

Pre-Medicare
Non-Medicare
SHARP

January 1

2015

12501 Old Columbia Pike Silver Spring, MD 20904

Supplemental
Healthcare,
Adventist
Retirement
Plan

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INTRODUCTION

The North American Division of Seventh-day Adventists (NAD) offers a healthcare assistance plan for certain retirees and their eligible spouses and eligible dependent children through its Adventist Retirement Plans office. Claims are managed by Adventist Risk Management, Inc. This document describes the Supplemental Healthcare, Adventist Retirement Plan (SHARP) Pre-Medicare/Non-Medicare Option for the 2015 Plan Year. Capitalized terms used in the Introduction, Eligibility, Enrollment and Earned Credit sections of this document are defined in the Glossary.

This Plan is a retirement medical benefit for those who have met vesting requirements under a NAD defined benefit and/or defined contribution retirement plan. The SHARP Pre-Medicare/Non-Medicare option is not an insurance program or policy. SHARP is an employer sponsored trust fund. The Plan provides a broad range of benefits for medical, vision, dental, and prescription expenses which you and your eligible dependents may incur in the United States. In addition, the SHARP Pre-Medicare/Non-Medicare Plan pays benefits for “emergency” medical expenses incurred anywhere in the world for hospital care, surgery, pre-admission testing and prescription drugs. The Plan pays a portion of the cost of these medical services according to the Schedule of Benefits.

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

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

The SHARP Non-Medicare Option provides medical, dental, vision, hearing and prescription benefits for eligible dependent children.

Many items are not covered by the Plan even though they may provide significant patient convenience or personal comfort. The Plan does not, and is not intended to, cover all health care services and products that are available, particularly treatment that is not medically necessary.

This Plan document describes the Plan’s provisions for the period of January 1, 2015 through December 31, 2015. All benefit limits and deductibles are based on the Plan Year. A member who enrolls in SHARP during the Plan Year will have access to full limits and will be subject to full deductible without pro-ration. The Plan may be amended or terminated at any time without prior notice by a resolution of the North American Division Committee of the General Conference of Seventh-day Adventists or by the Adventist Retirement Board. The right to amend includes the right to curtail or eliminate coverage for any treatment procedure, or service, regardless of whether any covered member is receiving such treatment for an injury, defect, illness, or disease contracted prior to the effective date of the amendment.

Retirees Share in SHARP Cost

The NAD pays part of the cost for SHARP Pre-Medicare/Non-Medicare 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 on page 17. The Eligible Retiree or Eligible Spouse pays the remainder of the cost.

Important Plan Changes for 2015

- The prescription drug Standard SHARP Rx Option copay has changed at the Brand and Non-preferred level of copay. (See the Schedule of Benefits)
- The SHARP Pre-Medicare/Non-Medicare, DVH and Rx Option monthly costs have changed for

the 2015 plan year.

- Effective January 1, 2015 Acupuncture therapy and Massage therapy will no longer be a covered benefit of the plan. The member will be 100% responsible for these services.

Timely Enrollment is Important

There is no automatic enrollment in SHARP. Retirees who do not timely enroll will not be eligible for assistance with health care costs. Enrollment forms are included at the end of this booklet.

Limited Options for Changing Benefits

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

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

ELIGIBILITY

The persons described below, referred to throughout this document as Members, are eligible to participate in the SHARP Pre-Medicare/Non-Medicare Option.

Retiree Eligibility

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

1. a beneficiary of the Defined Benefit Plan or Defined Contribution Plan, or
2. a beneficiary in the Canadian Retirement Plan operated by the Seventh-day Adventist Church in Canada and have a retirement benefit resulting from Retirement Plan Service in either the Defined Benefit Plan or the Defined Contribution Plans.

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

An Eligible Retiree who is:

1. less than age 65 may select coverage under Pre-Medicare SHARP, which provides medical coverage. If the Eligible Retiree wishes to have dental, vision, hearing and prescription coverage he/she must enroll in the SHARP DVH and Rx options.
2. less than age 65, *but is enrolled for Medicare Parts A and B because of a disability or other reason*, may select coverage only from the Standard SHARP Options. Please refer to the Standard SHARP booklet for coverage and enrollment.
3. age 65 or older may select coverage only from the Standard SHARP Options. Please refer to the Standard SHARP booklet for coverage and enrollment.

Spouse Eligibility

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

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

An Eligible Spouse who is:

1. less than age 65 may select coverage Pre-Medicare SHARP, which offers medical coverage. If the Eligible Spouse wishes to have dental, vision, hearing and prescription coverage he/she must enroll in the Standard SHARP DVH and Rx Options.
2. less than age 65, *but enrolled for Medicare Parts A and B because of disability or other reason*, may select coverage only from the Standard SHARP Options. Please refer to the Standard SHARP booklet for coverage and enrollment.

3. age 65 or older may select coverage only from the Standard SHARP Options. Please refer to the Standard SHARP booklet for coverage and enrollment.

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

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

The Plan reserves the right to review and approve spouse eligibility in the year of the retiree's retirement.

Dependent Children Eligibility

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

An Eligible Dependent is:

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

An Eligible Dependent described above shall remain an Eligible Dependent for 60 days following the death of the Eligible Retiree (or the second to die of both the Eligible Retiree and Eligible Spouse), and shall remain covered by the then existing coverage options until the end of such 60 days, unless an earlier termination of coverage is requested in writing on behalf of the Eligible Dependent. An Eligible Dependent described above shall cease to be eligible for benefits under SHARP Non-Medicare when he/she attains age 26.

An dependent child of an Eligible Retiree or Eligible Spouse who is not covered under Medicare is generally eligible for healthcare assistance while under age 26 (without regard to disability status). However, only Non-Medicare SHARP may be selected for dependent children.

Eligibility Exclusions

1. Beneficiaries of the Regional Retirement Plan are not eligible to participate in SHARP.
2. SHARP Pre-Medicare/Non-Medicare Options and the SHARP Rx Option are not available to individuals who reside outside of the United States.

ENROLLMENT AND ENROLLMENT CHANGES

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

Without a timely submitted and signed enrollment form from the Eligible Retiree, healthcare assistance will not be provided under SHARP.

Limits for Enrollment Changes

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

1. Within 30 days of the Eligible Retiree's effective date of retirement (or loss of other coverage as described under the new retiree Delayed Enrollment provision below).
2. A one-time open enrollment is available after an Eligible Retiree has been retired for three years. The one-time enrollment change is effective on the January 1 next following the third anniversary of the retirement date.
3. An Eligible Retiree or Eligible Spouse, who selects Pre-Medicare SHARP prior to age 65, may enroll in Standard SHARP within 30 days of reaching age 65. The Eligible Retiree or Eligible Spouse will then be entitled to select any of the Standard SHARP Options.
 - **Important Note:** With very limited exceptions identified below, the coverage selected during the above-listed enrollment opportunities will remain in effect during the life of the Eligible Retiree and the Eligible Spouse.

Delayed Enrollment Due to Other Coverage – New Retiree Only

A newly Eligible Retiree may choose to delay ALL SHARP coverage, for himself/herself or an Eligible Spouse or Eligible Dependent, if at his or her retirement effective date, other healthcare coverage was in place. If SHARP coverage is delayed for this reason, it can only be obtained in the future if one of the criteria listed in the previous section under 'Limits for Enrollment Changes' are met.

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

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

Loss of Other Coverage

For the purposes of this section, 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 employer healthcare coverage except for a reason described in (iii) above.

The Eligible Retiree must notify SHARP of a “loss of other coverage” within 30 days of the event.

In the case of an Eligible Retiree who is currently working within Retirement Plan guidelines for an employer that is participating in either the Defined Benefit Plan or the Defined Contribution 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 non-Eligible Spouse or any other Eligible Dependent in SHARP as a “special enrollee” if any one of the qualifying events happens:

1. Marriage
2. Birth of a newborn
3. Adoption or placement of a child in the home for adoption.
4. Loss of 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 **must enroll** the Eligible Spouse and/or Eligible Dependent **promptly**, within 30 days of the qualifying event.

Discretionary Special Enrollment

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

High Inflation Special Enrollment

Healthcare costs can increase significantly. The NAD Retirement Plans Committee 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, SHARP may allow a special enrollment period in which Eligible Retirees are permitted to permanently REDUCE Standard SHARP coverage.

Pre-Medicare SHARP Expiration

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

Re-Employment

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

Surviving Retiree or Eligible Spouse

Upon the death of either the covered Eligible Retiree or Eligible Spouse, SHARP will stop taking deductions for the deceased beneficiary. However, a surviving Eligible Retiree or Eligible Spouse will have a 90-day open enrollment period during which he/she may make changes to the SHARP benefits which were in place at the covered beneficiary's date of death.

Requested Termination of Benefit

If, at the request of the Eligible Retiree or Eligible Spouse, SHARP benefits are discontinued at a non-open enrollment period, the termination of benefits will may be considered permanent and will not be reinstated. This termination rule applies even if the person otherwise meets the requirements for a Standard SHARP open enrollment period described above in the Limits for Enrollment Changes section.

Your Responsibility to Report Family Changes

Since SHARP may be unaware of family changes that might affect you or your family member's eligibility for the Plan or the proper administration of the Plan, it is your responsibility to report changes in eligibility or general family or other status to SHARP within 30 days. Failure to do so may hamper SHARP's ability to effectively administer benefits under the Plan. Failure to notify SHARP in a timely manner may also delay the effective date of coverage under this Plan. Examples of the types of changes that you must report are: marital status changes such as divorces or legal separations, new employment status of your spouse, loss of disability or medical condition of a dependent child, address/telephone changes, child custody changes, loss of eligibility for Medicaid or SCHIP, and eligibility for Medicaid or SCHIP premium assistance.

It is considered fraud on the Plan if you fail to report events that result in an individual's ceasing to be eligible for the Plan. You must repay to the Plan any benefits that were erroneously paid for ineligible family member (such as a child who lost eligibility for the Plan) due to your failure to report family changes to the Plan. Examples of the types of changes that you must report are: marital status changes such as divorce or legal separation, new employment status of your spouse, loss of disability status or medical condition of a dependent child, address/telephone changes, child custody changes, loss of eligibility for Medicaid or SCHIP, and eligibility for Medicaid, Medicare or SCHIP premium assistance.

SHARP Options and Costs

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

- SHARP Pre-Medicare Option \$440/month/person
- Standard SHARP DVH Option \$65/month/person
- Standard SHARP Rx Option \$120/month/person
- SHARP Non-Medicare Option \$138/month/person

EARNED CREDIT – ELIGIBILITY AND AMOUNTS

SHARP Earned Credit – In General

An Earned Credit is calculated for Eligible Retirees based on years of Retirement Plan Service. The Earned Credit is the monthly amount that is made available to assist an Eligible Retiree with the costs of the SHARP Options selected. The Earned Credit is calculated on the total cost of the SHARP Base Option plus DVH Option plus Rx Option, in any given plan year.

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

The Earned Credit is applied to the total cost of the Options that each individual selects. If the costs of the selections exceed the Earned Credit, the balance will be withheld from the Eligible Retiree's monthly retirement benefits (or direct billing arrangements are made if no retirement benefit is available). If the cost of the SHARP Options is less than the Earned Credit, the amount left over is neither paid to the Eligible Retiree, nor can it be used to cover another family member.

Standard SHARP Earned Credit may only be used for Standard SHARP. This is true for Pre-Medicare SHARP and Non-Medicare SHARP as well. Pre-Medicare and Non-Medicare SHARP covered members may only use their Earned Credit for that category of coverage.

Determining the Earned Credit Category

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

- Pre-2000 years under the Defined Benefit Plan
- Post-1999 years under the Defined Contribution Plan
- 2000-2004 under the "career completion option" under the Defined Contribution Plan
- Canadian Retirement Plan
- Non-NAD service in foreign divisions for those who transferred to and began employment in the NAD before 2000.
- Bermuda

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

Eligibility for Earned Credit

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

- **For an Eligible Retiree:**
 - The retiree is at least age 65, or
 - The retiree is less than age 65 but has 40 years of qualifying denominational service, or
 - The retiree was eligible for early retirement prior to 2003, regardless of when retirement actually occurred, and was determined eligible for healthcare assistance with 15 or more years of Retirement Plan Service.
- **For an Eligible Spouse:**
 - The retiree must be eligible for Earned Credit,
 - The spouse must have been an Eligible Spouse as of the retiree's retirement effective date, and
 - No age requirement applies for the Eligible Spouse.
- **For Dependent Children:**
 - The retiree must be eligible for Earned Credit,
 - The Eligible Dependent must be under age 26, and
 - The child must have been determined to be an Eligible Dependent as of the Eligible Retiree's retirement effective date.
- **Future Eligibility for Earned Credit**

Retirees who are under age 65 and have fewer than 40 years of Retirement Plan Service (who are thus not eligible for an Earned Credit) may participate in Pre-Medicare SHARP, and the DVH or Rx Options, at their own cost.

An Eligible Retiree will become entitled to Earned Credit once he/she meets the Earned Credit eligibility as noted above.

An Eligible Spouse and/or eligible dependent children will qualify for an Earned Credit *only* when the Eligible Retiree qualifies for an Earned Credit.

Earned Credit Table for 2015

Retirement Plan Service Credit	35 Yrs.	30-34 Yrs.	25-29 Yrs.	20-24 Yrs.	15-19 Yrs.	8-14 Yrs.**	5-7 Yrs.**
Category	A	B	C	D	E	F	G
Standard SHARP (Eligible Retiree and Eligible Spouse)	\$220	\$200	\$175	\$155	\$130	\$110	\$90
Pre-Medicare SHARP (Eligible Retiree and Eligible Spouse)	\$440	\$385	\$330	\$275	\$220	\$170	\$110
Non-Medicare SHARP (eligible dependent children)	\$138	\$121	\$104	\$86	\$69	\$52	\$35

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

DENTAL, VISION, HEARING (DVH) OPTIONS

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. SHARP will pay 80% of reasonable and customary fees subject to a calendar year maximum SHARP paid amount of \$2,200. The covered member is responsible for the 20% coinsurance, charges above the annual maximum paid amount and any charges above reasonable and customary fees. Unused dental benefits may not be rolled over into the next calendar year. Services that begin in one calendar year will have a date of service in that calendar year. Prior authorization is not required.

Covered Dental Benefits

- Two cleanings per calendar year. Up to two additional cleanings may be authorized if recommended by a dentist for treatment of periodontal disease.
- One set of bite wing x-rays per calendar year
- Extractions and periodontal 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. SHARP will pay 80% of the costs subject to a calendar year maximum SHARP paid amount of \$400. 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 SHARP Pre-Medicare/Non-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. SHARP will pay 80% of the costs subject to a calendar year maximum SHARP paid amount of \$2,200. 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

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

The Rx Option benefit provides:

1. Prescription drugs subject to different copay levels for generic and brand name drugs. The co-pay applies to a 30-day supply of prescription drugs when purchased at a retail participating pharmacy, and applies to a 90-day supply when purchased through Express Scripts home delivery. If the actual cost of a medication is less than the co-pay, the covered member may pay the actual cost.
2. A Express Scripts identification card which can be used at retail participating pharmacies, as well as with the Express Scripts home delivery program.
3. Coverage for home health intravenous (IV) medications and the supplies used to administer them. The medication must be part of the drug formulary. SHARP reimburses these expenses at 80% of the cost. Claims are submitted to Express Scripts claims office indicated on the Express Scripts ID card.

The Rx Option includes a broad formulary. A formulary is a list of preferred drugs used as a guide for prescribing and dispensing. The formulary used by SHARP is incentive-based. Medications both on and off the formulary are covered, but at differing rates. Certain medications may have differing copayment amounts. SHARP in most instances pays higher benefits when the covered member uses drugs on the formulary list. Periodic changes are made to this list throughout the Plan Year without prior notice to covered members. For information on this formulary, visit the Express Scripts website at www.express-scripts.com or call Express Scripts Member Services toll free at (800) 841-5396. SHARP cannot advise members regarding the formulary and specific drug choices. Always discuss your medications with your treating doctor.

Cost Containment Rules for Prescriptions

As part of the SHARP RX Option prescription drug plan, Express Scripts needs to ensure that medications are dispensed in a safe and appropriate manner. As a result, certain medications may not be covered under SHARP without a review (referred to as “prior authorization”). The medications listed in the following section may be subject to review or quantity limitations based upon FDA approved indications, manufacturer’s product labeling and evidenced based clinical guidelines.

Please keep in mind that other medications may be added to these lists in the future without advance notice. For information about the prescription drug benefit, visit Express Scripts online at www.express-scripts.com or call Express Scripts Member Services toll-free at (800) 841-5396.

Medications Requiring Prior Authorization: The following medications will be covered for specific uses and will require that the covered member obtain prior authorization (pre-approval) for them to be covered. The prescribing doctor must provide additional information to Express Scripts to determine whether the use of these medications qualifies for coverage. If approved, the covered member will pay the normal copayment amount.

When obtaining prescription medication through a retail participating pharmacy or the mail order program, the following categories of medications may be subject to review and/or restrictions by SHARP:

- Amphetamines
- Analgesics (Stadol)
- Androgens/Anabolic Steroids
- Anti-Emetics
- Anti-Narcoleptic Agents
- Antiviral Agents
- Appetite Suppressants
- Atypical antipsychotic agents (select)
- Biotechnological Agents/Specialty Medications
- Cancer Therapy
- CNS Stimulants
- COX 2 Inhibitors (Celebrex)
- Select Dermatological
- Select Diabetic injectables (Victoza)
- Erythoid Stimulants
- Fertility Agents
- Growth Hormones
- Hypnotic Agents (Sleep Aids)
- Immune Globulins
- Interferon/Hepatitis C
- Leukotriene antagonists
- Migraine Therapy Drugs
- Multiple Sclerosis Medications
- Myeloid Stimulants
- Ophthalmic (select agents)
- Osteoporosis treatments
- Parkinson's Therapy (select agents)
- Pulmonary (select agents)
- Rheumatological
- Smoking Deterrents

Rx Option Exclusions:

1. Compound Medications: Compounds without National Drug Code (NDC) ingredients are not covered. A prior authorization will be required for a compound with an NDC ingredient.
2. Vitamins and/or dietary supplements are not covered.

Rx Option Considerations

1. **Member Pays the Difference for Brand Name Drugs:** If a generic medication is available and the covered member insists on the brand name medication, the covered member will be charged the brand name co-pay in addition to the difference in cost between the brand name medication and the generic medication.
2. **Step Therapy:** SHARP participates in Express Script's Step Therapy program which requires the covered member to first try one of more specified drugs to treat a particular condition before SHARP will cover another (usually more expensive) drug that the doctor may have prescribed. Step therapy is intended to reduce costs to the covered member and to SHARP by encouraging use of medications that are less expensive but can still treat a condition effectively.

If the covered member is taking a medication that requires step therapy, the covered member will receive a letter explaining that SHARP will not cover the medication unless the alternative medication is tried first. The letter will also have information on how to start a coverage review if the prescribing doctor believes the original prescribed medication should be taken. Please call Member Services, (800) 841-5396 or visit Express Script's website at www.express-scripts.com for further details.

Do not stop taking any medication prescribed by your doctor without first consulting with the doctor.

3. **Quantity per Dispensing Event:** If the prescription as written exceeds the generally accepted maximum quantity, the excess is not covered by SHARP.

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

- **Express Scripts Home Delivery:** Claims are automatically filed through the Express Scripts home delivery program.
- **Retail Pharmacy:** The co-payment on a prescription drug claim will be paid to the local pharmacy. The Express Scripts identification card indicates eligibility for the purchase of prescription drugs. Although most pharmacies participate with Express Script's pharmacy program, there are some that do not. If prescription drugs are purchased at a pharmacy that does NOT participate in the Express Scripts system, members will have to pay the full cost of the prescription filled and file a claim with Express Scripts for reimbursement. Contact Express Scripts at 1-800-841-5396 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.
- **Home Health Intravenous Medication:** Claims should be directed to the ARM claim office, either in the form of a paper or electronic claim, to the address listed on the back of the SHARP identification card. Only covered members who have selected the Rx Option are eligible for home health intravenous medication benefits.

Maximum Out of Pocket Limit for Prescription Drug Benefits

Unreimbursed eligible medical and prescription drug expenses under SHARP are limited to \$6,600 per person and \$13,200 per family in 2015. This out of pocket limit includes any co-payments and deductibles but does not include the premium costs.

Dental, Hearing and Vision Claim Submission:

Upon enrollment, the Eligible Retiree will receive a SHARP ID card, if they enrolled in the DVH Option. Healthcare providers may bill ARM directly.

- Paper claims should be sent to ARM at the address listed on the SHARP ID card.
- 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 on the back cover as well as on the back of the SHARP ID card.
- All claims must be filed within one year of the date of service.

NAD SHARP PLAN VENDOR PARTICIPANTS

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

HealthSCOPE Benefits



- Member Services – Medical
- Eligibility and Benefit Verification for providers (IVR available 24x7)
- Claims Processing Center – Medical
- Pre-Certification and Case Management
- On-line Member Portal
 - Track paid claims
 - Order replacement benefit ID cards
 - Credible medical information resource
 - And much more

Aetna Signature Administrators



- Preferred Provider Organization (PPO) – Medical
- Contracted rates and pre-determined discounting for provider services

Express Scripts



- Prescription Benefit Manager
- Member Services – Prescription benefits only
- Claims Processing Center – Prescription benefits only
- Specialty Pharmacy Services
- Pre-Certification – Prescription benefits only
- On-line Member Portal
 - Track and review paid prescription claims
 - Setup mail-order member responsibility payment
 - Designate mail-order shipping address if different than home address
 - And much more

BENEFIT PAYMENT PROVISIONS

There are several rules which affect how benefits are calculated under the Plan: in other words, these rules determine how each medical bill is paid by the Plan. These rules are described below. The services that are totally excluded from coverage under the Plan (for which no payment whatsoever is made) are listed in the Limitations and Exclusions Section of this document. Certain services require pre-certification for any benefit payment to be made and benefits for other services will be reduced if pre-certification is not obtained. The amount of the deductible, co-payments, co-insurance and out-of-pocket maximums differ depending upon whether you use in-network or out-of network providers.

DEDUCTIBLES

The deductible is the amount you must pay for health care services in most instances before the Plan begins to pay benefits. Deductible responsibilities are calculated and accrued based on dates of service, not date paid. Deductible amounts are calculated after all applicable PPO discounting has been applied. There is a deductible for most medical expenses (except medical benefits not requiring PPO access, office visits and preventive care services). There are no deductibles for medical benefits not requiring PPO access, dental, vision or hearing expenses (and these expenses do not count toward the medical deductible), and the deductible does not apply to certain preventive care services. (See the Schedule of Benefits for services that apply to the deductible). The Individual Plan Year Deductible is the amount of covered medical expenses with dates of service within the Plan Year period that must be paid first by or for each individual Member before benefits are paid by the Plan. The Family Plan Year Deductible is the amount of covered medical expenses with dates of service within the Plan Year period that must be paid first for all covered family members before benefits are paid by the Plan.

Benefit reductions due to non-compliance with the Plan or policy guidelines will not be credited toward the Deductibles.

CO-PAYMENTS

The Per Occurrence co-payment is an amount that is applied each time a specific type of medical service is provided before benefits are paid by the Plan (for example, use of emergency room). Amounts you pay for the Per Occurrence co-payments are not applied toward the individual or family plan year deductibles or out-of-pocket maximums.

The participating medical provider co-payment charge amount for office visits is less than the non-participating medical provider co-payment. The Plan pays the negotiated fee of the PPO provider less the flat dollar co-payment that you pay for participating provider and according to the Usual and Customary for non-participating providers.

PLAN'S PAYMENT OR PERCENTAGE RATE

After the applicable deductible, if any, has been met, the Plan pays a share of the medical expenses and the Member pays a share. The portion of the expenses that the Plan pays after you have met your deductible (or if no deductible applies to that expense) is known as the Plan's payment percentage or rate. The portion that the Member pays is known as the out-of-pocket or co-insurance. Co-payments does not apply toward a member's deductible or out-of-pocket amount (co-insurance). The Plan's payment rates for provider charges are outlined in the Schedule of Benefits section of this document.

OUT-OF-POCKET MAXIMUM (OOP)

There is an out-of-pocket maximum for medical expenses. After you have reached the out-of-pocket maximum towards all eligible medical services, the Plan will then pay 100% of the covered benefits, subject to any maximum payments provided in the Plan. Please refer to the Schedule of Benefits.

The following guidelines apply to Out-of-Pocket Maximum (OOP):

1. If you use a non-par provider, the out-of-pocket maximum (OOP) will **be greater than and separate from the OOP of the participating provider program**. Please refer to the Schedule of Benefits section of this document for the out-of-pocket maximum that applies when you use non-par providers.
2. Benefit reductions due to non-compliance with policy guidelines will not be credited towards the out-of-pocket maximum (OOP).
3. Plan Year deductibles, per occurrence co-payments, and office visit co-payments do not apply to the OOP.
4. See the Schedule of Benefits for specific items that are either included or excluded from the OOP. For example, Benefits not requiring PPO access do not count toward the OOP.

LIFETIME MAXIMUM BENEFITS

Maximum Lifetime Benefits are the maximum amount of covered Plan benefits for certain categories of medical services that will be paid on behalf of each Member by the Plan in the Member's lifetime while covered by the Plan. Please see the Schedule of Benefits for the specific benefit categories with lifetime limits and their respective maximum payable benefit amounts.

USUAL, REASONABLE, AND CUSTOMARY

"Usual, reasonable, and customary" (URC or U&C) fees are the reasonable fees usually charged in the geographic area where you receive the medical services, treatments, products, equipment or other items, or dental services. If your provider charges more than the "usual, reasonable, and customary" level, your benefits will be limited to and based on the usual, reasonable and customary charge for the services that you received. Out-of-network non-participating providers may bill you for differences between the Plan allowance, which is the amount paid by the Plan, and the provider's actual charge. This amount may be significant. Any charges in excess of the allowance are not covered under the plan. In-network, participating providers cannot bill you for charges in excess of their contracted allowable rates.

GENERAL BENEFIT RULES

Except for benefits paid for preventive services, benefits are only paid for medical expenses covered by the Plan if the expenses:

1. are medically necessary
2. represent a commonly accepted form of treatment and meet professionally recognized national standards of quality;
3. are recognized as generally accepted by the American medical community;
4. result from a non-occupational illness, injury or other event or cause;
5. are of a type specifically listed in the Plan Benefit Coverage section of this document;

6. are a type of expense for which the Plan does not otherwise limit or exclude payment; and
7. do not exceed Plan Year limits

All covered services, other than preventive care services, must be medically necessary. The Plan determines what is medically necessary and the decision is final and conclusive. Even though your Provider may recommend a procedure, service or supply, the recommendation does not always mean the care is medically necessary. **Medically necessary** means that a procedure, service or supply is **ALL** of the following:

1. Appropriate and necessary for the symptoms, diagnosis, and direct care or treatment of your illness or injury.
2. Consistent with professionally recognized standards of health care and given at the right time and in the right setting.
3. Not primarily for your convenience or the convenience of your primary care provider or other provider.
4. The most appropriate supply or level of service or supplies that can safely be provided.
5. Enables you to make reasonable progress in treatment.

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

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

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

Alternative treatment plans may be proposed by medical peer or utilization review organizations. However, the fact that a physician may prescribe, recommend, order, or approve a service or supply does not, of itself, determine medical necessity.

SCHEDULE OF BENEFITS***Plan Benefits Designated Provider Program January 1 – December 31, 2015**

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

MAJOR MEDICAL BENEFITS

Medical	Member Responsibility	
	In-Network	Out-of-Network
Preventive Services	0	50%
Paid at 100% of allowable charges in-network, 50% of U&C out-of-network		
<ul style="list-style-type: none"> • Age, gender and frequency criteria • Adult physical/immunizations • Well child visits/immunizations • Screenings 		
Plan Year Deductible		
Individual	\$600	\$2,500
Family	\$1,200	\$5,000
Co-Insurance (after deductible) Paid by Member	20%	50%
Out-of-Pocket Maximum		
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000
Office Visit (copays)	\$50	\$80
<ul style="list-style-type: none"> • Applies to office visit charge , based on contracted rate in-network or U&C out-of-network • Copay does not apply to Plan Year deductible • Copay does not apply to out-of-pocket maximum • All other services apply to deductible and coinsurance 		
Outpatient Services	20%	50%
<ul style="list-style-type: none"> • Paid at 80% of allowable charges in-network; 50% of U&C out-of-network • Applies to Plan Year deductible and coinsurance 		
Emergency Room (copays and co-insurance)	\$200 + 20%	\$200 + 20%
<ul style="list-style-type: none"> • Paid at 80% of allowable charges after \$200 copay per occurrence • Copay does not apply to Plan Year deductible or out-of-pocket maximum • Copayment waived if admitted 		

Schedule of Benefits-continued	In-Network	Out-of-Network
Urgent Care Centers	\$50 or \$200	\$80 or \$200
<ul style="list-style-type: none"> • May be paid as an office visit or as an Emergency Room visit according to provider contract • Payment based on contracted rate in-network; 50% of U&C out-of-network • Charges with no applicable copay apply to Plan Year deductible and out-of-pocket maximum • Facility fees for office visits are not paid 	+ 20%	+ 50%
<hr/>		
Inpatient/Outpatient Hospital Stays:		
Office/Ambulatory Surgical Procedures		
<p>Paid at 80% of allowable charges in-network; 50% of U&C out-of-network</p> <p>Pre-Certification required to receive full Plan benefits</p> <p>Applies to correlating Plan Year deductible and out-of-pocket maximum</p>	20%	50%
Durable Medical Equipment	20%	50%
<ul style="list-style-type: none"> • Paid at 80% of allowable charges in-network; 50% of U&C out-of-network • \$8,000 maximum payment per Plan Year • Charges above \$1,500 require pre-certification • All rentals require pre-certification • Applies to Plan Year deductible and out-of-pocket maximum 		
Mental Health Outpatient Services / Partial Hospitalization		
Copay applies only to counseling session , charges based on contracted rate in-network or U&C out-of-network	\$50	\$80
<ul style="list-style-type: none"> • Copay does not apply to Plan Year deductible or out-of-pocket maximums • All other charges are paid at 80% of in-network allowable; 50% of U&C out-of-network • Other charge apply to correlating Plan year deductible and out-of-pocket maximum • Some services may require pre-certification to receive full Plan benefits 	20%	50%
Mental Health Inpatient Services	20%	50%
<ul style="list-style-type: none"> • Paid at 80% of allowable charges in-network; 50% of U&C out-of-network • Pre-certification required to receive full Plan benefits • Applies to correlating Plan Year deductible and coinsurance 		

Substance Abuse/Chemical Dependency	\$50	\$80
Outpatient/Partial Facility Visits		
<ul style="list-style-type: none"> • Copay applies only to counseling session charge based on contracted rate in-network or U&C out-of-network • Copay does not apply to Plan Year deductible or out-of-pocket maximum • All other charges are paid at 80% of in-network allowable; 50% of U&C out-of-network • Other charges apply to correlating Plan Year deductible and out-of-pocket maximum • Services may require pre-certification to receive full Plan benefits 	20%	50%
Substance Abuse/Chemical Dependency		
Inpatient Treatment	20%	50%
<ul style="list-style-type: none"> • Paid at 80% of allowable charge in-network; 50% of U&C out-of-network • Pre-certification required to receive full Plan benefits • Applies to correlating Plan Year deductible and out-of-pocket maximum 		
Hearing Care Medical	20%	50%
Professional Testing and Services		
<ul style="list-style-type: none"> • Paid at 80% of allowable charges in-network; 50% of U&C out-of-network • Applies to correlating Plan Year deductible and out-of-pocket maximum 		
Home Health Care	20%	50%
<ul style="list-style-type: none"> • Paid at 80% of allowable charge in-network; 50% of U&C out-of-network • Maximum of 52 visits per Plan Year • Pre-certification required to receive full Plan benefits • Applies to correlating Plan Year deductible and out-of-pocket maximum 		
Hospice Care	0	0
<ul style="list-style-type: none"> • Paid at 100% of Provider's Charges • Pre-certification required to receive full Plan benefits 		
Organ/Tissue Transplants	20%	50%
<ul style="list-style-type: none"> • Pre-certification required to receive full Plan benefits • Applies to correlating Plan Year deductible and out-of-pocket maximum 		
Therapeutic Services	20%	50%
Physical Therapy		
Occupational Therapy		
Speech Therapy		
Vision Therapy		
<ul style="list-style-type: none"> • Maximum of 30 visits per therapeutic category • Applies to correlating Plan Year deductible and out-of-pocket maximum • Vision therapy requires pre-certification to receive full benefit 		

While categorized as medical benefits, the following services do not require PPO Network utilization

	Member Responsibility
Alternative Therapies	
Chiropractic Services	50%
<ul style="list-style-type: none"> • Paid at 50% of allowable charges • Maximum of 30 visits per Plan Year • Limited to spinal manipulation after annual office visit and x-ray • Does not apply to Plan Year deductible or out-of-pocket maximum • Must be age 10 or older 	
Acupuncture Therapy- Not Covered	100%
Massage Therapy- Not Covered	100%
Refractive Eye Surgery	
<ul style="list-style-type: none"> • Paid at 50% of allowable charges • Lifetime maximum payable benefit of \$2,400 • Does not apply to Plan Year deductible or out-of-pocket maximum 	50%

DENTAL BENEFIT

Co-Insurance	20%
Maximum Payable Benefit	
Individual	\$2,200
Dental Care	
• Paid at 80% of Provider's charges	20%
• Usual, Reasonable and Customary (U&C) applies	
Orthodontic Care – Non-Medicare Member Only	50%
• Paid at 50% of allowable charges in-network or out-of-network	
• \$2,300 maximum lifetime payable	
• Eligible up to age 24 (through age 23)	
• <u>Orthodontia Care for Non-Medicare Members only</u>	

HEARING AIDS BENEFIT

Hearing Aids	20%
• Paid at 80% of allowable charges	
• Plan Year maximum payable benefit of \$2,200	
• Does have a one year look back benefit	

VISION BENEFITS

Vision Care	20%
• Paid at 80% of allowable charges	
• Plan Year maximum payable benefit \$400	

PRESCRIPTION BENEFITS

Prescription copay responsibility

Retail – 30-day supply		Mail Order – 90-day Supply	
Generic	\$12	Generic	\$29
Brand (Preferred)	\$29	Brand (Preferred)	\$70
Non-Formulary	\$45	Non-Formulary	\$110

- Penalties for non-compliance
- Preventive Care prescriptions paid by Plan at 100% (and members pay \$0)

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

Any HealthSCOPE adjudication, pre-certification, Plan provision or requirement will take precedence over those documents in the SHARP Pre-Medicare/Non-Medicare plan.

Note: For all Health Plan Benefits, the following apply:

- Co-payments do not accrue toward deductible or out-of-pocket maximum
- All charges apply to deductible and out-of-pocket maximum unless otherwise noted
- Non-compliance penalties do not accrue toward deductible or out-of-pocket maximum
- Usual & Customer (U&C) applies to all out-of-network services. This includes preventive care, office visits and counseling sessions as well as all other medical and dental services.
- Charges in excess of U&C are member responsibility
- Any adjudication, pre-certification, Plan provision or requirement of the Plan's designated Pre-certification office will take precedence over those documented in the Plan.

If you reside in a PPO area, but you elect not to participate in the participating provider program, your covered benefits will be reduced in four major ways:

1. Difference in deductible from In-Network benefits to Out-of-Network benefits
2. Difference in out-of-pocket maximum paid from In-Network benefits to Out-of-Network benefits
3. Charges in excess of Usual and Customary
4. Difference in Copay from In-Network benefits to Out-of-Network benefits

NOTE: The Out-of-Network deductible and coinsurance responsibilities are in addition to or separate from the In-Network deductible and coinsurance responsibilities. If you utilize a combination of In-Network and Out-of-Network providers, your member responsibility could be as high as both In-Network and Out-of-Network responsibilities combined.

IMPORTANT NOTICE CONCERNING NON-PARTICIPATING BENEFITS

If you reside in a PPO area, but you elect not to participate in the participating provider program, your covered benefits will be reduced in five major ways:

1. The deductible non-participating provider charges are \$2,500/individual or \$5,000/family per Plan Year for Medical services. This is a separate, distinct and additional deductible responsibility from the in-network Plan Year deductible.
2. The out-of-pocket maximum (OOP) for non-participating provider charges is \$10,000/individual or \$20,000/family per Plan Year for Medical services. This is a separate, distinct and additional OOP responsibility from the in-network Plan Year OOP maximum.
3. Usual, Reasonable, and Customary applies (U&C) applies to all out-of-network service including preventive care, office visits and counseling session as well as all other Plan benefits.
4. After required deductibles have been met, charges for hospitals and facilities, outpatient services, office visits and urgent care centers will be paid at 50% of the Provider's charges not to exceed U&C. The Member's responsibility is 50% of allowable charges and as well as excess of U&C.
5. The \$80 office visit co-payment applies to non-participating providers; in addition, any applicable excess of U&C.

THE PLAN'S PRE-CERTIFICATION LIST

You must obtain a pre-certification of benefits for the following services noted as requiring pre-certification or your benefits will be reduced. This is an exemplary listing and not intended to be viewed as complete. Your provider must contact the Pre-Certification Department for appropriate guidelines for your specific circumstance.

Pre-certification is a determination of medical necessity only; it is not a guarantee of benefits or payment for services rendered, nor does it validate the PPO network participating status of the provider or facility.

SERVICE

All Inpatient Admissions

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

Ambulance Transport

Outpatient-Surgeries

- Back Surgeries
- Bowel and gastric surgeries (except routine preventive colonoscopy)
- Osteochondral Allograft, knee
- Hysterectomy (including prophylactic)
- Hearing implants
- Procedures related to Chiari's malformation
- Cosmetic Procedures (including but not limited to)
 - Abdominoplasty
 - Blepharoplasty
 - Facial skin lesions (MOHS, photo therapy, laser therapy)
 - Hernia repair, abdominal and incisional (only when associated with a cosmetic procedure)
 - IDET (Thermal Intradiscal Procedures)
 - Liposuction/lipectomy
 - Mammoplasty, augmentation and reduction (includes removal of implant)
 - Mastectomy, gynecomastia and prophylactic
 - Morbid obesity procedures
 - Orthognathic procedures (ex: Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
 - Otoplasty
 - Palatopharyngoplasty (UPP for snoring)
 - Panniculectomy
 - Rhinoplasty
 - Rhytidectomy
 - Scar revisions
 - Septoplasty
 - Varicose vein surgery/sclerotherapy

Outpatient – Continuing Care Services Pre-Certification

- Chemotherapy
- Radiation
- Dialysis
- Hyperbaric Oxygen
- Infusion Therapy in a Home Setting
- Infusion Therapy Drugs
- Prosthetics
- Pain Management Procedures (including epidural steroid injections)
- Outpatient Sub-acute
 - Home Health Care
 - Hospice
 - Durable Medical Equipment over \$1500
- Vision Therapy
- Intensive Outpatient/Partial Hospitalization

The provider should call the pre-certification telephone number listed on the back of your identification card to initiate pre-certification.

Whether you use a provider who is participating in the Preferred Provider Organization or is out-of-network, it is your responsibility to ensure the provider has obtained the required prior-certification, per Plan guidelines. You may be responsible for financial penalties if services requiring pre-certification are not pre-certified. There is a \$1,000 penalty for failure to pre-certify inpatient services or treatment, and a 20% reduction in benefits (up to a maximum of \$1,000) for failure to pre-certify outpatient services or treatment.

Pre-certification is not a determination of in-network status, eligibility or a guarantee of payment. Coverage and payment are contingent upon, among other things, the patient being eligible, i.e., actively enrolled in the health benefits plan when the pre-certification is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions and other specific terms of the health benefits plan that apply to the coverage request.

PREVENTIVE CARE SERVICES - MEDICAL

The Plan pays benefits for certain Preventive Care Services listed in this Section. These Preventive Care Services are summarized in this Section. Benefits will be covered under this Preventive Care Services benefit, not any other benefit, if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force, the Health Resources and Services Administration, or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC). In the event any of these bodies adopts a new or revised recommendation, this Plan has up to one year before coverage of the related services must be available and effective under this benefit.

If you utilize an in-network Provider, the Plan pays 100% of the cost of these Covered Services, without co-payments, and the Plan deductibles do not apply. **Preventive Care Services performed by an out-of-network provider will not qualify at the 100% benefit rate, but may be eligible for consideration at the out-of-network rate of 60% of Usual and Customary.**

Preventive Care services are generally performed to prevent disease or to catch the early warning signs of health problems. Preventive Care Services are only covered if you have no symptoms of disease. You are not eligible for these benefits if you are receiving medical services to treat an illness or injury, although you are eligible for benefits for services to treat an illness or injury under other provisions of the Plan. If during a preventive screening examination and/or service, a condition is discovered and treatment is rendered during that visit, the transition from 'preventive' status to 'treatment' status may cause the claim to be processed with applicable deductible and out-of-pocket responsibility.

Preventive Care services are periodically reviewed. The frequency or type of Preventive Care Services may change according to updated recommended guidelines by the Center for Disease Control or federal law. The Plan will provide notice of any such changes to SHARP or by amendment to the Plan.

This only describes the Preventive Care Services for which benefits are paid by the Plan. The Plan does not provide medical advice and is not to be considered a substitute for the medical judgment of your attending physician or other health care provider. Even though the Plan covers a test or an immunization, your physician may recommend that you do not undertake the test or immunization, and may recommend that you have tests or immunizations not covered by the Plan. In all instances, the final and ultimate decisions concerning the appropriate and desired immunizations, tests, and other preventive care measures and medical treatments are up to you and the physician or other professional providing your treatment.

1. Pediatric Preventive Care Covered Services

The Plan pays benefits for the following Pediatric Preventive Care Covered Services:

- a. Physical Examination, Routine History, Routine Diagnostic Tests. Benefits for well-baby care, which generally includes a medical history, height and weight measurement, physical examination and counseling, are limited to Members who are less than eighteen (18) years of age in accordance with the schedule shown below. When a range is given (i.e. 2-3 months), the dash indicates that benefits are provided for one service from two (2) months through three (3) months of age.

Twenty-four (24) examinations up to age seventeen (17) – according to each of the following age groupings:

- Eight (8) exams between the ages of 0-24 months, consisting of one (1) exam within each of the following age ranges:

0-1 months	9-11 months
2-3 months	12-14 months
4-5 months	15-17 months
6-8 months	18-24 months
- One (1) exam every calendar year between two (2) and seventeen (17) years of age

b. Blood Lead Screening. This blood test detects elevated lead levels in the blood.

Children participating in the Plan are covered for:

- One (1) test between 9-12 months of age
- One (1) test at twenty-four (24) months of age

c. Hemoglobin/Hematocrit. This blood test measures the size, shape, number and content of red blood cells. Children participating in the Plan are covered for:

- One (1) test between 0-12 months of age
- One (1) test between one (1) and four (4) years of age
- One (1) test between five (5) and twelve (12) years of age
- One (1) test between thirteen (13) and seventeen (17) years of age

d. Rubella Titer Test. The rubella titer blood test checks for the presence of rubella antibodies. If no antibodies are present, your physician may recommend that a rubella immunization should be given. The rubella titer blood test may be recommended by your physician if there is uncertainty whether the child has ever been immunized. Children participating in the Plan are covered for one (1) test and immunization between eleven (11) and seventeen (17) years of age.

e. Urinalysis. This test detects numerous abnormalities. Children are covered for:

- One (1) test every 365 days between 0-24 months of age
- One (1) test every calendar year between two (2) and seventeen (17) years of age

2. Pediatric Immunizations Preventive Care Covered Services

Benefits will be provided for those pediatric immunizations, including the immunizing agents, which conform to the Standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services (HHS). Benefits are limited to Covered Persons under twenty-one (21) years of age. Please contact Blue Cross to determine if a particular immunization is covered.

3. Adult Preventive Care Covered Services (18 Years or Older)

a. Physical Examination, Routine History. The Plan provides benefits for well-person physical examination and counseling for Members eighteen (18) years of age or older in accordance with the following schedule:

- One (1) examination every calendar year at eighteen (18), nineteen (19), twenty (20), and twenty-one (21) years of age
- One (1) examination every three (3) calendar years between twenty-two (22) and thirty-nine (39) years of age

- One (1) examination every calendar year, beginning at forty (40) years of age
- b. Adult Immunization. Benefits will be provided for these adult immunizations, including the immunizing agents, which conform to the Standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services (HHS). Benefits are limited to covered persons age 18 and over. Please contact Member Services to determine if a particular immunization is covered.
- c. Blood Cholesterol Test. High blood cholesterol is one of the risk factors for coronary artery disease. The Plan provides benefits for a blood test measuring the total serum cholesterol level in accordance with the following schedule
 - One (1) test every four (4) calendar years between eighteen (18) and thirty-nine (39) years of age
 - One (1) test every calendar year, beginning at forty (40) years of age
- d. Complete Blood Count (CBC). The Plan provides benefits for this blood test which checks the red and white blood cell levels, hemoglobin and hematocrit as follows:
 - One (1) test every calendar year at eighteen (18), nineteen (19), twenty (20), and twenty-one years of age
 - One (1) test every three (3) calendar years between twenty-two (22) and thirty-nine (39) years of age
 - One (1) test every calendar year, beginning at forty (40) years of age
- e. Fecal Occult Blood Test. The Plan provides benefits for this test checking the presence of blood in the feces, which is an early indicator of colorectal cancer as follows:
 - One (1) test every calendar year beginning at fifty (50) years of age
- f. Flexible Sigmoidoscopy. The Plan provides benefits for this test, which is conducted to detect possible colorectal cancer by use of a flexible fiber optic sigmoidoscope, as follows:
 - One (1) test every three (3) calendar years, beginning at fifty (50) years of age
- g. Prostate Specific Antigen (PSA). The Plan provides benefits for this blood test which may be used to detect tumors of the prostate, as follows:
 - One (1) test every calendar year for men, beginning at fifty (50) years of age
- h. Routine Colonoscopy. The Plan provides benefits for this test used to detect colorectal cancer by use of a flexible fiber optic colonoscope, as follows:
 - One (1) test every ten (10) calendar years, beginning at fifty (50) years of age
- i. Thyroid Function Test. The Plan pays benefits for this test to detect hyperthyroidism and hypothyroidism, as follows:
 - One (1) series of test every calendar year, beginning at eighteen (18) years of age
- j. Urinalysis. The Plan pays benefits for this test to detect numerous abnormalities, as follows:
 - One (1) test every calendar year, beginning at eighteen (18) years of age
- k. Fasting Blood Glucose Test. The Plan pays benefits for this test used for detection for diabetes, as follows:
 - One (1) test every three (3) years beginning at forty-five (45) years if age

- I. Abdominal Aortic Aneurysm screening. The Plan pays benefits for one (1) screening per lifetime for men only (this screening is not recommended by HHS for women). Your physician may recommend this screening for men with a smoking history.
 - One (1) ultrasound between sixty-five (65) and seventy-five (75) years of age.
- m. HIV Test. The Plan pays benefits for test to determine if the patient has HIV or any sexually transmitted disease.

4. Routine Gynecological Examination, Pap Smear

Benefits are provided for women covered by the Plan who are eighteen years of age or older for one (1) routine gynecological examination each calendar year, including a pelvic examination and clinical breast examination; and routine Pap smears in accordance with the recommendation of the American College of Obstetricians and Gynecologists. Benefits are provided for sterilization procedures for women. For women 30 years or older, benefits are provided for human papillomavirus (HPV) DNA testing. Benefits are provided for certain prenatal services as required by federal law such as testing for gestational diabetes.

5. Mammograms

Benefits are provided for women covered by the Plan who are eighteen (18) years of age or older, coverage for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992.

6. Breastfeeding support, supplies and counseling

Benefits are provided for support, supplies and counseling for women who are breastfeeding. (Additional maternity benefits are available through the “Maternity Management” program.)

7. Osteoporosis Screening (Bone Mineral Density Testing or BMDT)

Benefits are provided for Bone Mineral Density Testing using a U.S. Food and Drug Administration approved method. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength, which is the aggregate of bone density and bone quality. Bone quality refers to architecture, turnover and mineralization of bone. The BMDT must be prescribed by a Covered Provider legally authorized under law to prescribe such a test.

1. One (1) screening test every two calendar years beginning at age 65

8. Additional Immunizations for High Risk Members

If you are considered to be in a “high risk” population as determined by the Plan’s Case Management office, benefits may be provided for certain immunizations not otherwise covered by the Plan. Please contact the number on the back of your member ID card to determine if you are in a high risk population, and if so, which additional immunizations are covered by the Plan.

PREVENTIVE CARE SERVICES – PRESCRIPTION

The following list of preventive medications shall be used as a guide and should not be considered a comprehensive listing of medications available or covered without cost-sharing. Coverage of any of the listed medications requires a prescription from a licensed health care provider and must be filled at a participating network pharmacy. Additional plan requirements may apply (i.e., pre-authorization, home delivery).

Drug or Drug Category

Aspirin – to prevent cardiovascular events

Aspirin 81 MG and 325 MG

a. Men ages 45 to 79 years

b. Women ages 55 to 79 years

Bowel Prep Agents

Bisacodyl, Magnesium Citrate, Milk of Magnesia, PEG 3350-Electrolyte

a. Men and women ages >49 and <76 years of age

b. Fill Limit: 2 prescriptions per 365 days

Female Contraception Methods– all FDA-approved methods of contraception for women; hormonal, barrier, emergency, and implanted devices Includes over-the-counter contraceptive methods, oral contraceptives and contraceptive devices

Women up to age 50 years

Folic Acid

Folic acid tablet 0.4 MG and 0.8 MG; prenatal vitamins with folic acid; multivitamins with folic acid

Women through age 50 year

Iron Supplements

Iron (various strengths) drops, liquid, suspension, granules, chewable 0.25MG and 0.5MG, drops 0.25MG and 0.5MG suspension

Children ages 6 to 12 months who are at risk for iron deficiency anemia

Oral Fluoride

Fluoride chewable tablet 0.25 MG and 0.5 MG; Fluoride drops 0.125 MG, 0.25 MG and 0.5 MG

Children older than 6 months of age through age 5

Smoking Cessation

Bupropion SR 150 MG; Chantix; Nicotine gum, lozenge, and patch (OTC products only)

Men and women ages > 18 who use tobacco products

Vitamin D

Vitamin D 1,000 units or less per dose unit; calcium with vitamin D

Men and women ages >65 who are at risk of falls

BENEFIT PLAN COVERAGE

This section describes the benefits provided by your SHARP Pre-Medicare/Non-Medicare plan. Please refer to the Schedule of Benefits for the specific payment percentages, maximum amounts payable, and co-payment requirements.

MAJOR MEDICAL SERVICES

To avoid a reduction in benefits and potential excess charges above U&C, you must use a participating provider if there is one within the appropriate mile radius of where you live or work for your area. While this may be generally 25 miles, the determination is made based on the density of population and provider availability in a geographic area.

By choosing not to use a par provider to which you have access, your benefits are similar to the participating provider program, except for four major differences:

1. There is a separate and additional out-of-pocket maximum (OOP) for non-participating providers. See the Schedule of Benefits for specific Out-of-Pocket Maximum limits for the participating provider program and the out-of-network benefits.
2. After deductibles have been met, the Plan generally pays less of the charges for hospitals and facilities, outpatient services, office visits and urgent care centers as identified in the Schedule of Benefits.
3. Office Visits to non-participating providers have a higher co-payment than participating providers and Usual & Customary. The higher co-payment is the member responsibility. See the current Schedule of Benefits.
4. Usual, Reasonable and Customary applies, and you are responsible for paying 100% of all amounts which exceed the U&C amounts.

You are automatically deemed a participant in the participating provider program. However, if you reside outside of the chosen PPO's coverage area, you will be provided with the same benefits as those participating in the participating provider program. SHARP and the Plan Administrator will determine your participation based on PPO access.

NOTE: Plan provisions may vary based on location.

Your benefits and other plan provisions under the Plan may vary from state to state depending upon:

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

AMBULANCE SERVICES

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

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

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

1. No other method of transportation is appropriate.
2. The services necessary to treat this illness or injury are not available in the hospital or nursing facility where you may be an inpatient.
3. The hospital or nursing facility is nearby and adequate facilities are available to treat your medical condition.
4. Coverage for air ambulance services has been pre-certified by the Plan Administrator. Any ambulance transportation other than to a facility for urgent treatment must have prior approval. Non-approved charges will not be paid.

EMERGENCY/URGENT CARE SERVICES

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

HOSPITALIZATION AND SURGERY

Hospital, Skilled Nursing Facility, Ambulatory Surgery Center

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

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

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

ORGAN/TISSUE TRANSPLANT

Covered Services and Expenses

The Plan covers necessary expenses relating to organ and tissue transplants. Services and expenses related to organ/tissue transplant benefits must be pre-certified. Once services and/or treatment are pre-certified, a Member will be directed to a facility for the necessary services and/or treatment. Lack of pre-certification may result in forfeiture of all Plan benefits relating to the organ/tissue transplant.

A Member may be eligible as a recipient or donor under this benefit. A recipient is a Member who receives a body organ or tissue transplant and a donor is a Member, either living or deceased, who donates tissue or a body organ for transplant.

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

This benefit covers services and supplies as listed below up to the benefit amounts shown in the Schedule of Benefits section of this document.

Recipient Benefits

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

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

Donor Costs for Members

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

HOME HEALTH CARE

The Plan provides benefits for Home Health Care if provided by an appropriately licensed entity staffed by licensed and credentialed home health care professionals meeting all state and federal requirements. The Home Health Care Plan provides for medically warranted continued care and treatment after discharge from a hospital and must be in lieu of hospitalization.

Please refer to the Schedule of Benefits section of this document for benefits, coverage, limitations and member responsibility. Pre-certification requirements apply.

Pre-Certification Requirements

You must obtain pre-certification from the Pre-Certification Department. The home health agency must submit a Home Health Care Plan for approval prior to rendering of home health care services that are provided in lieu of hospitalization.

Limitations

Home Health Care does not include charges made for:

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

SKILLED NURSING FACILITIES

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

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

Skilled Nursing Facility Confinement Pre-Certification Requirements

Any Skilled Nursing Facility confinement must be pre-authorized by contacting the Plan's Pre-Certification Department who must pre-approve a treatment plan in order for the expenses to be covered by the Plan.

HOSPICE CARE

Covered Services and Expenses

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

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

Pre-Certification Requirements

In order to receive in-patient or respite benefits, you must obtain pre-certification before hospice care services are initiated.

Other Limitations

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

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

DURABLE MEDICAL EQUIPMENT**Covered Services and Expenses**

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

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

Rental Charges

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

Purchase Charges

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

Repair and Replacement

The Plan covers charges for repair of purchased equipment and accessories. Replacement of purchased equipment is covered only if the Pre-Certification Department determines that it is warranted due to change in the member’s physical condition or it is more cost effective to repair or rent like equipment.

Other Limitations or Exclusions

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

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

Pre-Certification Requirements

To receive any benefits for durable medical equipment, your physician must recommend the equipment or device. The Plan’s Pre-Certification Department must receive satisfactory evidence that the items involved are medically necessary and not for convenience purposes. If you have any questions whether a device is covered, please contact the Plan’s Member Services number on the back of your benefit identification card.

PROSTHETICS

Pre-certification of preferred supplies is required for items with a billed amount that exceeds \$1,500 (including replacement and repairs). Failure to pre-certify preferred services will result in a reduction in benefits payable by the Plan.

THERAPEUTIC CARE

Physical Therapy

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

No referral from your MD/DO is necessary.

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

Occupational Therapy

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

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

Speech and Language Pathology Therapy

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

Vision Therapy

The Plan provides coverage for orthoptic/pleoptic training. See the Schedule of Benefits that describes the applicable visit limits and co-insurance amounts.

Vision Therapy services require pre-certification for full consideration of coverage and payment. Charges may be denied or **paid with a non-certification penalty** without pre-certification.

Other Plan Limitations and Exclusions

There are a maximum number of visits for each type of care covered per Plan Year and these services are subject to a co-insurance percentage. See the Schedule of Benefits that describes the applicable visit limits and co-insurance amounts.

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

HEARING CARE - Medical

Covered services for hearing care assistance include:

1. audiometricians
2. hearing specialists
3. hearing aids and repairs (does not require PPO network utilization); and

4. surgically placed devices such as cochlear implants upon prior certification by the Plan's Pre-Certification Department

MENTAL HEALTH SERVICES

Covered Services and Expenses

The Plan covers physicians' and other authorized providers' charges for inpatient and partial hospitalization, of mental health disorders, and for counseling services for marital and family conflicts, and social adjustment subject to the limitations indicated below.

Inpatient and intensive out-patient/partial hospitalization mental health services are subject to pre-certification by the Pre-Certification Department. Reference the Schedule of Benefits for member responsibility.

Residential care and treatment are not covered.

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

SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY TREATMENT

Covered Services and Expenses

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

Inpatient substance abuse and chemical dependency treatments are subject to pre-certification by the Pre-Certification Department.

Inpatient and intensive out-patient/partial hospitalization mental health services are subject to pre-certification by the Pre-Certification Department. Reference the Schedule of Benefits for member responsibility.

Residential care and treatment are not covered.

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

ALTERNATIVE THERAPIES

Complementary and Alternative Medicine

The Plan recognizes the National Center for Complementary and Alternative Medicine (NCCAM) as the authority in defining complementary and alternative medicines (CAM). CAM, as defined by the NCCAM, is a group of diverse medical and health care systems, practices, and products that are not presently considered part of conventional medicine. Coverage for CAM is limited under the Plan. The coverage is limited to Chiropractic Treatment. All other CAM therapies, services, tests, laboratory tests, procedures, products, and practices are not covered under the Plan.

Chiropractic Treatment

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

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

Participants must be age 10 or older to be eligible for chiropractic benefits.

REFRACTIVE EYE SURGERY

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

COORDINATION OF BENEFITS

When a Member also has coverage under another group health plan, the Plan coordinates benefits with the other plan. The Plan follows the rules set forth below to determine whether this Plan pays first, or whether this Plan pays second. If this Plan pays first, benefits under this Plan are determined without considering the benefits available to the Member under another group health plan. When this Plan is second, the benefits under this Plan are determined after those of the other plan and may be reduced because of the other plan's benefits. Total payments between this Plan and another group plan will not exceed this Plan's payment responsibility as if this Plan had been primary. There is no coordination of benefits of this Plan to itself.

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

- other coverage from current employment of an Eligible Spouse.

COORDINATION OF BENEFITS DEFINITIONS

The following definitions will apply only to this Coordination of Benefits section of this document:

1. "Adventist Plan" means the Plan described in this booklet.
2. "Benefit Plan" means any group health plan, including the Adventist Plan, which provides benefits or services for medical care or treatment that is a plan of:
 - a. Group insurance and group subscriber coverage and any other program of benefits or services for individuals as a group, whether insured or not
 - b. Group prepaid coverage plans
 - c. Group or group-type coverage through HMOs and other prepayment, group practice, blanket or service plans
 - d. Any coverage through labor-management plans
 - e. Medicare or any other governmental program except for Medicaid; or
 - f. Automobile or no-fault insurance policy (group or individual). The term does not include individual or family insurance contracts or policies, individual or family coverage through HMOs, except for automobile or no-fault insurance policies.
3. "Other Plan" means any Benefit Plan other than the Adventist Plan.
4. "Birthday" means the month and day in a calendar year, and does not consider the year in which the person was born

COORDINATION WITH MEDICARE BENEFITS

Medicare is the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended. The coordination of benefit rules for Medicare and the Adventist Plan are as follows:

1. **Persons Who Reject Adventist Coverage.** Persons who are entitled to Medicare may elect to reject coverage under the Adventist Plan and choose coverage under Medicare as their primary payer. If such an election is made, coverage under the Adventist Plan will cease for all categories of health care services.
2. **Persons Covered by Both Medicare and the Adventist Plan.** To the extent required by federal

law, the Adventist Plan will be first and Medicare benefits will be second. In all other instances, Medicare benefits will be first and the Adventist Plan second. The most important federal law Medicare coordination of benefits rules are as follows:

- a. End Stage Renal Disease. The Adventist Plan pays first, and Medicare pays second during the first thirty (30) consecutive months after a Member is first eligible for Medicare due to End Stage Renal Disease (“ESRD”) if a Member is eligible for Medicare benefits solely because of ESRD.

After the first thirty (30) consecutive months after a Member is first eligible for Medicare due to ESRD, Medicare will pay first; and the SHARP Plan second. Members are required to apply for Medicare Part A and Part B benefits for ESRD as soon as they are diagnosed with ESRD. Enrollment in Standard SHARP is required once Medicare Part A & Part B are primary for the member.

- b. If you are eligible for Medicare due to disability or ESRD, and in all instances in which your coverage under the Adventist Plan is being provided as Continuation Coverage, you and each dependent covered by the Adventist Plan must enroll in Medicare Part A and Part B as soon as possible. Coverage will automatically be coordinated with any governmental plan, such as Medicare or Medicare Advantage, for which a Member would be eligible at the time the Member incurs a medical expense, whether or not the Member has actually applied for such governmental coverage, is covered to receive payment from the governmental plan, or whether the provider is an eligible provider for the governmental plan. Thus, once a Member is eligible for Medicare or other governmental plan and the Adventist Plan would be secondary to Medicare or other governmental plan, the Adventist Plan will treat the Participant’s bills as having been paid by the governmental plan such as Medicare (on a primary basis) whether or not the bills have so been paid by the governmental plan. The Member’s benefits under the Adventist Plan are limited to what the Adventist Plan would have paid, including deductions or benefits under the Adventist Plan’s coordination of benefits rules, if the Member had applied for, been eligible for the governmental plan and had received services from an eligible provider for the governmental plan.

Regarding this provision in the Adventist Plan which operates to carve out of the Adventist Plan’s coverage an amount equivalent to the Medicare payment that would be made if the services were provided by a provider to whom payment would be made under Part A or Part B of Medicare or other governmental plan, the Adventist Plan specifically disallows payment as the primary payer to all medical providers to whom payment would be made and would not be made under Medicare or other governmental plan (including payment under Part A, Part B, a Medicare HMO, or a Medicare Advantage Plan).

COORDINATION OF BENEFITS WITH AUTOMOBILE POLICIES

Except as otherwise required by state law, the automobile or no-fault insurance pays first and the Adventist Plan pays second.

COORDINATION OF BENEFITS WITH OTHER PLANS

When a person is covered by the Adventist Plan and is also covered by another plan that is not Medicare or an automobile or no-fault insurance policy, the rules for deciding which Benefit Plan pays first are as follows:

Other Plan with No Coordination of Benefits Rules

If the Other Plan does not have a coordination of benefits provision, the Other Plan always pays first and the Adventist Plan pays second.

Longer/Shorter Length of Coverage Rule

If none of the above rules determines the order of benefits, the benefits of the Benefit Plan that covered a retiree, member or subscriber longer are determined before those of the plan that covered that person for the shorter time.

Special Coordination of Benefit Rules

Notwithstanding the rules stated above, the Adventist Plan coordinates benefits as follows in the situation listed below.

Rule For Other Plans, Which Are Always Excess or Second. If the Other Plan provides that its coverage is “excess” to all others or that it is always second, the Adventist Plan shall pay as primary.

Coordination of Benefits-Effects on Benefits

1. If the Adventist Plan is Primary - Under the rules set forth above, Plan benefits are paid without consideration of the benefits available or paid under the Other Plan.
2. If Adventist Plan is Secondary - When the Adventist Plan is secondary under the rules set forth above to any Other Plan, the Adventist Plan pays an amount equal to the Plan benefits or an amount that, when added to the primary payer payment amount, equals no more than this Plan's total payment responsibility.

EXCHANGE OF INFORMATION AND PAYMENT**Allocation of Benefits and Deductibles**

When benefits provided under an Other Plan are not allocated to a specific service, the benefits will be deemed by the Adventist Plan to apply pro rata to the services for which the benefits are paid. When a deductible amount applies to the benefits under an Other Plan, the deductible shall be deemed by the Adventist Plan to apply pro rata to each of the benefits factors under the Other Plan.

Discovery of Other Plans

The Adventist Plan assumes no obligation to discover the existence of coverage under Other Plans or for benefits payable under Other Plans when they are discovered.

Release of Information

Information may be released or obtained about coverage, expenses, and benefits under the Adventist Plan that is needed to apply the Coordination of Benefits provisions of the Adventist Plan or an Other Benefit Plan, without the prior notice or consent by you. Any person who claims benefits under the Adventist Plan shall, as a condition precedent to payment of benefits under the Adventist Plan, give his or her Plan Administrator any necessary information concerning coverage under Other Plans that is required to apply the Coordination of Benefit provisions.

Overpayments

If the Adventist Plan makes an overpayment, SHARP, acting on behalf of the Adventist Plan, has the right at any time to recover the amount of the overpayment from anyone who benefited from the overpayment, including, but not limited to, any person to whom payments are made, a covered employer, a provider or any Other Plan. The Adventist Plan has the right, when benefits have been paid by an Other Plan, to pay to the Other Plan any portion of the benefits available under the Adventist Plan in order to give effect to the intent of the Coordination of Benefit rules. The amounts so paid to the Other Plan shall be deemed to be benefits provided under the Adventist Plan.

Estimate of Benefits

If the Adventist Plan is secondary, but is unable to determine the benefits of the coverage of the Other Plan for the charges involved, the Plan Administrator will estimate in good faith the benefits of the Other Plan and provide benefits under the Adventist Plan on the basis of that estimate. The Plan Administrator may make adjustments if the actual benefits under the Other Plan are later determined within 24 months of the date of service.

Special Coordination of Benefits Rules for Idaho Members:

Instead of the coordination of benefit rules set forth above the National Association of Insurance Commissions (NAIC) Model Coordination of Benefits provisions shall apply.

PRE-CERTIFICATION

The Plan has certain procedures that must be followed to reduce the cost of Plan benefits, such as a pre-admission review process called pre-certification. The Plan's Pre-Certification Department can be reached by calling the number on the back of your benefit ID card.

The purpose of pre-certification or utilization management is to contain the cost of Plan benefits by encouraging prudent and reasonable use of health care and health care facilities. These measures are only decisions on the benefits the Plan will cover, not what course of medical treatment is appropriate or desired.

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

The SHARP Plan, the Plan Administrator, and their employees, members, agents and representatives, are not liable for any act or omission by any hospital, physician, other providers or supplier, their agents or employees, in caring for a person covered by this Plan, and no responsibility attaches under this Plan for any error or inability of any supplier to furnish accommodations or services to you.

PRE-CERTIFICATION PROCESS

Pre-certification is a process that takes place when a doctor recommends hospitalization or certain other types of medical services for a Member. The process involves pre-certification staff members who evaluate proposed admissions and other treatments to verify whether the Plan will pay benefits for the proposed Admission to a hospital or other treatments and/or to discuss other alternative care options that may exist.

Your Responsibility

You do not need to obtain pre-certification for routine health care performed in a provider's office, urgent care center, or emergency room. It is your responsibility to obtain appropriate pre-certification for diagnostic testing, out-patient procedures, etc., as per Plan guidelines. Your provider can initiate this by calling the number for pre-certification found on the back of your benefit ID card. If your care results in a hospital admission your provider must call the Pre-Certification Department no later than the next business day after the admission.

When you know in advance that you or a covered family member needs to be hospitalized, you or your doctor must contact the Pre-Certification Department prior to admission at the number on the back of your benefit ID card.

In case of an emergency hospital admission or surgery, you or your doctor must notify the Pre-Certification Department within 24 hours of the admission or on the next business day following admission.

Failure to Adhere to the Pre-Certification Process

If pre-certification was not obtained your hospitalization benefits will be paid at the appropriate rate stated in the Schedule of Benefit, less appropriate reduction for each day that the hospitalization is not pre-certified. It is your responsibility to make sure that the pre-admission process has been followed.

SERVICES REQUIRING PRE-CERTIFICATION BY THE PRE-CERTIFICATION DEPARTMENT

In addition to the in-patient hospital admission discussed above, there are additional services under the Plan for which you may not receive benefits or you may receive reduced benefits if you fail to obtain prior approval from the Plan's Pre-Certification Department before obtaining the service or incurring the expense.

Please call the Plan's Pre-Certification Department at the phone number on the back of your benefit ID card to fulfill any pre-certification requirements and obtain prior authorization approvals or guidance for those services. The Plan's Pre-Certification Department handles all pre-certification and prior authorizations, and follows the guidelines set forth by the American Medical Association (AMA) in determining medical necessity and appropriateness of these services.

For an exemplary listing, please see the addendum following the summary schedule of benefits.

CLAIM REVIEW

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

EFFECT ON DEDUCTIBLES AND OUT-OF-POCKET LIMIT

If you assume additional expenses for the medical bills due to the application of the Pre-Certification provisions described in this document, any additional expenses so assumed will not be used to meet the out-of-pocket maximum (OOP) described in the Benefit Payment Provisions Section of this document, and are not credited towards meeting any of the Plan deductibles.

LIMITATIONS AND EXCLUSIONS

In addition to the Limitations and Exclusions found elsewhere in the Plan, the Plan does not cover the expenses described in the following General Exclusions and Specific Exclusions.

GENERAL EXCLUSIONS

Occupational Illness and Injury

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

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise or
2. No final determination is made that the injury of illness was sustained in the course of or resulted from employment or
3. The amount of Workers' Compensation due is not agreed upon or defined by the Member or the Workers' Compensation carrier or
4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise

A Member will not enter into a compromise or hold harmless agreement relating to any work related claims paid by the Plan, whether or not such claims are disputed by the Workers' Compensation insurer, without the express written agreement of the Plan.

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

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

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

Usual Reasonable and Customary - In certain situations (such as use of a non-participating provider or services not requiring utilization of a provider participating in the Plan's PPO network), the Plan does not cover medical expenses which exceed the Usual, Reasonable and Customary (U&C) fees as determined by the Plan Administrator.

SPECIFIC EXCLUSIONS

Coverage is NOT provided for the following charges or expenses:

1. Abortions. The Plan does not cover the expenses of an elective abortion, including medical complications that arise from an elective abortion, except in cases where continuation of the pregnancy endangers the life of the mother and in cases where pregnancy is the result of incest.
2. Career or Financial Counseling Services.
3. Charges for Missed Appointments.
4. Complementary and Alternative Medicine. The Plan recognizes the National Center for Complementary and Alternative Medicine (NCCAM) as the authority in defining complementary and alternative medicines (CAM). CAM, as defined by the NCCAM, is a group of diverse medical and health care systems, practices, and products that are not presently considered part of conventional medicine. Coverage for CAM is limited under the Plan. The exception is limited to chiropractic treatment. All other CAM therapies, services, tests, laboratory tests, procedures, products, and practices are not covered under the Plan.
5. Vitamins, (except for physician prescribed vitamin B12 injections and prenatal care vitamin supplements, or as defined under the Preventive Care List section of this document), dietary supplements and foods, herbs, minerals, nutritional supplements.
6. Custodial Care and Services. The Plan does not cover custodial care and services. Custodial care and services are services and supplies that are furnished mainly to train or assist a person in personal hygiene and other activities of daily living rather than to provide therapeutic treatment. Activities of daily living includes such things as bathing, feeding, dressing, walking, and taking oral medicines and any other services which can safely and adequately be provided by persons without the technical skills of a nurse or health care professional. Such care is considered to be custodial regardless of who recommends, provides or directs the care, where the care is provided and whether or not the individual family member can be or is being trained to care for him or herself. The Plan also considers any care or services to be custodial if they are or would be considered custodial for Medicare purposes.
7. Elective surgeries for preventive reasons.
8. All non-emergency medical services outside the United States.
9. Experimental Services and Procedures. The Plan does not cover procedures, services, drugs and other supplies that are determined by the Plan Administrator to be experimental or still under clinical investigation by health professionals. A procedure is considered to be experimental if it is generally deemed so by medical professionals, the Food and Drug Administration, the National Institutes of Health or by Medicare and/or Medicaid guidelines.
10. First Aid Supplies.
11. Genetic testing (except as medically necessary).
12. Governmental Treatment. Except as otherwise provided by law, the Plan does not cover services or supplies for care or treatment provided by the United States Government or any state or local government when, without Plan coverage, the person would not be required to make payment.
13. Health Enhancement Programs, Life Style Center Programs, Residential Diabetes Treatment Programs, or any regimen designed to prevent future health problems or to influence adoption of a healthier lifestyle with a secondary objective of providing necessary medical treatment. The Plan would encourage you to engage in relevant and appropriate educational classes through your Health and Wellness benefit.

14. Late Hospital Charges. The Plan does not cover charges submitted more than 60 days after the date of the service was provided by a hospital.
15. Licensing Exams. The Plan does not cover physical examinations for the purpose of licensing or regulatory requirements.
16. Military Injuries. The Plan does not provide benefits for the illnesses and injuries of employees returning from military leave under Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), if the Secretary of Veterans Affairs determines that the illness or injury was incurred in, or aggravated during, performance of service in the Uniformed Services (as that term is defined by USERRA).
17. Nail Debridement. The Plan does not cover nail debridement, except for Members with the diagnosis of diabetes.
18. Non-Emergency Ground or Air Ambulance Travel.
19. Non-prescription glasses or sunglasses.
20. Nutritional counseling.
21. Obesity Related Treatment, including Gastric Surgery, or Prescription Drug Therapy for obesity treatment. Upon review by the Plan's Pre-Certification Department and/or the Prescription Drug Plan Administrator, exceptions for those diagnosed with "Clinically Severe Obesity" or a significantly high "Body Mass Index" and certain co-morbidities may be granted.
22. Plastic, Reconstructive, Cosmetic Procedures and Surgeries. The Plan does not cover charges for plastic, reconstructive, or cosmetic procedures, surgeries, services or supplies (whether or not for psychological or emotional reasons) for the purpose of enhancing, altering, or improving personal appearance or comfort. Limited exceptions may be obtained after first being reviewed by the Plan's Pre-Certification Department, to the extent that the surgery or procedure is necessary to:
 - a. improve the function of a part of the body that is malformed; or
 - b. correct a condition resulting from a severe birth defect; or
 - c. correct a condition that is a direct result of a disease or surgery performed to treat a disease or injury; or
 - d. repair an injury, but only if the surgery is performed within twenty-four months of the accident causing the injury
23. Pregnancies of Dependent Children are not covered, including medical complications resulting from a pregnancy.
24. Prenatal and Parent Training Classes.
25. Sexual Transformations and Trans Gender procedures.
26. Telephone Consultations.
27. Treatment by Household Members. The Plan does not cover services of a person who ordinarily resides in the home of the patient.
28. Virtual scans and physicals are not covered.

The NAD Supplemental Health Care Adventist Retirement Plan follows the CMS approval guidelines.

AUTHORIZED PROVIDERS

Your Plan covers services received only from professional medical care providers who meet certain licensing, accreditation, and certification standards.

The Plan considers the following to be Authorized Providers when they perform services within the scope of their license or certification:

1. Physician - Doctors of medicine (M.D.); osteopathy (D.O.); dental surgery (D.D.S.); medical dentistry (D.M.D.); podiatric medicine (D.P.M.); and optometry (O.D.).
2. Independent Laboratory - A laboratory that is licensed under State law or, where no licensing requirement exists, that is approved by the Plan.
3. Qualified Clinical Psychologist - A psychologist who:
 - a. is licensed or certified in the state where the services are performed
 - b. has a doctoral degree in psychology (or an allied degree, if the academic licensing/certification requirement for clinical psychologist in that state is met by an allied degree) or is approved by the Local Plan and
 - c. has met the clinical psychological experience requirements of the individual State Licensing Board
4. MS in psychology - A person who:
 - a. has a MS in psychology and
 - b. is licensed or certified to provide services based on state licensing guidelines
5. Certified Nurse Midwife (CNM) - A person who is certified by the American College of Nurse Midwives and, is licensed or certified to provide services based on state licensing guidelines; must be licensed in the state where the Member will deliver.
6. Nurse Practitioner/Clinical Specialist - A person who:
 - a. has an active R.N. license in the United States
 - b. has a baccalaureate or higher degree in nursing and
 - c. Is licensed or certified to provide services based on state licensing guidelines

The services of a nurse practitioner/clinical nurse specialist are covered only if provided under the supervision of a medical doctor (unless state law overrides this requirement).

7. Clinical Social Worker - A social worker who:
 - a. has a master's or doctoral degree in social work
 - b. has at least two years of clinical social work practice and
 - c. Is licensed or certified, to provide services based on state licensing guidelines
8. Physical, Speech, and Occupational Therapist - Professionals who are licensed in the areas where the services are performed.
9. Acupuncturist - A professional therapist licensed in the state of residency and/or certified by the National Certification Commission for Oriental Medicine.

10. Audiologist - A professional who, is licensed or certified to provide services based on state licensing guidelines.
11. Dietician - A professional who is licensed or certified to provide services based on state licensing guidelines.
12. Nutritionist - A professional who is licensed or certified to provide services based on state licensing guidelines.
13. Certified Registered Nurse Anesthetist (CRNA).
14. Doctor of Chiropractic (DC).
15. Certified Licensed Massage Therapist (CLMT).
16. Physician Assistant - A professional who is licensed or certified to provide services based on state licensing guidelines.

EXCLUDED PROVIDERS

The services of the following Providers are NOT covered by the Plan:

1. Doctors of Naturopathy.
2. Recreational Therapists, Ayurnouvedic Physicians, Christian Scientist Practitioners, Homeopaths, Naturopaths, Certified Clinical Hypnotherapists, Oriental Body Works Practitioners, Aroma Therapists, Masters of Iridology, Certified Healing Touch Practitioners, Myotherapists, Certified Rebalancing Therapists, Roling Practitioners, and Dulan Practitioners.

When Coverage Ends Under the Plan

Coverage under this Plan ends on the following dates:

1. The date on which you retiree or fail to meet eligibility requirements of the Plan
2. The date on which you turn age 65
3. The date on which you return to full-time denominational employment
4. The date on which your spouse does not meet eligibility requirements of the Plan
5. The date of a divorce or annulment based upon court order
6. The date on which a child no longer meets each of the eligibility requirements for dependent children under the plan.

Participation in the Plan also can be terminated for cause by the Plan Administrator or SHARP if you and/or your family members present, prepare, or cause to be prepared or presented, false information to the Plan, or if you and/or your family members embezzle or otherwise wrongfully obtain Plan funds, or otherwise commit fraud or make a material misrepresentation on the Plan. This includes, but is not limited to, such actions as making false statements on a claim form, an application to enroll, or other Plan form or document. You can also be terminated for cause if you refuse to repay, when asked to do so, the Plan for claims or benefits wrongfully paid by the Plan.

CLAIMS, PAYMENTS & CLAIMS REVIEW PROCESS

PLAN ADMINISTRATION

SHARP is responsible for funding the benefits provided by this Plan. Adventist Risk Management (“ARM”) has been designated by SHARP to administer the Plan and serves as Plan Administrator. Adventist Risk Management, Inc. oversees the Plan, and through its contracted representatives, coordinates pre-certification, receives, reviews and pays the claims presented, in accordance with the provisions of the Plan.

Questions about your health plan, medical benefits, should be directed to Member Services at the phone numbers on the back of your HealthSCOPE benefit ID card. Adventist Risk Management Inc. also provides internet service for this purpose; (see www.adventistrisk.org).

Questions about your dental, vision and hearing benefit, if you are enrolled, should be directed to the Member Services number at the phone number on the back of your SHARP ID card.

Questions about your prescription drug benefit, if you are enrolled, should be directed to the Member Services of Express Scripts at the phone number on the back of your Express Scripts ID card.

Final Authority

Except for Level 2 claims appeals, the Plan Administrator has the final authority for the administration and interpretation of this Plan document; however, the Plan Administrator may not discriminate unfairly between individuals in similar situations at the time of such actions.

Powers of Plan Administrator

The Plan Administrator has all powers and discretion necessary to fully discharge its duties described in the Plan, including but not by way of limitation, the following powers and duties:

1. to construe and interpret the Plan, decide all questions of eligibility and determine the amount, manner and time of payment of Plan benefits
2. to prescribe procedures to be followed by members and providers in obtaining benefits
3. to make a determination as to the right of any person to a benefit
4. to make factual determinations upon which decisions as to benefits are based and
5. to receive from members and others, information that may be necessary for proper administration of the Plan

CLAIMS PROCESSING PROCEDURES

All medical claims should be routed by your provider to either the physical address or the Electronic Data Interchange (EDI) address on the back of your HealthSCOPE ID card. Claims for chiropractic services, dental, vision or hearing aide benefits should be routed to the address on the back of your SHARP ID card. Claims for prescriptions purchased without the use of the prescription ID card must be submitted directly to the Pharmacy Benefits Manager, Express Scripts.

An authorized representative may act on the Member’s behalf in making the claim, provided that the Member appointed the representative in writing. In the case of Urgent Care Claims (see definition below), a Physician or other healthcare professional who is licensed, accredited, or certified to perform specified health services consistent with state law and who has knowledge of the Member’s medical condition is always permitted to act as an authorized representative. A claim for prescription drug benefits is not considered to be made until a written claim is filed by the Plan Participant with Express Scripts.

For purposes of these Claims Procedures, the Claims Administrators by Product or Benefit are:

Medical Claims: HealthSCOPE Benefits (HSB)
P.O. Box 16203
Lubbock, TX 79490-6203
EDI: 71063
Voice (888) ARM-4SDA or (888) 276-4732

Prescription Claims: Express Scripts (ESI)
Voice (800)841-5396

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

For purposes of the Claims Review/appeal the contact is:

Medical Claims: HealthSCOPE Benefits, Member Appeals Unit, P.O. Box 16203,
Lubbock, TX 79490-6203
Prescription: Adventist Risk Management, Member Appeals Unit, P.O. Box 4288,
Silver Spring, MD 20914
Dental, Vision and Hearing: Adventist Risk Management, Member Appeals Unit,
P.O. Box 1928, Grapevine, TX 76099-1928

FILING A CLAIM

Because of the large number of medical and dental claims submitted each year, it is necessary to have some rules to facilitate processing. It is imperative that you follow these rules.

Procedure

When visiting a provider, you should always present the appropriate health care benefit ID card to the provider for the services you are receiving. This ensures that the provider obtains the appropriate billing information for you and the Plan through the contact information on the back of the benefit ID card.

1. Be sure the patient information on the claim form is correct
2. Original bills of the providers must be provided and they cannot be returned. If you cannot submit original bills because you have already submitted the bill to another plan which is the “primary plan” (see the Plan’s coordination of benefit rules), photocopies of these bills will be accepted when submitted with the primary plan’s explanation of benefits. Original bills of providers are acceptable if they are on the appropriate claim form, and contain the following information:
 - a. Provider’s name, address, and Federal Identification Number
 - b. Name of patient and name of member
 - c. Member ID number
 - d. Date of service, treatment or purchase
 - e. Type of treatment
 - f. Diagnosis

- g. CPT code related to service provided
- h. Each item or service for which you are charged and
- i. Amount of charge (Non-itemized receipts or billings are not acceptable)

Claim Deadline

All claims for a benefit payment should be filed promptly. Generally, you should submit requests for payment as soon as you receive bills or receipts. In this way providers can be paid promptly and your records can be kept as up-to-date as possible. The deadline for filing a claim is within one year of date of service. Claims filed after that date will be denied for untimely filing and not be covered by the Plan.

Complete and Accurate Information Required

When filing a claim for benefits under the Plan, it is necessary that accurate and complete information be given. If relevant information is misstated or not disclosed, the benefit payments will be recalculated based upon the correct information and you will be obligated to refund the Plan any overpayment received. If you refuse to submit any documentation requested by the Plan Administrator or otherwise fail to cooperate in the processing of your claim, the claim may be denied on that basis alone.

Record keeping

Please keep records of your claims. If you want to maintain personal records, be certain to keep copies of each medical/dental bill and claim that is submitted along with the explanation of benefit (EOB) document you receive as claims are processed and paid. This information is also available to you on-line. To learn how to set up your own User-ID and password, please contact Member Services (888-276-4SDA).

PAYMENTS

In most instances the payments of benefits under this Plan are made to the provider or supplier that rendered the service or supply. However, the Plan Administrator has the discretion in most instances to make payments directly to the member, rather than to the provider or supplier, if the member has paid the provider or supplier and the member so informs the Plan Administrator at the time the claim is made. In addition, Plan payments may be made to any other person, such as a custodial parent, an adult child or a state agency, in accordance with a medical child support order. Any benefits which are payable to a member, if unpaid at his or her death, are paid to the surviving spouse of the member. If the member does not have a surviving spouse, then the Plan benefits shall be paid to the member's estate. Any benefits payable to any other natural person, if unpaid at the person's death, shall be paid to the person's estate.

Claims for benefits are processed when the Plan Administrator receives the complete, necessary written proof to support your claim. In general, claims are processed in the order received by the Plan Administrator. The date the expense was incurred is used to determine if there were any deductibles, Plan maximums, and/or other limitations applicable to those claims.

DECISIONS ON YOUR INITIAL CLAIMS

Types of Claims

Under these procedures, there are three types of claims. The first type is a regular claim for benefits after you have received your medical treatment. This type of claim is called a "Post-Service Claim". The second type is a claim for benefits before you receive your medical treatment, such as a request for pre-certification. This type of claim is called a "Pre-Service Claim". The third type of claim for benefits is an urgent medical claim, which is a Pre-Service Claim that must be handled urgently because failure to do so would either (1) seriously jeopardize your life or health or your ability to regain maximum functions; or

(2) subject you, in the opinion of a physician (who knows about your medical condition), to severe pain that cannot be adequately managed without the medical treatment that is the subject of the claim. The third type of claim is called an “Urgent-Care Claim”.

Post-Service Claims

As stated above, Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. Most of your claims will be Post-Service Claims. If your Post-Service Claim is denied in whole or in part, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim. If the claim does not contain all the necessary information, your claim may be denied or you may be asked to provide the missing information. The 30-day period may be extended by an additional 15 days if the Claims Administrator decides that such an extension is necessary due to matters beyond the Claims Administrator’s control. If the Claims Administrator decides that a 15-day extension period is necessary, the Claims Administrator will notify you before the end of the 30-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide your claim, the notice of extension will specifically describe the required information. You will be given at least 45 days to provide the specified information, during which time the extension period will be suspended.

If you enrolled in the Standard SHARP Rx Option, you should follow this procedure by filing a written claim with Express Scripts if you are asked to pay the full cost of the prescription when it is filled at a pharmacy and you believe that the Plan should have paid for it. You should also follow this procedure by filing a written claim with Express Scripts if you pay a co-payment and believe that the amount of the co-payment was incorrect.

Pre-Service Claims

Pre-Service Claims are those claims that require notification or approval by the Plan prior to receiving medical care, such as pre-certification. If your Pre-Service Claim is submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the Pre-Service Claim was received. This notification may be oral unless otherwise requested by you or your authorized representative. If the claim does not contain all of the necessary information, your claim may be denied or you may be asked to provide the missing information. The 15-day period may be extended by an additional 15 days if the Claims Administrator decides that such an extension is necessary due to matters beyond the control of the Plan. If the Claims Administrator decides that a 15-day extension is necessary, you will be notified before the end of the original 15-day period of the circumstances requiring the extension and the date by which a decision is expected to be rendered. If such an extension is necessary because you failed to submit the information necessary to decide your claim, the notice of the extension will specifically describe the required information. You will be given at least 45 days to provide the specified information, during which time the extension period will be suspended.

If you are enrolled in the Standard SHARP Rx Option, you should follow this procedure by filing written claim with Express Scripts if a retail or mail order pharmacy fails to fill a prescription that you have presented.

The Claims Administrator is only required to provide a notice to you that you have failed to follow the procedures for Pre-Service Claims if failure involves a communication by you or your authorized representative and such communication names:

- a specific person claiming the benefits
- a specific medical condition or symptom; and
- a specific treatment, service, or product for which approval is requested.

Urgent-Care Claims

Urgent-Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain.

A claim qualifies as an Urgent-Care Claim that could seriously jeopardize your life or your ability to regain maximum function if:

- a physician with knowledge of your medical condition determines that these factors are met; or
- an individual acting on behalf of the Plan applying the judgement of a prudent layperson that possesses an average knowledge of health and medicine determines that the factors are met. The individual is required to consider only the information provided by you or your representative in making the determination of whether the claim involves urgent care.

The Plan will defer to the determination of your attending medical provider as to whether the claim qualifies as an Urgent-Care Claim. Urgent-Care Claims arise only on rare occasions. In these situations:

- You will receive notice of the decision concerning your benefit in writing or electronically within 72 hours after the Claim Administrator receives all necessary information, taking into account the seriousness of your condition.
- A notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you file an Urgent-Care Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent-Care Claims was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You will then have 48 hours to provide the required information.

You will be notified of a determination no later than 48 hours after the earlier of:

- The Claim Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

Concurrent Care Decisions

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatment, any reduction or termination by the Plan of such course of treatment (other than by plan amendment or termination) before the end of such time or number of treatments will constitute a claim denial for purposes of these procedures. The Claim Administrator will notify you of the reduction or termination sufficiently in advance of the reduction or termination in order to allow you to appeal and obtain a decision on the appeal before the benefits are reduced or terminated.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided that your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from the receipt of your request. If your request for extended treatment as an Urgent Care Claim is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above for other Urgent Care Claims.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and you ask to extend treatment under non-urgent circumstances, your request will be considered a new claim and decided according to Post-Service or Pre-Service Claim timeframes described above, whichever applies.

PROCEDURES APPLICABLE TO ALL CLAIMS

Benefit Interpretation and Administration

In its consideration of the claim, the Claims Administrator or Claims Reviewer will consult the documents and instruments constituting the Plan and all other documents that may have a bearing on the interpretation of the Plan, including past interpretations or claims of the same general type. The Claims Administrator or Claims Reviewer will also, where appropriate, consult the Internal Revenue Service, the Department of Labor, or other governmental or private publications or authorities that may assist them in interpreting language or administrative procedures of the Plan.

If in connection with the denial the Claims Administrator obtained on its behalf the advice of any medical or vocational experts, such expert(s) shall be identified, whether or not their advice was relied upon in the denial.

Upon request, you have reasonable access to, and may obtain free copies of, all documents, records and other information that are relevant to the claim. A document, record or other information is considered to be relevant to a claim if it:

- Was relied upon, submitted, considered or generated in the course of making the benefit decision;
- Demonstrates compliance with the administrative processes and safeguards required in the making of the benefit decision; or
- constitutes a statement of policy or guidelines with respect to the Plan concerning the benefit denied for your diagnosis.

Content of Notice of Denial

If a claim is denied (either in whole or in part), you will receive a written notice from the Claims Administrator that includes the following information;

- information sufficient to identify the claim involved (including the date of services, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of (1) the diagnosis code and its corresponding meaning, and (2) the treatment code and its corresponding meaning);
- the specific reason(s) for the denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- the specific provisions of the Plan upon which the decision is based;
- a description and explanation of any additional material or information needed for you to perfect the claim;
- a description of the Plan's appeal procedures and applicable time limit, including an explanation of:
 - the internal appeals procedures and the external review process;
 - how to initiate and follow those appeals and external review procedures;
 - the right to submit written comments, documents, records and other information relating to the claim and have them considered; and
 - the right to have reasonable access to, and copies of (on request and at no charge), relevant documents and other information;
- any internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, either:
 - a copy of such internal rule, guideline, protocol, or other similar criterion; or
 - a statement that such internal rule, guideline, protocol, or other similar criterion was relied upon and that a copy is available to you at no charge upon request.
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination that applies the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge on request.
- if the claim involved urgent care, a description of the expedited appeal process that applies to the claim; and
- the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman.

Notice of denial described in this section shall be given in writing or electronically. If the denial concerns an Urgent Care Claim, the information described in this section may be communicated orally to you within the applicable time period, provided that written or electronic notice is furnished to you no later than 3

days after the oral notification.

APPEALING A DENIED CLAIM

If your claim is entirely or partially denied, you may appeal the decision to the Claims Reviewer, who will review the claim and the denial. You must follow these procedures or you will lose your rights to contest the decision of the Plan. You must make this request no later than 180 days after receiving the written notice of denial described above. The names and address of the Claims Reviewer are found at the beginning of this Claims Procedure.

Mandatory Appeal Procedure

You may submit written comments, documents, records, or other information to the Claims Reviewer relating to the claim for consideration in the appeal. The review on appeal shall take into account all such information submitted by you, regardless of whether it was previously submitted or considered. On appeal, no deference shall be given to the initial claim denial. The appeal review shall be conducted by an employee or group of employees of the Claims Reviewer, who shall not be the same individual or individuals who denied the claim that is the subject of the appeal, nor the subordinates of such individual or individuals. If in connection with the denial the Claims Reviewer obtained on its behalf the advice of any medical or vocational experts, such expert(s) shall be identified, whether or not their advice was relied upon in the denial. In deciding an appeal of any denial that is based in whole or in part on a medical judgment, including determinations with regard to a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Claims Reviewer shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be the individual or subordinate of the individual who was consulted in connection with the denial that is the subject of the appeal. Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your denial shall be identified, regardless of whether such advice was relied upon in making the benefit determination.

Upon request, you have reasonable access to, and may obtain free copies of, all documents, records and other information that are relevant to the claim. A document, record or other information is considered to be relevant to a claim if it:

- was relied upon, submitted, considered or generated in the course of making the benefit decision;
- demonstrates compliance with the administrative processes and safeguards required in the making of the benefit decision; or
- constitutes a statement of policy or guidance with respect to the Plan concerning the benefit denied for your diagnosis.

A denial of a claim involving urgent care is eligible for an expedited appeal. You may submit a request for an expedited appeal orally or in writing. All necessary information, including the decision on review, will be sent to you by telephone, fax, or other similar method that is available.

Notice of Decision on Appeal

The Claims Reviewer will notify you in writing of its decision on appeal. In the case of a claim involving urgent care, the Claims Reviewer shall notify you of the decision on appeal as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of your request for the appeal of the claim denial. If a request for urgent care treatment was denied and you obtained the treatment on your own, the appeal to the Claims Reviewer shall not be treated as an Urgent Care Claim. In the case of Pre-Service Claim (i.e., not involving urgent care), the Claims Reviewer shall notify you of the benefit determination on appeal within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt by the Plan of your request for an appeal of the denial. In the case of a Post-Service Claim, the Claims Reviewer shall notify you of the determination on appeal within a reasonable period of time, but no later than 60 days after receipt by the Plan of your request for an appeal of the denial. All necessary information, including the benefit determination on appeal, shall be transmitted between the Plan and you by telephone, fax or other available method that is similarly quick.

For the purposes of this section, the period of time within which a benefit determination on appeal is required to be made shall begin at the time an appeal is filed with the Claims Reviewer, without regard to whether all the information necessary to make a benefit determination on appeal accompanies the filing. If the appeal decision is adverse to you, the notification will contain:

- information sufficient to identify the claim involved (including the date of service), the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of (1) the diagnosis code and its corresponding meaning, and (2) the treatment code and its corresponding meaning;
- the specific reason(s) for the adverse decision on appeal;
- specific provisions of the Plan upon which the appeal decision is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant (as defined above) to the claim for benefits;
- if any internal rule, guideline, protocol, or other similar criterion; or
- a statement that such internal rule, guideline, protocol, or other similar criterion was relied upon and that a copy is available to you at no charge upon request; and
- the following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

This claims procedure is designed so that it does not contain any provisions that unduly inhibit or hamper the filing or processing of claims for benefits, nor will it be administered in such a manner. No fee shall be charged as a prerequisite to making a claim or seeking an appeal of a claim denial.

Under these Claims Procedures, there is no requirement that claim denial must be submitted to binding arbitration. Also, no claim shall be denied for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize your life or health.

External Appeal to an Independent Review Organization

An appeal to an Independent Review Organization (IRO) is available only after you have exhausted your appeal to the Claims Reviewer, or if the Claims Reviewer has failed to provide you with a decision on appeal with the timeframes given.

Until such time as otherwise required by federal law, external appeals are not available for eligibility determinations, and are only available for other benefit claims if the adverse benefit determination involves (1) medical judgment as determined by the IRO; or (2) a rescission of coverage (a retroactive termination of coverage).

The Claims Reviewer coordinates the external appeal, but the decision is made by the IRO at no cost to you. External appeals must be initiated in writing. An external appeal, including expedited appeals, must be pursued within four months of your receipt of the Claims Reviewer's decision on appeal. If you don't appeal to the IRO within this time period, you will not be able to continue to pursue the external appeal process and you will jeopardize your ability to pursue the matter in any forum.

Within five days following receipt of your written request for an external appeal, the Claims Reviewer or the Plan Administrator will complete a preliminary review of the request to determine whether it is eligible for an external appeal. Within one business day after completing the preliminary review, the Claims Reviewer or the Plan Administrator will notify you of its determination. If your request is complete but not eligible for external review, such notification will include the reason for its ineligibility. If the request is not complete, the notification will describe the information or material needed to make the request complete and you will be allowed to perfect the request for an external appeal within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

If you are eligible for an external appeal, the Claims Reviewer or the Plan Administrator will assign an IRO for your appeal. The IRO will timely notify you in writing that your request has been accepted for an external appeal. The notice will explain that you have ten days to submit in writing any additional information you want the IRO to consider. The IRO is required to consider information you submit within ten days. The IRO may, but is not required to accept and consider additional information submitted after ten business days.

The IRO will review all of the information and documents timely received and reach a decision that is not based on the decision of the Claims Reviewer that decided the appeal of the Claims Administrator's decision. The IRO must provide written notice of its decision on the external appeal within 45 days after the IRO receives the request for the external appeal. The IRO's notice will contain the following:

- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning);
- the date the IRO received the request for an external appeal, and the date of the IRO's decision;
- references to the evidence or documentation, including specific, coverage provisions and evidence-based standards, considered in reaching its decision;
- 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;
- 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 you;

- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Expedited Appeals

An Expedited Appeal is available if you have an Urgent Care claim.

The appeal of an Urgent Care Claim should state the need for a decision on an expedited basis and must include documentation necessary for the decision on appeal. Expedited Appeals reviewed by the Claims Reviewer, which consists of employees who were not involved in, or subordinate to anyone involved in, the initial determination by the Claims Administrator to deny your claim. You, or your representative on your behalf, will be given the opportunity (within the constraints of the expedited appeals timeframe) to participate via telephone and/or provide written materials. A verbal and written notice of the decision will be provided to you and our representative as soon as possible after the decision, but no later than 24 hours of receipt of the appeal.

If you disagree with the decision made by the Claims Reviewer and you or your Representative reasonably believes that pre-certification remains clinically urgent (Pre-Service), you may request an expedited external appeal to an IRO. The criteria for an expedited external appeal to an IRO are the same as described above for a non-urgent external appeal. The procedures for expedited external appeals are the same as those for non-urgent external appeals, except that your request for an expedited external appeal will be reviewed by the Claims Administrator or the Plan Administrator immediately, and the IRO will provide notice of its decision as expeditiously as your medical condition or circumstances require, but in no more than 72 hours after the IRO receives the request for an expedited external appeal. If the IRO's notice is not in writing, the IRO will provide written confirmation of the decision within 48 hours of providing that notice.

Final Appeal

In most instances, questions concerning your assistance or claim denial can be resolved to your satisfaction with appeals described above. If however, after receiving a decision on your appeal (including your appeal, if applicable, to the IRO), you still believe that your claim has not been handled properly or that there are some points that the Claims Reviewer or IRO may have overlooked, you may submit a Final Appeal in writing to the Plan Administrator who will then submit your appeal to the controlling committee of your employer. Direct these Final Appeals to Adventist Risk Management, Final Appeals Unit, P.O. Box 4288 Silver Spring, MD 20914. This process will assure that your Private health Information (PHI) is kept confidential in so far as required by state or federal laws in effect at the time of your Final Appeal.

Since Final Appeals generally are requests for exceptions to the Plan benefit provisions you should be aware that any payment by your employer or the Plan may generate taxable income for you. Any payment of exceptions by the Plan Administrator will not be included in any specific or aggregate stop loss calculation by your employer's stop loss carrier. In addition, there may be a processing fee of \$125 for any exceptions to the Plan. Your employer may reduce your benefits in the amount of \$125 to recover this expense.

Timing of Appeal – The deadline for filing a written Final Appeal is 60 days after you have exhausted all other applicable appeals listed in the Claims Procedure.

Contents of Appeal – The Final Appeal is the final step of the review process. Therefore, include all the information you submitted with your previous appeals, as well as any additional information that will be of assistance in the review of your appeal.

Review of Documents – In preparing your appeal, you may request to review any pertinent documents.

Decision of Appeal – Once the controlling committee of your employer receives your request for review, it will then carefully review the facts, the reasons for the Claim Reviewer's or the Plan Administrator's decision, and the points you have raised about your claim, as well as the document provided by you and the Plan Administrator. The controlling committee may request that the patient be examined by a medical consultant recommended by the Plan Administrator at the Employers expense. The Plan Administrator will notify you of the controlling committee's final decision within 60 days after your appeal is received. If a longer time is required, you will be notified in writing. Except in extraordinary situations, a decision will be rendered within an additional 60 days. The decision will be in writing and will include specific reasons and specific references to the pertinent Plan provisions on which the decision is based. The decision of the controlling committee upon review shall be final and binding.

Non-English Languages: Notices and Services

In United States counties in which 10% or more of the population residing in the county is literate only in the same non-English language, all notices under this Claims Procedures sent to addresses in such counties will contain a statement, in such non-English language, that (1) the Plan will provide, upon request, the notice in such non-English language; and (2) the Plan provides oral language services that include answering questions in such non-English language and assistance with filing claims and appeals (including external review appeals) in such non-English language.

How to Appeal a SHARP Eligibility, Dental, Vision or Hearing Claim

The following procedures have been adopted to ensure that your appeal of the SHARP dental, vision or hearing claim will be handled promptly and in a fair, reasonable, and consistent manner. It is important for you to follow the deadlines set forth below for the filing of an appeal of a claim. Any appeal not submitted on time will be denied automatically.

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. The appeal process for Express Scripts Medicare PDP is outlined in the Express Scripts Evidence of Coverage document. All appeals for Express Scripts claims must follow the appeal guidelines as provided in the Evidence of Coverage document.

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

Questions about medical claims can be resolved by contacting HealthSCOPE, at P.O. Box 16203 Lubbock, TX 77949-6203. The customer service number is 1-888-276-4732.

Adventist Retirement Appeals Procedures

The following appeal procedures apply to claims denied for benefits under Standard SHARP. Plan information may be downloaded¹ by Eligible Retirees and Eligible Spouses. The documents are maintained and amended from time to time by the Adventist Retirement Board, under authority delegated to it by the NAD.

An Eligible Retiree or Eligible Spouse/Eligible Dependent or his/her authorized representative (also referred to as the “claimant”) may request a review of a denial of benefits under Standard SHARP DVH Option. The SHARP Office (in this section referred to as the “Plan Administrator”) (including the person or committee who has been designated by the Plan Administrator) shall have the power, including, without limitation, discretionary power, to make all determinations that Standard SHARP requires for its administration, and to construe and interpret Standard SHARP whenever necessary to carry out its intent and purpose and to facilitate its administration, including but not by way of limitation, the discretion to grant or deny claims for benefits under Standard SHARP. Subject to the claimant’s right to have the denial of a formal claim reviewed (as explained below), all rules, regulations, determinations, constructions and interpretations made by the Plan Administrator (including the person or committee who has been designated by the Plan Administrator) shall be conclusive and binding.

The Plan Administrator will process claim and appeal determinations in accordance with the HIPAA privacy rules. The Plan Administrator will use and disclose protected health information in accordance with HIPAA obligations. Generally, all identifiable health information will be removed before the appeal is submitted to the Level II and Level III review committees (described below). To the extent it is not feasible to remove identifiable health information; the information will be disclosed to the committees only to the extent permitted by HIPAA. In final appeals, it may be necessary for the claimant to submit a HIPAA-compliant authorization in order for the committees to consider an appeal. All medical information submitted by a claimant with respect to an appeal will be treated as confidential information.

The terms of Standard SHARP govern the administration of Standard SHARP. The Plan Administrator must interpret Standard SHARP in accordance with its terms. The Plan Administrator cannot grant variance from Plan terms and policies. For example, the Plan Administrator cannot change the terms of Standard SHARP to overturn a benefit determination based upon:

- Documentation of employer promises to provide service credit for ineligible employment;
- Testimonials by employers that an employee qualified for credit when the employee’s service record does not support such testimony;
- Requests for benefit enhancements because of proximity to a benefit threshold; or
- Need-based enhancement of benefits.

Review Process

There are three levels of appeal. All appeal levels must be exhausted prior to filing any civil action for benefits under Standard SHARP.

- Level I: Plan Administrator Review
- Level II: Committee Review
- Level III: Board Appeal Committee Review

Level I Appeal

A claimant may file a request for a review of the initial claim determination by submitting a request in the form required by the Plan Administrator. The request for appeal must be submitted in writing to the address below and must be filed within 45 days after the date of Standard SHARP's initial claim determination.

Attn: Administrative Appeal
Adventist Retirement
12501 Old Columbia Pike
Silver Spring, MD 20904

The appeal request should include the claimant's name, address, contact phone number, email address and last four digits of the covered member's social security number. If a claimant is an authorized representative of the Eligible Retiree or Eligible Spouse/Eligible Dependent, the claimant must present evidence of his or her authority to act on behalf of the Eligible Retiree or Eligible Spouse/Eligible Dependent. The claimant should also include a copy of Standard SHARP's initial claim determination and the basis upon which the appeal is being made. If appropriate, this information will include a reference to Standard SHARP or policy provisions which the claimant believes supports his or her claim for benefits. The claimant may also submit any other information to the Plan Administrator in support of the claimant's position.

A delegate for the Plan Administrator will review the appeal and relevant information provided by Standard SHARP to make a determination with respect to whether Standard SHARP or policy was appropriately interpreted and calculations appropriately done. The Plan Administrator's Level I decision will be provided to the claimant in writing within 30 days of the receipt of the appeal, unless the Plan Administrator determines that special circumstances require an extension of time to consider the claim. A claimant will be notified in the event an extension is necessary or additional information must be provided. Once all necessary information is provided by the claimant, the Plan Administrator will consider the claim and respond to the claimant in writing within 30 days.

Level II Appeal

If the Plan Administrator does not grant the claimant's Level I appeal, the claimant may submit a Level II appeal to:

Secretary, SHARP Committee
Adventist Retirement Plans
12501 Old Columbia Pike
Silver Spring, MD 20904

The appeal must be sent in writing to the applicable address above within 45 days of the date of the Level I appeal determination notification. The appeal must include a description of the basis upon which the appeal is being made. A claimant may submit any written documentation in support of his or her claim, but is not permitted to appear in person before the committee. The SHARP Committee generally will not consult an independent medical examiner to review a claim; however, a claimant may submit any evidence in support of his or her position with respect to the claim, including the opinion of a medical examiner.

The SHARP Committee generally meets on a quarterly basis and will review the facts of the determination to determine whether the Level I response was appropriate and in accordance with the terms of Standard SHARP. The SHARP Committee will consider the appeal at the next scheduled

meeting which occurs so long as the appeal information is received at least 10 days prior to the date of the regularly scheduled meeting. The SHARP Committee will review the Level I appeal record provided by the Plan Administrator. The applicable committee may request additional information from the claimant. The SHARP Committee will notify the claimant of its decision regarding the appeal in writing and within 10 days after the committee meeting in which the appeal was considered, unless special circumstances require an extension of time in which to consider the claim. A claimant will be notified in the event an extension is necessary or additional information must be provided.

Level III Appeal

A claimant may request a final appeal by submitting a request to the Retirement Appeals Committee for review of a determination made by the SHARP Committee under a Level II Appeal.

A written request for appeal must be submitted within 45 days of the date of the Level II appeal determination notification to:

Chairman, Retirement Appeals Committee
Adventist Retirement Plans
12501 Old Columbia Pike
Silver Spring, MD 20904

The appeal must include a description of the basis upon which the appeal is being made. A claimant requesting a final appeal of a claim must complete a HIPAA-complaint authorization in order to authorize the release of appeal information to the Retirement Appeals Committee. A claimant may submit any written documentation in support of his or her claim, but is not permitted to appear in person before the committee. The Retirement Appeals Committee will review the Level I and the Level II appeal records provided by the Plan Administrator. The Retirement Appeals Committee generally will not consult an independent medical examiner to review a claim; however, a claimant may submit any evidence in support of his or her position with respect to the claim, including the opinion of a medical examiner.

The Retirement Appeals Committee is made up of individuals appointed by the Adventist Retirement Board. The Retirement Appeals Committee does not include any employees who work with Plan administration, although the Plan Administrator will meet with the Retirement Appeals Committee to assist the committee members in understanding Standard SHARP policies and the history of this and similar cases.

The Retirement Appeals Committee will meet on an as-needed basis and will respond to the claimant in writing within 60 days of receipt of the Level III appeal, unless special circumstances require an extension of time in which to consider the appeal. A claimant will be notified in the event an extension is necessary or additional information must be provided.

External Claim Appeal Process

The Medicare appeal process can be found by visiting www.medicare.gov/publications in the booklet "Medicare Appeals". You may also call Medicare at 1-800-MEDICARE (1-800-633-4227).

The external claim appeal process for SHARP is administered through Adventist Risk Management, Inc. as noted in the **External Appeal to an Independent Review Organization** section of this document.

MISCELLANEOUS PROVISIONS

RECOVERY RIGHTS (SUBROGATION AND REIMBURSEMENT)

Definition of Subrogation and Reimbursement

When you or your dependent has an illness or injury caused by another, a third party (including an insurance company) may be liable for damages or may be willing to pay money in settlement of a claim. When the Plan pays benefits for the illness or injury, the Plan has the right to recover benefits paid or payable under this Plan and is subrogated to all and any of your rights and your dependent's rights to recover from the third party and to any money paid in settlement of a claim, whether or not such recovery or settlement represents medical expenses, but only up to the amount of the benefits provided by the Plan. Each Member, whether an member or a dependent, is individually obligated to comply with the provisions of this section.

- 1. Reimbursement to Plan.** When you and your dependents receive or claim Plan benefits for an illness or injury caused by another, you and your dependents agree to immediately reimburse the Plan for benefits paid out of any recovery from any third party as a result of judgment, settlement, award or otherwise. In situations where the Plan Administrator determines that a third party may be liable for medical expenses, the Plan Administrator may nonetheless agree to conditionally pay the claims relating to such expenses in advance pending a final determination of a) whether a third party or the Member is responsible for such expenses instead of the Plan; and/or b) the claims are excluded from coverage under this Plan. Each Member agrees to reimburse the Plan for such conditional payments when a final determination is made by the Plan Administrator that the Plan is not responsible for the payment of such claims. The Plan is entitled to reimbursement and/or recovery under this section from any judgment, award, and other types of recovery or settlement received by a Member, regardless of whether the recovery is characterized as relating to medical expenses.
- 2. Cooperation.** You and your dependents are also required under this Plan to cooperate with the Plan Administrator to effectuate the terms of this Recovery Rights (Subrogation and Reimbursement) section and to do whatever may be necessary to secure the recovery by the Plan of the amount of the benefits paid, including execution of all appropriate papers, furnishing of information and assistance. You and your dependents also agree not to interfere with the Plan's rights under this Section.
- 3. Actions to Recover.** The Plan Administrator is entitled to institute actions in its own name or in your or your dependent's name or to join any action brought by you, your dependents or your representatives, with or without specific consent, and to participate in any judgment, award or settlement to the extent of the Plan's interest. You and your dependents may not take any action that may prejudice the Plan's rights of recovery. You and your dependents must notify the Plan Administrator before filing any suit or settling any claim so as to enable the Plan Administrator to participate in the suit or settlement to protect and enforce the Plan's rights under this subrogation provision. You and your dependents agree to keep the Plan Administrator fully informed and advised of all developments in any such suit or settlement negotiations. The Plan also is entitled to recover from you and your dependents the value of the services provided and benefits paid for, when you or your dependents are reimbursed or paid by another party, specifically unreduced by any legal or other fees and costs incurred by you or your dependents in seeking recovery from such other party (whether the other party is the responsible party or is an insurer), except if the Plan Administrator specifically agrees to participate in the attorney's fees under the item 6 below.
- 4. No Benefits; Refusal to Pay Benefits.** In situations in which the Plan Administer determines, in its sole discretion, that it has or may have rights of recovery and that its rights of recovery may be or have been compromised, threatened or jeopardized, the Plan Administrator may refuse to pay benefits otherwise covered under this Plan. This Plan does not pay benefits for illnesses and injuries when your medical expenses are the responsibility of, or are paid by, a third party (or a third party's insurer) who has caused your illness or injury.

5. **Binding Effect.** The Plan's provisions regarding recovery are binding upon you and your dependents and binding upon your and your dependent's guardians, heirs, executors, assigns and other representatives.
6. **Participation Attorney's Fees.** The Plan does not normally participate in the costs of recovering amounts from a third party, such as attorney's fees and litigation costs. However, if the Plan Administrator determines, in its discretion that participating in such costs would benefit the Plan, it may agree to participate in such fees as follows:
 - a. When the amount of the recovery or settlement from the third party is equal to or less than the amount of Plan benefits payable relating to the incident, the Plan Administrator may agree to waive its rights of subrogation in an amount equal to up to one-third of the recovery or settlement amount for payment or reimbursement of legal and litigation costs. For example, if the Plan has paid \$30,000 in claims and you settle a claim for \$30,000, the Plan Administrator may agree to waive the Plan's subrogation rights in an amount not to exceed \$10,000 for the payment of attorney's fees and litigation costs. If the Plan has paid \$30,000 in claims and you settle a claim for \$15,000, the Plan Administrator may agree to waive the Plan's subrogation rights in an amount not to exceed \$5,000.
 - b. When the amount of the recovery or settlement from the third party is greater than the amount of Plan benefits relating to the incident, the Plan Administrator may agree to waive its rights of subrogation for reimbursement of legal and litigation costs up to the following amount:
 - c. One-third of amount of Plan benefits paid or payable minus the amount by which the settlement or recovery exceeds the amount of Plan benefits paid or payable.
 - d. For example, if the Plan has paid \$30,000 in claims, and you settle the claim for \$35,000, the Plan could waive up to \$5,000 (\$10,000 minus \$5,000) of its subrogation rights for the payment of attorney's fees and litigation costs.
 - e. The Plan Administrator also has the right, in its sole discretion, to approve alternative methods of participating in attorney's fees and litigation costs when the Plan Administrator determines that such methods are in the best interest of the Plan or the Plan may engage its own counsel at its own expense.
7. **Written Agreement.** You and your dependents must execute a written recovery agreement as a condition of payment on claims arising from injuries or illnesses caused by third parties. If your dependent is so injured or has such an illness, both you and your dependent are required to execute the written recovery agreement. If the injured or ill person is a minor or legally incompetent, the written recovery agreement must be executed by the person's parent(s), managing conservator and/or guardian. If you or your dependent has died, you or your dependent's legal representative must execute the agreement. Members and all other parties in interest discussed above are jointly and severally liable for reimbursing the Plan in these situations. Any Plan benefits paid must be returned to the Plan immediately in the event that the Plan Administrator requests that a recovery agreement be signed and there is a failure of refusal to execute the recovery agreement. The Plan's Rights of Recovery are not waived if the Plan does not request a Written Agreement under this section. In addition, no plan benefits will be provided by the Plan unless all information, documentation and agreements required by the Plan Administrator to process a claim, including an executed recovery agreement, are filed with the Plan Administrator within one year of the date of the injury.
8. **Recovery Rights.** As a condition to receiving benefits under this Plan, you and your dependents agree not to bring or assert a make whole, common fund, collateral source or other apportionment action or claim in contravention of the Plan's Recovery Rights described above.
9. **Plan's Rights If a Member Fails to Comply with this Section.** If a Member fails to comply with this Recovery Rights section, the Plan may

- a. offset the amount of recovery or reimbursement due the Plan against future benefits under the Plan;
- b. enforce its rights through garnishment or attachment of your wages;
- c. enforce its rights in any other manner allowed by law.

PRIVACY AMENDMENT AND SECURITY

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

However, HIPAA allows medical information, including PHI, to be disclosed by the Plan to the Plan Sponsor and to be used by the Plan Sponsor (the General Conference of the Seventh-day Adventist Church, North American Division). The permitted disclosures to and uses by the Plan Sponsor of medical information are as follows:

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

- f. payment under a contract for reinsurance
- g. review of health care services with respect to medical necessity, coverage under the health plan, appropriateness of care, or justification of charges
- h. utilization review activities, including 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.

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

1. The Plan Sponsor will not use or further disclose the PHI except a) as described above or b) as otherwise required by law.
2. Any agents or subcontractors of the Plan Sponsor to whom the Plan Sponsor provides PHI will agree to the same restrictions and conditions on the use and disclosure of PHI that apply to the Plan Sponsor. Any agents or subcontractors of the Plan Sponsor to whom the Plan Sponsor provides electronic PHI must agree to implement reasonable and appropriate security measures to protect the information.
3. The Plan Sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or members benefit plan of the Plan Sponsor.
4. The Plan Sponsor will report to the Plan any use or disclosure of the PHI that is inconsistent with the permitted uses and disclosures of which the Plan Sponsor becomes aware. The Plan Sponsor will report to the Plan any security incident of which the Plan Sponsor becomes aware.
5. The Plan Sponsor will give you access and provide copies to you of your PHI in accordance with

the HIPAA Regulations.

6. The Plan Sponsor will allow you to amend your PHI in accordance with the HIPAA Regulations.
7. The Plan Sponsor will make available PHI to you in order to make an accounting of PHI in accordance with the HIPAA Regulations.
8. The Plan Sponsor will make available its internal practices, books and records relating to the use and disclosure of PHI received from the Plan to the Secretary of Health and Human Services (or the Secretary's designee) for determining compliance by the Plan with the HIPAA Regulations.
9. The Plan Sponsor will, if feasible, return or destroy all protected PHI received from the Plan and retain no copies of the PHI when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.
10. The Plan Sponsor will ensure that adequate separation between the Plan and Plan Sponsor is established. Only the following employees or classes of employees or other persons under the control of the Plan Sponsor will be given access to the PHI to be disclosed:
 - a. Officers of the Plan Administrator
 - b. Employees of the Plan Administrator (Adventist Risk Management Health Care Department)
 - c. Plan Sponsor's designated Benefit Coordinator and Controlling Committee
11. The Plan Sponsor will ensure that this adequate separation is supported by reasonable and appropriate security measures to the extent that these individuals have access to electronic PHI.
12. The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan, except enrollment/disenrollment information and Summary Information, which are not subject to these restrictions.

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

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

RELEASE OF MEDICAL INFORMATION

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

FURNISHING INFORMATION

A person covered by the Plan must furnish all information needed to effect coverage under the Plan and termination or changes in such coverage. The Plan Administrator may require that a Member provide

certain personal data (including reasonable proof of the accuracy of the data) necessary for the determination of the person's benefits. Failure to furnish the data (or proof of its accuracy) may delay the payment of benefits. Benefit payments may be adjusted to reflect correction of inaccurate or incomplete information, and an retiree, other Member and/or medical provider may be required to make up any overpayments, and the Plan may make up any underpayments.

NO ASSIGNMENT OF BENEFITS

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

LEGAL ACTIONS

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

NO WAIVER

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

STOP LOSS COVERAGE

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

PLAN AMENDMENT AND TERMINATION

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

RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 was enacted on October 21, 1998 and requires that health plans cover post-mastectomy reconstructive breast surgery if they provide medical and surgical coverage for mastectomies. Specifically, health plans must cover:

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

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

FOREIGN LANGUAGE NOTICE

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

OTHER PLAN INFORMATION**Plan Name**

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

Plan Sponsor

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

Plan Documents

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

MEDICARE PRESCRIPTION DRUG PLAN INFORMATION

Important Notice about the SHARP 2014 Prescription Drug Coverage (Rx Option) and the Medicare Prescription Drug Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Supplemental Healthcare, Adventist Retirement Plan (SHARP) Rx Option² and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage under the SHARP Rx Option, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is provided at the end of this notice.

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

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

¹ SHARP's Rx Option is the only coverage available to participants in SHARP that offers prescription drug coverage to persons eligible for Medicare.

When Can You Join a Medicare Drug Plan?

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

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

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

If you do decide to enroll in a Medicare prescription drug plan and drop (or decline to enroll in) SHARP Rx Option coverage, be aware that you will not be able to get the SHARP Rx Option coverage back.

Under SHARP, you are not allowed to receive prescription drug coverage under both Medicare prescription drug coverage and the SHARP Rx Option. You must choose one or the other. Therefore, it is important to make an informed deliberate decision. Do not enroll in Medicare prescription drug coverage "just in case."

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

1. You may stay with SHARP's Rx Option coverage and not enroll in the Medicare prescription drug coverage at this time. You will be able to enroll in the Medicare prescription drug coverage at a later date without penalty, either (1) during a Medicare prescription drug open enrollment period; or (2) if you lose coverage under SHARP.
2. You may drop your SHARP's Rx Option coverage (when allowed to do so under SHARP), or decline to enroll in the Rx Option, and instead enroll in Medicare prescription drug coverage. If and when you enroll in a Medicare prescription drug plan, you become ineligible to participate in SHARP's Rx Option, and SHARP will not assist you with the premium you will pay to participate in a Medicare prescription drug plan. You will not be able to enroll or reenroll in SHARP's Rx Option coverage until the next open enrollment period for such coverage, and you will only be able to enroll or reenroll if you drop your Medicare prescription drug coverage. **If you do decide to enroll in a Medicare prescription drug plan and decline or drop SHARP Rx Option prescription drug coverage, be aware that you may not be able to get SHARP Rx Option drug coverage until the next open enrollment period.** If you have chosen not to participate in the SHARP Rx Option, you may continue to participate in other SHARP options provided, such as Dental/Vision/Hearing and Medicare Extension.

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

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

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

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

If you go 63 continuous days or longer without prescription drug coverage that's creditable coverage (at least as good as Medicare's prescription drug coverage), your monthly premium for Medicare prescription

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

For More Information about This Notice or Your Current Prescription Drug Coverage:

Read the SHARP booklet carefully. Then, for further questions, contact our office (email and phone listed below) for further information regarding SHARP Rx Option. However, please note that our office cannot assist you with information about a Medicare Prescription Drug Plan.

E-mail: SHARP@nad.adventist.org (preferred method).

SHARP Healthcare Enrollment line: (301) 680-5036 8:00 am -5:00 pm Monday-Thursday, Eastern Time.

NOTE: You will receive this notice every year. You will also get it before the next period you can join a Medicare drug plan, and if the SHARP Rx Option coverage changes. You also may request a copy at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage:

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: October 1, 2014

Name of Entity/Sender: Supplemental Healthcare, Adventist Retirement Plan

Contact--Position/Office: Administrator

Address: 12501 Old Columbia Pike, Silver Spring MD 20904

Phone Number: 301-680-5036

MEDICAID AND CHIP NOTICE

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
ALASKA – Medicaid	INDIANA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949

COLORADO – Medicaid	IOWA – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	KANSAS – Medicaid
Website: https://www.flmedicaidprecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	NEW YORK – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	NORTH CAROLINA – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	OREGON – Medicaid
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	PENNSYLVANIA – Medicaid
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462

NEVADA – Medicaid	RHODE ISLAND – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
 Employee Benefits Security Administration
www.dol.gov/ebsa
 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
 1-877-267-2323, Menu Option 4, Ext. 61565

Glossary

“ARM” means Adventist Risk Management, Inc.

“Base Option” means a medical benefits option that supplements Medicare benefits as described in this document.

“Canadian Retirement Plan” means the retirement plan sponsored by the Seventh-Day Adventists - Canadian Division.

“Defined Benefit Plan” means the Seventh-day Adventist Retirement Plan of the North American Division.

“Defined Contribution Plan” means the Adventist Retirement Plan.

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

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

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

“Eligible Retiree” means a retiree of an NAD 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 SHARP. A Spouse married after the retiree’s effective retirement date is considered a non-eligible spouse for purposes of the Plan.

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

“MCx Option” means a medical benefits option that supplements Medicare benefits as described in this document.

“NAD Retirement Plans Committee” means the Committee that is responsible for the administration of Standard SHARP and the various other NAD programs available to NAD retirees.

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

“North American Division” or “NAD” means the North American Division of the General Conference of Seventh Day Adventists.

“Plan Year” means the calendar year.

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

“Retirement Plan Service” means the service credited under the Defined Benefit Plan, the Defined Contribution Plan or the Canadian Retirement Plan as described in this document. Service under the Seventh-Day Adventist Hospital Plan does not count as Retirement Plan Service for purposes of SHARP Earned Credit.

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

“SHARP” means the Supplemental Healthcare, Adventist Retirement Plan.

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

“Standard SHARP” means the plan of benefit options described in the Standard SHARP 2013 document.

Instructions for Completing the SHARP Forms

The age 65 Eligible Retiree and/or Eligible Spouse must be enrolled in Medicare.

1. The SHARP form completion depends upon meeting the eligibility requirement for either the Standard SHARP or the Pre-Medicare/Non-Medicare Options. Refer to the Eligibility section of this document to determine which coverage the correct one is for your needs. **All Medicare-eligible** individuals may only choose from the Standard SHARP Option.
2. For each individual seeking healthcare benefits please complete the Name, Date of Birth (DOB) and Social Security Number (SSN) on the form. Use the Standard SHARP Form for age 65 and older. Use the SHARP Pre-Medicare/Non-Medicare SHARP Form, found in the Pre-Medicare/Non-Medicare SHARP document, for those less than age 65 and dependent children. Enter the dollar amount for the options have selected.
3. Pre-Medicare: Remember inpatient & outpatient medical benefits are separate from DVH & Rx benefits. If the Pre-Medicare retiree wishes to also have dental, vision, hearing and prescription benefits he/she *must enroll separately with on the Pre-Medicare/Non-Medicare enrollment form* for each benefit and for each eligible individual.
4. Non-Medicare: This coverage includes medical inpatient and outpatient expenses, dental, vision, hearing and prescription drugs as described within the policy. See the Pre-Medicare/Non-Medicare document Schedule of Benefits.
5. Total ALL monthly selections.
6. If the retiree meets the eligibility requirements refer to the Earned Credit Table in the Earned Credit section. Enter the Earned Credit for the retiree, spouse and dependent child. Remember, only spouses who are eligible on the date the retiree has retired are eligible for the Earned Credit.
7. Add the total cost of all Options selected. Subtract the Earned Credit if eligible. The "Total" will be the monthly cost for the retiree's elected benefits.
8. For each individual who selects SHARP Options, Step 6 should be completed.
9. **Read all conditions carefully and sign the form.** Return the form within **30** days of retirement to the SHARP Office for processing. Be sure to sign the form. If there is no signature, the application and enrollment will NOT be processed.
10. For assistance at any time with the enrollment process please contact the SHARP Office at: 301-680-5036 / Monday–Thursday / 8 a.m.– 5 p.m. EST.

Pre-Medicare / Non-Medicare SHARP Form -- 2015

Retiree Name: _____ SSN: _____

	Retiree Name	Spouse Name
	DOB:	DOB:
	SSN:	SSN:

Pre-Medicare

Pre-Medicare - \$440/month/person		
Minus Pre-Medicare Earned Credit	-	-
Net Pre-Medicare Cost	\$ 0.00	\$ 0.00

Standard SHARP

DVH - \$65/month/person		
Rx - \$120/month/person		
Gross DVH and/or Rx Cost	\$	\$
Minus Standard SHARP Earned Credit	-	-
Net DVH and/or Rx Cost	\$ -	\$ -
Total Pre-Medicare/DVH/Rx:	\$ 0.00	\$ 0.00

Non-Medicare

	Dependent Child Name	Dependent Child Name	Dependent Child
	DOB:	DOB:	DOB:
	SSN:	SSN:	SSN:
Non-Medicare -- \$138/month/child			
Minus Earned Credit	-	-	-
Net Non-Medicare Cost	\$ 0.00	0.00	0.00

Total Cost for All Options Selected \$

Please enroll me in the SHARP coverage as requested above and accept my signature below as agreement to the following:

- * I authorize SHARP to deduct monthly contributions based on the options I selected. If the cost of my options is greater than my monthly pension, I agree to make quarterly or monthly payments in advance.
- * I understand that I and my eligible joint and survivor spouse, non-eligible spouse or eligible ex-spouse are allowed to join SHARP or request changes to SHARP at specific times including Delayed enrollment and the one-time three-year open
- * I understand that the non-eligible spouse is not eligible for the Earned Credit.
- * I understand that there are deductibles and maximums in SHARP.
- * I hereby certify that any child listed meets eligibility requirements. I am responsible to notify SHARP when my child becomes ineligible.
- * I understand that the Pre-Medicare/Non-Medicare SHARP **requires** participation in Aetna ASA PPO and are limited to inpatient and outpatient medical expenses only. I must select the DVH or Rx options if I wish to have benefits for those types of services.
- * I understand that the options selected and associated costs must be reviewed and authorized by the Retirement Office.
- * I understand that the Non-Medicare SHARP **requires** participation in Aetna ASA PPO. The eligibility and Earned Credit for Non-Medicare is available up to the 26th birthday.

Retiree Signature _____

Date _____

Effective Date of Options Selected: _____

Please sign & return within 30 days to:

Adventist Retirement/SHARP
12501 Old Columbia Pike
Silver Spring, MD 20904

Phone: 301-680-5036
Fax: 301-680-6190

NOTES

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

Privacy Officer
888-276-4732
privacyofficer@adventistrisk.org

Contracted Supporting Organizations

Member Services/Medical Benefit
Voice (888) ARM-4SDA or (888) 276-4732
Option #2
Mon – Thur, 7:00 a.m. – 6:00 p.m. Eastern
Friday 7:00 a.m. – 4:00 p.m. Eastern
healthcare@adventistrisk.org

Provider Services/Medical Benefit
Voice (888) ARM-4SDA or (888) 276-4732
Option #1
Interactive Voice Response 24/7

Medical Claims Office
HealthSCOPE Benefits
P O Box 16203
Lubbock, TX 79490-6203
EDI: 71063
Fax (915) 581-7537
Voice (888) ARM-4SDA or (888) 276-4732

Prescription Claims Office
Express Scripts
Voice 800-841-5396

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