims. Claims filed late will not be reimbursed. Upon enrollment, the Eligible Retiree will receive a Plan ID card indicating the medical Options selected. Healthcare providers may bill ARM directly.

Paper Claims Address (on the Plan ID card):

Adventist Risk Management, Inc.
PO Box 1928
Grapevine, TX 76099-1928

Electronic Claims Address (on the Plan ID card):

WebMD/Envoy Payer ID 75261 CMS Crossover Enabled

- **Medicare Primary claims** are first billed by the provider directly to Medicare. Medicare then automatically sends an electronic claim to Adventist Risk Management, Inc. providing explanation on what services were approved and paid by Medicare. Any remaining balances will be considered for payment for covered members. All claims submitted by a covered member for reimbursement after Medicare payment must include a copy of the Medicare Summary Notice (MSN). Most providers will bill Medicare. Generally it will not be necessary for a covered member to submit balances for payment since Medicare submits these automatically to Adventist Risk Management, Inc.
- **Claims paid first by the covered member** should be submitted with clear proof of payment and a request for reimbursement to be paid to the covered member. Such claims should be mailed to Adventist Risk Management, Inc. at the address listed above or on the back of the Plan ID card.

Prescription drug Claims must be submitted per the below requirements.

All claims under the Rx Option must be filed within one year of the date of service.

- **Home Delivery program:** Claims are automatically filed through the ESI home delivery program.
- **Retail Pharmacy:** The co-payment on a prescription drug claim will be paid to the local pharmacy. The ESI ID card indicates eligibility for the purchase of prescription drugs. Although most pharmacies participate with the ESI pharmacy program, there are some that do not. If prescription drugs are purchased at a pharmacy that does NOT participate in the ESI network the Plan has chosen to participate in, members will have to pay the full cost of the prescription filled and file a claim with ESI for reimbursement. Contact ESI to obtain a form for direct reimbursement. Direct reimbursement for a prescription obtained at a non- participating pharmacy will likely result in a higher cost to the covered person.
- **Self-administered Drug:** The self-administered drug must be a part of the ESI drug formulary. Contact ESI at 800-841-5396 to see if your medication is covered. You may submit the claim to ESI. If the drug is available through ESI, the appropriate copayment will apply. If the drug is not available through ESI, submit the claim to the ARM claim office listed on your Plan ID card. Plan reimbursement is at 80% of the cost.
- **Home Health Medication Infusions:** Generally, these claims are covered through Medicare as primary claims as medical services. These claims should be directed to be billed to Medicare first, then the remaining balance to be billed to the ARM claim office, either in the form of a paper or electronic claim, to the address listed on the back of the RESHARP ID card.
- **Outpatient Hospital Infusions:** Generally, these claims are covered through Medicare as primary claims as medical services. These claims should be directed to be billed to Medicare first, then the remaining balance to be billed to the ARM claim office, either in the form of a paper or electronic claim, to the address listed on the back of the RESHARP ID card.
- **Shingles vaccine:** If a member has purchased/paid for the vaccine separate from a physician office visit, the claim is submitted to ESI. To review the Express Scripts Medicare PDP program vaccine

coverage, review the Evidence of Coverage document. If the retiree incurs a prescription drug copay, the receipt of the copay may be submitted to ARM at the address on the RESHARP ID card. Contact Express Scripts customer service at 1-866-838-3974 for additional information regarding this benefit.

Appeals

The following measures have been adopted to ensure that an appeal of a denied claim will be handled promptly and in a fair, reasonable and consistent manner.

If an Eligible Retiree or Eligible Spouse/Eligible Dependent disputes a claim denial as incorrect, he/she may have the claim reconsidered by submitting an appeal in writing.

Summary of Appeals Timeframes

DEADLINE TO FILE AN APPEAL:
180 days from your receipt of a denial of the claim.

Where to file your first appeal:

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

If your first appeal is denied:

DEADLINE TO REQUEST SECOND REVIEW:
Four months from your receipt of the denial of the appeal

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

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

Appointment of Authorized Representative

You may appoint an authorized representative in writing to act on your behalf with respect to appeals. Additionally, the Plan shall, even in the absence of a signed Appointment of Authorized Representative form, recognize a physician or professional provider with knowledge of the claimant's medical condition (e.g., the treating physician) or the facility where the claimant is/was treated as the claimant's authorized representative unless the claimant provides specific written direction otherwise, and an employee is automatically deemed to be the authorized representative of his or her covered dependent who is under

age 18. An Appointment of Authorized Representative form may be obtained from WebTPA by calling 888-276-4732. Completed forms must be submitted to the utilization review manager, WebTPA, or Express Scripts (depending on the proper recipient of the claim or appeal). An attempted assignment for purposes of payment does not constitute appointment of an authorized representative. Once an authorized representative is appointed, recognized, or deemed, the Plan shall direct all information, notification, etc. regarding the claim to the authorized representative. The claimant shall be copied on all notifications regarding decisions, unless the claimant provides specific written direction otherwise. Any reference in this Section to "claimant" is intended to include the authorized representative of such claimant appointed in compliance with the above procedures.

Four Types of Claims

Different Rules Apply

There are, as described below, four categories of claims that can be made under the Plan, each with somewhat different appeal rules. The federal regulations set different requirements based on the type of claim involved. The primary difference is the timeframe within which appeals must be determined.

1. **Pre-Certification Claim**

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

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

   To receive medical necessity pre-certification you must contact Customer Service at 888-276-4732 before you receive the medical care. For prescription drug pre-certification, call Express Scripts at 800-841-5396.

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

2. **Urgent Pre-Certification Claim**

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

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

   Throughout the "Appeals" Section, when the terms "pre-certification" and "pre-certification claim" are used without the term "urgent," they are used to describe non-urgent pre-certification claims.

3. **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.

4. **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.

5. **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 appeals, the claim may be re-characterized. For example, a claim may initially be an urgent pre-certification claim. If the urgency subsides, it may be re-characterized as a pre-certification claim.

6. **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 Customer Service at 888-276-4732.

Notification of Initial Benefit Decision by Plan

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

2. **Notification of Adverse Benefit Determination**
   Written notification shall be provided to the claimant of the Plan's adverse benefit determination on a claim and shall include the following, in a manner calculated to be understood by the claimant:
   - information sufficient to identify the claim involved, including, if applicable: (i) the date of service, (ii) the health care provider, (iii) the claim amount, and (iv) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
   - a statement of the specific reason(s) for the decision, including (i) the Plan's denial code and its corresponding meaning (ii) the Plan's standard, if any, that was used in denying the appeal; and (iii), for final internal adverse benefit determinations, a discussion of the decision;
   - a reference to the specific Plan provision(s) on which the decision is based;
   - a description of any additional material or information necessary for the claimant to perfect the claim/ appeal and an explanation of why such material or information is necessary;
   - a description of the Plan's review procedures and the time limits applicable to such procedures;
   - a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
   - for adverse benefit determinations (including final internal adverse benefit determinations) of appeals, a statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination;

- if the decision is based on a medical necessity or experimental treatment or similar exclusion or limit, disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge on request.
- in the case of an urgent pre-certification claim, an explanation of the expedited review methods available for such claims/appeals;
- a statement describing any remaining mandatory appeal and information regarding how to initiate any such remaining appeal;
- a statement of the right to sue in State court; and
- the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act § 2793 to assist individuals with the internal claims and appeals and external review processes.

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

How to Appeal an Adverse Benefit Determination

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

1. **Right to Appeal**
   A claimant, or the claimant's authorized representative, has a right to appeal an adverse benefit determination under this Section.
2. **How to File Your Appeal: Urgent Pre-Certification Appeals**
   In light of the expedited timeframes for decision of urgent pre-certification claims, an urgent pre-certification appeal may be submitted to the utilization review manager by phone at 888-276-4732. All necessary information in connection with an urgent pre-certification appeal shall be transmitted between the Plan and the claimant by telephone, fax, or e-mail.
3. **How to File Your Appeal: Pre-Certification Appeals**
   An appeal of an adverse benefit determination involving a pre-certification claim should be submitted to the utilization review manager. Details on how to submit an appeal to the utilization review manager will be provided by the utilization review manager upon an adverse benefit determination. You may call the utilization review manager at 888-276-4732 for more information.
4. **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 Customer Service at 888-276-4732 for more information. Except in the case of an appeal relating to prescription drug benefits, a post-service appeal of an adverse benefit determination that does not require a determination involving medical judgment is filed by submitting a written Request for Review form to WebTPA. A claimant has the right to submit documents, written comments, or other information in support of an appeal. Request for Review forms may be obtained by contacting the utilization review manager or WebTPA via Customer Service at 888-276-4732.

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

5. **How to File Your Appeal: Prescription Drug Appeals**
   To appeal a denied prescription drug benefit claim, follow the instructions on the adverse benefit determination you received from ESI.
6. **Important Appeal Deadline**
   The appeal of an adverse benefit determination must be filed within 180 days following the claimant's receipt of the notification of adverse benefit determination, except that the appeal of a decision by the Plan to reduce or terminate an initially approved course of treatment (see the definition of concurrent care decision) must be filed within 30 days of the claimant's receipt of the notification of the Plan's decision to reduce or terminate. Failure to comply with this important deadline will cause the claimant to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.

How Your Appeal Will Be Decided

The following procedures will be followed for all appeal decisions:

1. **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.
2. **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.
3. **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.
4. **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.

Timeframes for Deciding Benefits Appeals

1. **Pre-Certification Claims**
   The appeal of an adverse benefit determination relating to a pre-certification claim shall be decided within a reasonable time appropriate to the medical circumstances but no later than thirty (30) days after receipt of the appeal.
2. **Urgent Pre-Certification Claims**
   The appeal of an adverse benefit determination relating to an urgent pre-certification claim will be decided as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt of the appeal.

3. **Post-Service Claims**
   The appeal of an adverse benefit determination relating to a post-service claim shall be decided within a reasonable period but no later than sixty (60) days after receipt of the appeal.
4. **Concurrent Care Claims**
   The appeal of a decision by the Plan to reduce or terminate an initially approved course of treatment shall be decided before the proposed reduction or termination takes place. The appeal of a denied request to extend any concurrent care shall be decided in the appeal timeframe for pre-certification claims or urgent pre-certification claims described above, as appropriate to the request.

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 provided above, written in a manner calculated to be understood by the claimant. Notification of an adverse benefit determination on appeal of an urgent pre-certification claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

Review of Appeal Decision That Does Not Involve Medical Judgment—Second Appeal

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

   Adventist Risk Management
   12501 Old Columbia Pike
   Silver Spring, MD 20904
   800-447-5002
   benefits@adventistrisk.org

   The plan administrator will assign an appointee to review your second appeal. The appointee will follow the procedure described in "How Your Appeal Will Be Decided" above when reviewing your second appeal, and you have the rights described in that Section.

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

   No deference will be given to the initial benefit decision or the first appeal, and the person who reviews and decides the second appeal will not be the same person who made the initial benefit decision, the person who decided the first appeal, or either person's subordinate.
2. **Deadline for Request for Second Appeal for Claim that Does Not Involve Medical Judgment**
   You must submit your request for a second appeal within four months after the date of receipt of the notice of adverse benefit determination from your first appeal (for example, if the notice is received on March 15, then the request must be filed by July 15). If there is no corresponding date, then the deadline is the first day of the fifth month following receipt of the notice (for example, if the notice is received on October 30, since there is no February 30, the request must be filed by March 1). If the filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
3. **Notification of Non-Medical Judgment Decision on Second Appeal**
   The appointee of the plan administrator will provide written notice of the Plan's decision within 45 days of its receipt of your request for second appeal, unless the second appeal involves (1)

a medical condition where this timeframe would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or (2) an admission, availability of care, continued stay, or health care item of service for which the claimant received emergency services, but has not been discharged, in which case the appointee will provide notice within 72 hours (and then, if the notice is not in writing, will provide written confirmation within 48 hours of the initial verbal notice).

If the decision is an adverse benefit determination, the written notification shall include the information required above, written in a manner calculated to be understood by the claimant.

4. **Exhaustion and Deemed Exhaustion of a Claim that Does Not Involve Medical Judgment**
   The Plan will not consider you to have exhausted the administrative remedies available under the Plan until you have properly filed and received a decision on your second appeal.

   If you fail to follow the requirements laid forth in the Appeals Section, if you miss any of the above-stated deadlines for filing a claim or an appeal, or if you otherwise fail to exhaust all of the administrative remedies under the Plan, then you will forfeit any right to pursue any remedies under State or federal law.

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

Exhaustion and Deemed Exhaustion of Internal Claims and Appeals Processes

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

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

External Review (For Review of an Appeal Decision Involving Medical Judgment)

1. **In General**
   As required by the Patient Protection and Affordable Care Act, the Plan complies with the federal external review process. This means that you are eligible to have certain adverse benefit determinations reviewed by an independent review organization and the decision reached through the external review is binding on the Plan. The Plan will pay the cost of external reviews.

2. **Eligibility for External Review**

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

Requirements:

(i) The adverse benefit determination (including final internal adverse benefit determinations) must involve (a) rescission of coverage, (b) application of the No Surprises Act, or (c) medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or the Plan's determination that a treatment is experimental or investigational), as determined by the external reviewer.

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

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

3. **Request for External Review**

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

4. **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:

(iii) 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;

(iv) 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);

(v) The claimant has exhausted the Plan's internal appeal process or if the claimant is deemed to have exhausted the internal appeals process; and

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

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

If the Plan determines the claim request is complete and is eligible for external review, it will forward

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

5. **Expedited External Review**
   A claimant may request an expedited external review if the claimant receives:

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

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

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

6. **Assignment to and Consideration by Independent Review Organization**
   Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an independent review organization 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.

7. **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.

8. **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.

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 appeals procedures, contact the plan administrator.

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

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

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

HIPAA allows certain medical information, including PHI, to be disclosed by the Plan to the Seventh-Day Adventist Regional Conferences of the North American Division (Regional Conference) and the Regional Conference Retirement Plan as the plan sponsors of the Plan, for uses permitted under HIPAA. Details regarding uses of PHI are available in the Adventist Retirement Plans *Notice of Privacy Practices*. This Section explains how certain health information about you and your covered dependents may be used or

released to the plan sponsor by the Plan. If you wish to obtain a copy of the *Notice of Privacy Practices,* it is located on the Retirement website at www.adventistretirement.org. You may print it or call 301-680-6249 to request a copy.

The Regional Retirement Office has authorized Adventist Risk Management, Inc. (ARM) to administer the Plan claims on a day-to-day basis. ARM has access to PHI as an administrator and business associate of the Plan, and its rights and obligations with respect to PHI are similar to those described under 4 below and governed by a HIPAA business associate agreement between the Plan and ARM. The Regional Retirement Office, as plan sponsor, may have access to information as set forth below.

1. The Plan may disclose to the plan sponsor, and the plan sponsor may use, information on whether you or your dependents are participating in the Plan or enrolling or dis-enrolling in the Plan.
2. The Plan may disclose to the plan sponsor de-identified claims information (e.g. information that is stripped of all information that could be used to identify the individual incurring the claim) in order to facilitate your participating employer's obligation to fund claims incurred by you or your dependents under the Plan.
3. The Plan may disclose summary health information (information that summarizes claims history, claims expenses or types of claims experienced by Plan members) to the plan sponsor if they request the summary information for the purpose of:
    a. obtaining premium bids for providing insurance coverage; or
    b. modifying, amending, or terminating the Plan ("Summary Information").

    The plan sponsor may use Summary Information so received from the Plan only for these two listed purposes.
4. The Plan may disclose PHI to the plan sponsor, and the plan sponsor may use PHI, to carry out plan administration functions, such as activities relating to:
    a. obtaining employee share contributions or to determining or fulfilling responsibility for coverage and provision of benefits under the Plan
    b. payment for or obtaining or providing reimbursement for healthcare services—Payments under this Plan generally are made either to the health care provider or to the employee. All Members should be aware that the Plan will be providing PHI concerning all dependents of an employee to the employee as part of the Explanation of Benefits and when reimbursing the employee for covered services under the Plan. If there is some reason why a dependent (spouse or child) of an employee does not want the employee to receive PHI, the dependent should so inform his or her healthcare provider and should also contact the plan administrator
    c. determining eligibility for the Plan or eligibility for one or more types of coverage or benefits provided under the Plan
    d. coordination of benefits or determinations of co- payments or other cost sharing mechanisms
    e. adjudication and subrogation of claims, billing, claims management, collection activities and related healthcare data processing
    f. payment under a contract for reinsurance
    g. review of healthcare services with respect to medical necessity, coverage under the health plan, appropriateness of care, or justification of charges
    h. utilization review activities, including precertification and preauthorization of services and concurrent and retrospective review of services
    i. disclosure to consumer reporting agencies of any of the following PHI regarding collection of premiums or reimbursement: name and address, date of birth, Social Security Number,

payment history, account number and name and address of the health plan

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

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

l. resolution of internal grievances

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

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

o. evaluating health care provider performance or Plan performance

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

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

In connection with the plan sponsors' access to PHI as described above, the plan sponsor has agreed to (and the Plan has received a certification from the plan sponsor evidencing such agreement) the following restrictions:

1. The plan sponsor will not use or further disclose the PHI except as described above or as otherwise required by law.
2. Any agents or subcontractors of the plan sponsor to whom the plan sponsor provides PHI will agree to the same restrictions and conditions on the use and disclosure of PHI that apply to the plan sponsor. Any agents or subcontractors of the plan sponsor to whom the plan sponsor provides electronic PHI must agree to implement reasonable and appropriate security measures to protect the information.
3. The plan sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.
4. The plan sponsor will report to the Plan any use or disclosure of the PHI that is inconsistent with the permitted uses and disclosures of which the plan sponsor becomes aware. The plan sponsor will report to the Plan any security incident of which the plan sponsor becomes aware.
5. The plan sponsor will (or will cooperate with the plan administrator to) give you access and provide copies to you of your PHI in accordance with the HIPAA Regulations.
6. The plan sponsor will (or will cooperate with the plan administrator to) allow you to amend your PHI in accordance with the HIPAA Regulations.
7. The plan sponsor will (or will cooperate with the plan administrator to) make available PHI to you in order to make an accounting of PHI in accordance with the HIPAA Regulations.
8. The plan sponsor will (or will cooperate with the plan administrator to) make available its internal practices, books and records relating to the use and disclosure of PHI received from the Plan to the Secretary of Health and Human Services (or the Secretary's designee) for determining compliance by the Plan with the HIPAA Regulations.
9. The plan sponsor will, if feasible, return or destroy all protected PHI received from the Plan and retain no copies of the PHI when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

10. The plan sponsor will ensure that adequate separation between the Plan and plan sponsor is established. Only the following employees or classes of employees or other persons under the control of the plan sponsor will be given access to the PHI to be disclosed:
    a. Members of the administrative committee at each plan sponsor
11. The plan sponsor will ensure that this adequate separation is supported by reasonable and appropriate security measures to the extent that these individuals have access to electronic PHI.
12. The plan sponsor will (and will cooperate with the plan administrator to) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the plan sponsor creates, receives, maintains or transmits on behalf of the Plan, except enrollment/disenrollment information and Summary Information, which are not subject to these restrictions.

The access to and use by the employees described above is limited to the Plan administration functions that ARM (and the plan administrator) performs for the Plan. This may involve sharing Plan enrollment or de-identified information with the plan sponsor, but the plan sponsor will not have access to any other PHI. Employees who violate this section are subject to disciplinary action by the plan sponsor, including, but not limited to, reprimands and termination.

General Information

Administration

The Plan is governed by the Seventh-day Adventist Regional Conference Plan Retirement Board, and administered by the Seventh-day Adventist Regional Conference Plan Retirement Board. Claims are managed by Adventist Risk Management, Inc. (ARM).

Changes to RESHARP

The Board reserves the right to amend the Plan based on financial considerations or other unanticipated circumstances such as changes to Medicare. This may result in changes in provisions, in contributions and in Earned Credits.

Plan Year

The Plan Year is January 1 to December 31. All benefit limits and deductibles are based on the Plan Year. A covered member who enrolls in the Plan mid-Plan Year will have access to full limits and will be subject to full deductibles without pro-ration.

Glossary

“ARM” means Adventist Risk Management, Inc.

“DVH Option” means the Plan dental, vision and hearing coverage option described in this document.

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

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

"Eligible Retiree" means a retiree of a Regional Conference participating employer organization who satisfies the requirements for eligibility described in the Eligibility section of this document.

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

"Evidence of Coverage document" means the separate document produced by Express Scripts which contains all of the rules and penalties for the Express Scripts Medicare (PDP) Plan Rx Option for prescription drugs.

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

"MCx Option" means Medicare Extension, a medical benefits option that supplements Medicare benefits as described in this document.

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

"Plan or RESHARP" means this Regional Conference Supplemental Healthcare Adventist Retirement Plan.

"Plan Year" means the calendar year.

"Regional Conference" means the Seventh-day Adventist Regional Conferences of the North American Division.

"Regional Conference Office" means the Regional Conference administrative staff of the Regional Conference Retirement Plans office listed in the Contact Information section of this document.

"Seventh-day Adventist Regional Conference Plan Retirement Board" or **"Board"** means the board established by the Seventh-day Adventist Regional Conferences of the North American Division to maintain and amend from time to time the Plan and the various other programs available to retirees.

"Regional Retirement Plan" means the Seventh-day Adventist Regional Conference Retirement Plan Defined Benefit Pension Plan.

"Retirement Plan Service" means the service credited under the Regional Retirement Plan. If a retiree was with the Regional Conference as of January 1, 2000 and signed a waiver to have all of their years of service count towards the Regional Conference Retirement Plan, then their eligible NAD and/or Bermuda years of service are counted towards their overall years of service with the Regional Conference Retirement Plan.

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

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

a) **Medical:** For eligible claims submitted for services covered under this Plan where Medicare is not primary or did not pay, the allowable charge will be based on the normal and necessary charges submitted or made for similar services or supplies provided by other providers with like experience in the same geographic area. The term "geographic area" as it applies to any particular service,

medicine, or supply means a county or such greater area as is necessary to obtain a statistically representative cross-section of the level of charges. The U&C is determined using the 80th percentile of all charges for the same service or supply in the geographic area based on survey data collected and maintained.

b) **Dental:** For eligible claims submitted for dental services, the allowable charge will be based on the normal and necessary charges submitted or made for similar services or supplies provided by other providers with like experience in the same geographic area. The term “geographic area” means a county or such greater area as is necessary to obtain a statistically representative cross-section of the level of charges. The U&C is determined using the 80th percentile of all charges for the same service or supply in the geographic area based on survey data collected and maintained.

Appendix A: Preventive Care Services

The following is a list of preventive care services recommended by the U.S. Preventive Services Task Force, the Advisory Commission on Immunization Practices of the Centers for Disease Control, and the Health Resources and Services Administration. These preventive care services are covered either under Medicare Part B or under the Plan. Any of the preventive services listed below which are not covered by Medicare Part B will be reimbursed under the Plan at no cost to the covered individual. The Plan will not pay for any of the listed preventive care services which are eligible for coverage under Medicare Part B, nor will it pay for services listed below that exceed the frequency specified. If a frequency for the service is not specified, one such service per calendar year will be covered. Claims for the preventive services listed below will be submitted to ARM at PO Box 1928 Grapevine, TX 76099- 1928.

Covered Preventive Services for All Adults

- **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin** use for men and women of certain ages
- **Blood Pressure** screening for all adults
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults over 50
- **Depression** screening for adults
- **Type 2 Diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at higher risk for chronic disease
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults—doses, recommended ages, and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus
  - Influenza (Flu Shot)
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, Diphtheria, Pertussis
  - Varicella
- **Obesity** screening and counseling for all adults
- **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
- **Tobacco** Use screening for all adults and cessation interventions for tobacco users
- **Syphilis** screening for all adults at higher risk
- **Vitamin D** for individuals over age 65 who are at increased risk for falls

Covered Preventive Services for Women

- **Anemia** screening on a routine basis for pregnant women
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk
- **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
- **Breast Cancer Chemoprevention** counseling for women at higher risk
- **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
- **Cervical Cancer** screening for sexually active women
- **Chlamydia** Infection screening for younger women and other women at higher risk
- **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- **Domestic and Interpersonal Violence** screening and counseling for all women
- **Folic Acid** supplements for women who may become pregnant
- **Gestational Diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- **Gonorrhea** screening for all women at higher risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women
- **Human Papillomavirus (HPV) DNA Test:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- **Osteoporosis** screening for women over age 60 depending on risk factors
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Sexually Transmitted Infections (STI)** counseling for sexually active women
- **Syphilis** screening for all pregnant women or other women at increased risk
- **Well-Woman Visits** to obtain recommended preventive services

Preventive Care Services—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:

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;
2. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of

the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to women, to the extent not described in (1) above, evidence informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
5. Smoking cessation drugs that are prescribed by a physician and approved by the plan administrator are covered with no copayment and no deductible (if received from an in-network pharmacy).
6. If prescribed by a physician and received directly from ESI or a pharmacy contracted with ESI, the preventive services covered under this section are covered with no cost-sharing required on your part (that is, no copayment, no coinsurance, and no deductible; this is often referred to as “first-dollar coverage”).

Preventive prescription drugs will not include any items or services specified in any recommendation or guideline described in (1)-(4) above after the recommendation or guideline is no longer described in (1)-(4) above. Preventive prescription drugs may be subject to the same pre-certification and step therapy requirements as other covered prescription drugs (described above).

Instructions for Completing the RESHARP Forms

The Eligible Retiree and/or Eligible Spouse must be enrolled in Medicare.

1. The RESHARP form completion depends upon meeting the eligibility requirements for the Plan. Refer to the Eligibility sections above for additional information.
2. For each individual seeking healthcare benefits please complete the Name, Date of Birth (DOB) and Social Security Number (SSN) on the form.
3. Total the Eligible Retiree and, if applicable, Eligible Spouse selections.
4. If the retiree meets the eligibility requirements refer to the Earned Credit Table in the Earned Credit section. Enter the Earned Credit for the retiree and spouse. Remember, only spouses who are eligible on the date the retiree has retired are eligible for the Earned Credit. Special enrollees are not eligible for Earned Credit.
5. Add the total cost of all Options selected. Subtract the Earned Credit if eligible. The "Total" will be the monthly cost for the retiree's elected benefits.
6. **Read all conditions carefully and sign the form**. Return the form within 30 days of retirement to the Regional Conference Office for processing. If there is no signature, the application and enrollment will NOT be processed.
7. 7. For assistance with the enrollment process please contact the Regional Conference Office at: 256-830-5002 / Monday–hursday / 8 a.m.–5 p.m. Eastern Standard Time.

2024 Medicare Supplemental Healthcare Insurance Application

Regional Conference Retirement Plan Enrollment Form

Sign and Mail IMMEDIATELY to:
Regional Conference Retirement Plan **(RESHARP)**
7000 Adventist Blvd.
Huntsville, Alabama 35896
Office (256) 830-5002
FAX (256) 830-5078

Social Sec. #
Birthdate:
Name:
Address:
City,State,Zip:
Daytime Ph. #
Effective Date:

	Your Retiree Category ➔		**Instructions:**
	Healthcare Qualifying Years of Service		
	Options & Cost ***Per Person Covered***		
✓	**Base** **Dental, Vision, Hearing** (DVH) **Prescription Drugs Enhancement** (Rx) **Medicare Extension** (MCx)	$355.00	
Total Cost		**$ 355.00**	
Less Your Earned Credit		—$.00	RESHARP pays this. **Subtract from "Total Cost" above.**
Net Retiree Cost Per Covered Person - Worker ***Spouse** **TOTAL to be deducted monthly from your retirement benefit check**		$00.00 00.00 **$00.00**	This will be withheld from your monthly benefits for you and a like amount for your eligible spouse.

***PLEASE PRINT – SPOUSE INFO** (IF APPLICABLE):		
Name:	Birthdate:	SSN:

Please enroll me in RESHARP. I understand that my monthly benefits will be reduced by the Net Retiree Cost per Person, as selected above.

Signature: ☒ _____ **Date:** _____

FOR RESHARP use ONLY	**Date Sent to ARM:**	**Initials:**

For ARM *Retirement Office Use Only* **AUTHORIZED BY:**

ARM Default Code _____ Processor's Initials _____

Insurx Code (S/F) _____ # Dep. Children _____ Spouse ARM Default Code if Different from Retiree _____

Retire Effect Date ____/____/____ Monthly Contribution $ _____x _____Months=Retroactive Contributions $ _____

Contact Information

REGIONAL CONFERENCE OFFICE

Email (preferred method of contact): **benefits@regionalretirement.org**

Phone: 256-830-5002

Website: **https://www.regionalretirement.org/**

Fax: 256-830-5078

Address: Regional Conference Retirement Plan
Attn: RESHARP
7000 Adventist Blvd.
Huntsville, AL 35896

Reasons to contact the Regional Conference Office

- Enrollment questions
- Appeals
- Request replacement ID card

ADVENTIST RISK MANAGEMENT, INC. (ARM)

Customer Service, Claims: 1-800-447-5002

Benefits & Prior-Authorization: **www.webtpa.com**

Claims Address: Adventist Risk Management, Inc.
PO Box 1928
Grapevine, TX 76090-1928

Reasons to contact ARM:

- All claim payment issues
- Verification of benefits

EXPRESS SCRIPTS

Phone and Prior-Authorization: 1-866-838-3974

Website: **www.express-scripts.com**

Claims Address: PO Box 66577
(Must use a Prescription Drug Reimbursement Form) St Louis, MO 63166-8838

Reasons to contact Express Scripts:

- Prior-Authorization required for certain medications
- Obtain the Prescription Drug Reimbursement Form

OTHER

Medicare: **www.medicare.gov**
1-800-633-4227

Contact for the RESHARP Privacy Officer: 1-301-680-6249