Standard SHARP

January 1

2016

12501 Old Columbia Pike Silver Spring, MD 20904

Supplemental Healthcare Adventist Retirement Plan

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Supplemental Healthcare Adventist Retirement Plan Standard Program

January 1 to December 31, 2016

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. This document describes the Standard Supplemental Healthcare Adventist Retirement Plan (SHARP) for the 2016 Plan Year. Capitalized terms used in this document are defined in the Glossary.

Under Standard SHARP, retirees may choose among the following SHARP Options:

- Base Option or MCx (Medicare Extension) Option, each of which provides coverage that coordinates with Medicare Part A and B benefits,
- DVH Option (Dental, Vision and Hearing),
- Rx Option (Prescription Drug, or
- A combination of these Options.

Other healthcare assistance programs are available to certain retirees, eligible spouses and dependent children who are not entitled to Medicare. Refer to the 2016 SHARP Pre-Medicare / Non-Medicare document for information about those programs.

Important Plan Changes for 2016

- The Standard SHARP Rx Option has a $200 deductible effective 1-1-2016. (See page 13 for the Standard SHARP Schedule of Benefits and the Express Scripts Medicare PDP coverage of benefits document for more details)
- The Standard SHARP Option costs have changed for the 2016 plan year. (See page 14 and the Standard SHARP enrollment form)
- The Earned Credit will be frozen at the 2015 levels.

Coordination with Medicare

The Base, MCx and Rx Options require eligibility for and enrollment in original Medicare (Parts A and B). Medicare requires U.S. residency. SHARP is not a qualified 'Medicare supplemental coverage' plan as administered by various insurance companies

(Medicare Advantage and MediGap plans) and regulated by states, generally designated as plans A – N of Medicare.

The Base, MCx and Rx Options are described later in this booklet. The Rx Option is also described in more detail in the Express Scripts Evidence of Coverage document. The SHARP plan prohibits concurrent enrollment in the SHARP Rx Option and a Medicare Part D program.

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

A retired minister who has opted out of Social Security and who will not become eligible for Medicare may not select the Base, MCx or Rx Options because Medicare Part A and B enrollment is required to participate in those Options.

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

This Plan document describes the Plan's provisions for the period January 1, 2016 through December 31, 2016. All benefit limits and deductibles are based on the Plan Year. A member who enrolls in SHARP during the Plan Year will have access to full limits and will be subject to full deductible without pro-ration.

Retirees Share in SHARP Cost

The NAD pays part of the cost for SHARP coverage. This is based primarily on years of qualifying church service credit and the policies in place at retirement as described in the Earned Credit section. Eligible Retirees pay the remainder of the cost.

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. An enrollment form is included at the end of this booklet.

Limited Options for Changing Benefits

There are limited opportunities to change benefit selections under SHARP. 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.

Eligibility

Retiree Eligibility

To be an Eligible Retiree in the Standard SHARP Base, MCx and Rx Options, a retiree must be enrolled in Medicare Parts A and B. To enroll in all SHARP options, including the DVH Option, an Eligible 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.

A retired minister who has opted out of Social Security and who will not become eligible for Medicare may not select the Base, MCx or Rx Options because Medicare Part A and B enrollment is required to participate in those Options. The DVH Option is the only benefit available to this category of retiree.

An Eligible Retiree who is:

1. less than age 65 may select coverage under Pre-Medicare SHARP, which offers choices of medical, DVH and Rx options. The Pre-Medicare SHARP Options are described in a separate document.

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.

3. age 65 or older may select coverage only from the Standard SHARP Options.

Spouse Eligibility

To be an Eligible Spouse in Standard SHARP, an Eligible Retiree's spouse:

1. must be entitled to Medicare Parts A and B, and

2. must 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 under Pre-Medicare SHARP, which offers choices of medical, DVH and Rx Options. The Pre-Medicare SHARP Options are described in a separate document.

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.

3. age 65 or older may select coverage only from the Standard SHARP Options.

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

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

The Plan reserves the right to review and approve 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 Standard 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 the Eligible Retiree's retirement, or a child who becomes eligible under the special rules described in the section on Special Enrollment Rights – Family Status Changes; 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 Standard SHARP when he/she attains age 26.

A 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. Please refer to the Non-Medicare SHARP document for information about dependent child eligibility and benefits.

Eligibility Exclusions

1. Beneficiaries of the Regional Retirement Plan are not eligible to participate in SHARP.

2. The SHARP Base, MCx and Rx Options are not available to individuals who reside outside of the United States.

Enrollment and Enrollment Changes

The effective date for Standard SHARP coverage is generally the same as the retirement effective date for the Eligible Retiree. An Eligible Retiree must select Standard SHARP Options for himself/herself, as well as for any Eligible Spouse or Eligible Dependent, within 30 days of the retirement effective date. The Base, MCx and Rx Options of SHARP require eligibility for and enrollment in original Medicare (Parts A and B).

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

Limits for Enrollment Changes

Except as provided below in the section on Delayed Enrollment Due to Other Coverage and the section on Special Enrollment Rights, each Eligible Retiree and Eligible Spouse has only the following opportunities to *elect* Standard SHARP 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 Standard 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 Standard SHARP coverage is delayed for this reason, it can only be obtained in the future if one of the criteria listed in the section 'Loss of Other Coverage' are met.

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

1. Within 30 days of retirement, the Eligible Retiree must provide the following information to the SHARP Office:

    a. the name of each person with current other coverage

    b. the 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 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. 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 newly acquired non-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 Standard SHARP. Should this occur, SHARP may provide an opportunity to change some or all elections previously made under Standard SHARP.

High Inflation Special Enrollment

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

Medicare Part D

This Plan prohibits concurrent enrollment in SHARP’s Rx Option and another Medicare Part D plan. If SHARP discovers that an Rx enrollee is also enrolled in a Medicare Part D prescription drug plan, that enrollee will be terminated from SHARP’s Rx Option.

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.

Re-Employment

If an Eligible Retiree or Eligible Spouse returns to full-time employment subsequent to enrollment in Standard SHARP and becomes eligible for an employer healthcare coverage, Standard SHARP requires the Eligible Retiree and/or Eligible Spouse to terminate benefits in Standard SHARP. To be reinstated into Standard 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/Eligible Dependent, 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 Standard 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 Base, MCx, Rx or DVH benefits are discontinued at a non-open enrollment period, the termination of benefits will be considered permanent and will not be reinstated. This termination rule applies 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 and your family member's eligibility for the Plan or the proper administration of the Plan, it is your responsibility to report change in eligibility of general family or other status to SHARP within 30 days of the change. Failure to do so may hamper SHARP's ability to effectively administer benefits under the Plan. Examples of the types of changes that you must report are: marital status changes such as divorce, full time employment, loss of disability status of a dependent child, change in address/telephone number, eligibility for Medicaid assistance.

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 Standard SHARP Options selected.

Each Eligible Retiree (and each Eligible Spouse and/or Eligible Dependent) will receive his/her own Earned Credit. That means that both the Eligible Retiree and Eligible Spouse are covered under Standard SHARP, they will each receive an Earned Credit for Standard 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 Retirement Plan 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 an Eligible Dependent:**
  - 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 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 for an Earned Credit once he/she meets the Earned Credit eligibility as described above.

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

Earned Credit Table for 2016

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)	$130	$114	$98	$81	$65	$49	$33

****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.

Medicare Part B Premium Reimbursement

The Eligible Retiree or Eligible Spouse with combined Defined Benefit and Defined Contribution service credit is eligible to receive reimbursement for a percentage of the regular Medicare Part B premium if the individual is at least age 65 and the Eligible Retiree has 15 or more years of Retirement Plan Service and is eligible for an Earned Credit.

If the effective retirement date is 1-1-2015 or later, and the Eligible Retiree has only post-1999 service (Defined Contribution), there is no Medicare Part B premium reimbursement benefit for the Eligible Retiree or Eligible Spouse.

Medicare Part B premium reimbursement is based on $104.90. A copy of the Medicare Health Insurance card must be submitted to the SHARP Office for the reimbursement to be included in the monthly retirement benefits. Cards submitted after the Medicare Part B effective date will be retroactively reimbursed to the later of the Medicare Part B effective date or the Eligible Retiree's retirement effective date, but for no more than 12 months of retroactive reimbursement per covered member.

Participants in the Canadian Retirement Plan and the Retirement Plan who are eligible for healthcare assistance may only participate in one healthcare plan at a time. They must choose between SHARP and the Canadian healthcare plan. Based upon primary residence they may change from one plan to the other no more frequently than every 18 months. Medicare Part B premiums may be reimbursed to those who qualify even if they are not participating in SHARP and are participating in the Canadian healthcare plan.

Medicare Part B Premium Reimbursement Table							
SHARP Category	A	B	C	D	E	F	G
Years of Retirement Plan Service	35+	30-34	25-29	20-24	15-19	8-14**	5-7**
Reimbursement	90%	80%	70%	60%	50%	40%	30%
Monthly Reimbursement	$94.41	$83.92	$73.43	$62.94	$52.45	$41.96	$31.47

**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.

Schedule of Standard SHARP Benefits

January 1, 2016 To December 31, 2016

Service	Medicare Pays	SHARP Pays		You Pay	
		Base Option	**MCx Option**	**Base Option**	**MCx Option**
Deductibles	**Medicare pays on approved services after a deductible:** Medicare Part A (Inpatient): $1,288 Medicare Part B (Outpatient): $166	All Medicare approved services after member $2,100 annual deductible	Balance of Medicare approved expenses	$2,100 Annual Deductible	$0
Hospital Expenses					
Semi-Private Room & Board, General Nursing & Miscellaneous Services & supplies**	days 1-60 -- 100%	$0*	$0	$0*	$0
	days 61-90 -- all but $322/day	$322*	$322	$0*	$0
	days 91-150 -- all but $644/day	$644*	$644	$0*	$0
	days over 150 -- $0	$0	$0	all costs	all costs
Skilled Nursing Facility* **					
Semi-Private Room & Board, General Nursing & Miscellaneous Services & supplies	days 1-20 -- 100%	$0*	$0	$0*	$0
	days 21-100 -- all but $161/day	$161*/day	$161/day	$0*	0
	days over 100 -- $0	$0*	$0	all costs	all costs
Outpatient Medical Services					
Outpatient services	80%	20%*	20%	$0*	$0
Blood (first 3 pints)	$0	100%	20%	$0	$0
Colostomy/Ileostomy Supplies	$0	80%	80%	20%	20%
Medical Supplies	$0	80% up to $500/yr	80% up to $500/yr	$0	$0
Mental Health	80%	20%*	$0	$0*	$0
Hospice Care****	100%	$0*	$0	$0*	$0
Foreign Travel Emergency $1000 deductible	Not Covered	80% up to $50,000/yr	80% up to $50,000/yr	20%	$0
Orthotics/Orthopedic Shoes	$0	80% up to $600/yr	80% up to $600/yr	20%	20%

* $2,100 deductible applies.

** Services not approved by Medicare will be denied by the Plan.

*** Custodial Care and Nursing Home expenses are not covered.

**** Physician must certify as a terminal illness.

Service	Annual SHARP Payment Limit	SHARP Pays		You Pay	
DVH - Dental, Vision, Hearing					
Dental	$2,200 person/year	80%		20%	
Vision	$400 person/year	80%		20%	
Hearing	$2,200 person/year	80%		20%	
Rx	**The Rx Option will have a $200 deductible in 2016**	Retail	Mail Order	Retail 30 day	Mail 90 day
Generic Drugs		cost of medication		$12*****	$29*****
Preferred Brand Drugs		cost of medication		$29*****	$70*****
Non-Preferred Brand Drugs		cost of medication		$45*****	$110*****
Home IV Therapy		80%		20%	
Shingles Vaccine		100%		0%	

***** Plus costs resulting from non-compliance with plan rules

Standard SHARP Options and Costs

Standard SHARP Options can be selected individually or in combination with each other, except that the Base and the MCx Options may not be elected together.

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

The **Base Option** has an ***annual*** deductible of $2,100 per person. The **MCx Option** has ***no*** annual deductible. The provisions of Standard SHARP do not restrict members to seeking services within a provider network.

The following four Standard SHARP Options with 2016 costs are available:

- Base Option: **$35**/month/person
- DVH Option: **$75**/month/person
- MCx Option: **$175**/month/person
- Rx Option: **$120**/month/person

Married members may select from the four Standard SHARP Options independently of each other.

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

Medical Benefits: Base and MCx Options

The Base and MCx Options generally provide the same limited level of medical benefits. The primary difference between the Base Option and the MCx Option is the following:

- Base Option is subject to an annual deductible
- MCx Option is ***not*** subject to an annual deductible

For payment percentages and limits, see the Schedule of Standard SHARP Benefits.

Covered Expenses

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

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

a. Medicare hospitalization deductible

b. Medicare outpatient annual deductible

c. Medicare co-insurance for hospital days 61 – 90

d. Medicare co-insurance for hospital days 91 – 150

e. Skilled nursing facility days 21 – 100

f. Preventive Services described in Appendix A on page 41

Excluded Expenses

Expenses ***not*** covered under the Base and MCx Options include:

a. Expenses not approved by Medicare,

b. Expenses that exceed Medicare limits and maximums,

c. Expenses for nursing home care and custodial care, and

d. Expenses for skilled nursing facility charges for stays exceeding Medicare limits.

Base and MCx Option – <u>Coverage Exceptions</u>:

1. **Blood:** Medicare will usually deny the first 3 pints of blood each calendar year. The Base and MCx Options cover this expense.

2. **Medical Supplies:** The Base and MCx Options provide limited assistance for medical supplies not covered by Medicare such as blood pressure monitors, but only if accompanied by a letter of medical necessity from the treating physician. Reimbursement for these medical supplies (not including colostomy/ileostomy supplies described below) is 80% of the expense with a maximum of $500 per calendar year.

3. **Colostomy/ileostomy Supplies:** The Base and MCx Options provide assistance for colostomy and ileostomy supplies at 80% reimbursement, but only if denied by Medicare.

4. **Incontinence Supplies:** not covered.

5. **Orthopedic Shoes:** Medicare may deny assistance for orthopedic shoes, shoe inserts or similar devices. Under the Base and MCx Options, a covered member can submit such Medicare-denied expenses for reimbursement at 80% of the reasonable and customary cost with a maximum of $600 per calendar year. The claim must include a doctor's written statement of medical necessity, shoe-fitting documentation and a copy of the Medicare denial.

6. **Support stockings:** not covered.

7. **Wigs:** not covered.

8. **Preventive Care:** Standard SHARP will cover certain preventive care services not otherwise covered by Medicare as described in Appendix A.

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

One Annual Dental Cleaning/Exam

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

Maximum Out of Pocket Limit for Medical Benefits

Unreimbursed eligible medical essential health benefit expenses and prescription drug benefit expenses under Standard SHARP are limited to $6,600 per person and $13,200 per family in 2016. This out of pocket limit includes any co-payments and deductibles but does not include the premium costs.

Foreign Travel Emergency Medical Benefit

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

Reimbursement is limited to unexpected or emergency medical expenses incurred during a personal trip lasting less than 60 days. This benefit has a separate $1,000 per person/year deductible and is not subject to the Base Option deductible. Covered expenses are reimbursed at 80% with a $50,000 maximum benefit per calendar year. Reimbursement is subject to the following terms and limitations:

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

For information regarding short-term medical coverage that can be purchased for denominationally and volunteer sponsored trips or personal trips, please contact ARM:

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

Dental, Vision, Hearing (DVH) Option

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

The Dental benefit provides coverage for dental services based upon reasonable and customary fees for the geographical area in which the services are rendered. SHARP will pay 80% of reasonable and customary fees subject to a calendar year SHARP maximum paid amount of $2,200. Any expenses above this maximum amount are not eligible expenses under SHARP. 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
- 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 SHARP maximum paid amount of $400. Any expenses above this maximum amount are not eligible expenses under SHARP. The covered member is responsible for the 20% coinsurance and charges above the calendar year maximum paid amount. Surgery or other procedures considered to be medical in nature are not covered under the Vision benefit, but may be covered by Medicare. Unused Vision benefits may not be rolled over into the next calendar year.

The Hearing benefit provides coverage for services including hearing tests, hearing aids and the repair of hearing aids. SHARP will pay 80% of the costs subject to a calendar year SHARP maximum paid amount of $2,200. Any expenses above this maximum amount are not eligible expenses under SHARP. 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

Express Scripts Medicare (PDP) is the pharmacy benefit manager for the SHARP Rx Option for Medicare age eligible members. The rules of the plan, formulary guidelines and penalties are described in detail in the Evidence of Coverage and Formulary document mailed by Express Scripts to each enrollee. A notice of privacy practices and creditable coverage information for Express Scripts Medicare PDP is included in the welcome kit of each new enrollee and in the annual notice of coverage letter. In addition the Schedule of Benefits section of this document has the outline of the amount of the drug copayment levels. Non-compliance with the Express Scripts Medicare (PDP) cost containment and plan rules may result in additional out-of-pocket costs to the covered member. The Express Scripts Medicare customer service telephone number is 1-866-838-3974, the website is www.express-scripts.com.

The SHARP Rx Option Express Scripts commercial is the prescription drug program available to members who are not Medicare age eligible and meet specific requirements. This program requires the covered member to pay a portion of the cost of medications in the form of a copayment. Please see the Pre-Medicare/Non-Medicare SHARP document for the prescription drug guidelines.

Specialty Drug and Medicare Part B Prescriptions:

- **Mail Order Option. Express Scripts** offers a service that allows the covered member to fill Medicare Part B eligible prescriptions through mail order. The covered member will initially send the prescription to Express Scripts. Depending on the type of medication or supply requested, Express Scripts transfers the prescription to one of Accredo's Medicare Part B participating mail-order pharmacies. Accredo has extensive experience with Medicare Part B and Specialty Drugs and support the dispensing and billing of these prescriptions. The covered member will typically receive his or her medication within 10 days from when the prescription arrives at the mail-order pharmacy. The prescribing doctor may be contacted by Accredo if questions arise about the covered member's prescription. The covered member is responsible to pay the Medicare coinsurance percentage. The Standard SHARP Rx Option co-pay does not apply to the Medicare Part B prescription.

- **Retail Participating Pharmacy Option**. The covered member may prefer to use a participating retail pharmacy to fill a prescription for Medicare Part B eligible medications and supplies. When using a retail pharmacy, the covered member will be asked to present his or her Medicare identification card. The retail pharmacy will work with the covered member to bill Medicare on his or her behalf. The retail pharmacy will also submit electronically any other claims that may be eligible for additional coverage. Most independent pharmacies and national chains are Medicare providers.

- **Eligible Medicare Part B Medications**. Medications and supplies typically eligible for Medicare Part B coverage are:

    i. Diabetic supplies such as test strips and meters. The prescription for insulin and syringes is covered by Express Scripts. The mail-order or retail co-pay will apply.

    ii. Transplants – certain medications to aid tissue acceptance for Medicare-approved organ transplants

    iii. Cancer – certain oral medications used to treat cancer

    iv. Chronic Kidney Disease – certain medications used in situations where the kidneys have completely failed

    v. Respiratory – certain inhaled medications used in a device such as a nebulizer to receive the medication in mist form

    vi. Colostomy/ileostomy supplies

If the prescription is not eligible for Medicare Part B coverage, the mail-order or retail pharmacies will bill the usual co-pay for the medications and supplies. Information about which medications or supplies are Medicare Part B eligible can be found at www.medicare.gov or by calling Medicare at 1-800-633-4227.

Maximum Out of Pocket Limit for Prescription Drug Benefits

Unreimbursed eligible medical essential health benefit expenses and prescription drug benefit expenses under Standard SHARP are limited to $6,850 per person and $13,700 per family in 2016. This out of pocket limit includes any co-payments and deductibles but does not include the premium costs.

Prescription Drug Claims

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

- **Home Delivery program:** Claims are automatically filed through the 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 ID card indicates eligibility for the purchase of prescription drugs. Although most pharmacies participate with the Express Scripts pharmacy program, there are some that do not. If prescription drugs are purchased at a pharmacy that does NOT participate in the Express Scripts network the Plan has chosen to participate in, members will have to pay

the full cost of the prescription filled and file a claim with Express Scripts for reimbursement. Contact Express Scripts 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 ID card. The medication is obtained through the pharmacy benefit manager, Express Scripts, if available. Only covered members who have selected the SHARP Rx Option are eligible for home health intravenous medication benefits.

- **Self-administered Drug:** Drugs administered in an outpatient hospital setting denied by Medicare. The member must be a participant in the SHARP Rx Option. The self-administered drug must be a part of the SHARP drug formulary. The Express Scripts Medicare PDP benefit may provide coverage for some self-administered drugs. Contact Express Scripts Medicare PDP at 1-866-838-3974 to see if your medication is covered. You may submit the claim to Express Scripts. If the drug is available through Express Scripts, the appropriate copayment will apply. If the drug is not available through Express Scripts, submit the claim to the ARM claim office listed on your SHARP identification card. The SHARP reimbursement is at 80% of the cost.

- **Shingles vaccine:** If a member has purchased/paid for the vaccine separate from a physician office visit, and the member participates in the SHARP Rx Option, the claim is submitted to Express Scripts. To review the Express Scripts Medicare PDP program vaccine coverage, review the Evidence of Coverage document. If the retiree incurs a prescription drug copay, the receipt of the copay may be submitted to ARM at the address on the SHARP ID card. Contact Express Scripts customer service at 1-866-838-3974 for additional information regarding this benefit.

Coordination of Benefits

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

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

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

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

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

Coordination Rules

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

Medicaid

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

Filing Claims

Timely Filing Requirements

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

Paper Claims Address (on the SHARP ID card):

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

Electronic Claims Address (on the SHARP ID card):

WebMD/Envoy Payer ID 75261 CMS Crossover Enabled

Prescription Claims must be submitted per the guidelines of the Express Scripts Medicare PDP document. Follow the instructions in the Quick Reference guide of the Evidence of Coverage documents from Express Scripts.

- **Medicare Primary claims** are first billed by the provider directly to Medicare. Medicare then automatically sends an electronic claim to Adventist Risk Management, Inc. providing explanation on what services were approved and paid by Medicare. Any remaining balances will be considered for payment for those covered members who have the Base or MCx Option under Standard SHARP. All claims submitted by a covered member for reimbursement after Medicare payment must include a copy of the Medicare Summary Notice (MSN). Most providers will bill Medicare. Generally it will not be necessary for a covered member to submit balances for payment since Medicare submits these automatically to Adventist Risk Management, Inc.

- **Claims paid first by the covered member** should be submitted with clear proof of payment and a request for reimbursement to be paid to the covered member. Such claims should be mailed to Adventist Risk Management, Inc. at the address listed above or on the back of the SHARP ID card.

Appeals of Denied Claims

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 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 Adventist Risk Management, Inc. (ARM), at P.O. Box 1928 Grapevine, TX 76099-1928. The customer service number is 1-800-447-5002. Any appeal must be submitted within the timeline of 12 months from the date of service for the claim.

Adventist Retirement Appeals Procedures

The following appeal procedures apply to claims denied for benefits under Standard SHARP. Plan information may be downloaded[1] 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. 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

[1] Plan information may be found on the Retirees tab at www.adventistretirement.org

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 Plans
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-compliant 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.

HIPAA

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 Standard SHARP 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 Standard SHARP 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 Standard SHARP to the Adventist Retirement Board for uses permitted under HIPAA. Details regarding uses of PHI are available in the Adventist Retirement Plans *Notice of Privacy Practices*. This notice explains how certain health information about you and your covered dependents may be used or released by SHARP. If you wish to obtain a copy of the *Notice of Privacy Practices,* it is located on the Retirement website at www.adventistretirement.org. You may print it or call 301-680-6249 to request a copy.

The North American Division of Seventh-day Adventist Retirement Plans is the plan sponsor of the Supplemental Healthcare Adventist Retirement Plan. The Adventist Retirement Board of Trustees has been given the authority by the North American Division to oversee and administer the Plan. The Board, in turn, has authorized Adventist Risk Management, Inc. to administer the Plan claims on a day-to-day basis. The Plan is required by law to provide you with a copy of this Notice.

NOTICE OF PRIVACY PRACTICES

General Provisions

This Article of the Plan applies to the uses and disclosures of Protected Health Information ("PHI") made on or after April 14, 2004.

Uses and Disclosures of PHI

The North American Division of Seventh-day Adventist Retirement Plans/SHARP may use and disclose a Participant's PHI for Plan Administration Functions, including, but not limited to, Treatment, Payment, and Health Care Operations. Notwithstanding anything to the contrary herein, the Sponsor may only use and disclose PHI to the extent of, and in accordance with, the uses and disclosures described in the Plan's notice of privacy practices (as in effect at the time in question), as permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or as otherwise Required by Law.

Restriction on Plan's Disclosure to the Sponsor

Except as otherwise permitted or required by Law, neither Plan, nor any of its Business Associates, shall disclose PHI to the Sponsor except upon receipt of a certification from the Sponsor that the Plan has been amended to include the provisions of this Article.

Privacy Agreements of the Sponsor

As a condition for obtaining PHI from the Plan and its Business Associates, the Sponsor agrees it will:

a. Not use or further disclose such PHI other than
    1) as permitted or required by Section of this Article,
    2) as permitted by 45 Code of Federal Regulations ("CFR") Section 164.508, 45 CFR Section 164.512, or other sections of the regulations under HIPAA, or
    3) as Required by Law.
b. Ensure that any of its agents, subcontractors, and other parties to whom it provides PHI received from the Plan agrees to the same or substantially similar restrictions and conditions that apply to the Sponsor with respect to such information. To be considered

substantially similar, such restrictions and conditions must meet the requirements of 45 CFR Section 164.504(f)(2)(ii)(B).

c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Sponsor.
d. Report to the Plan any use or disclosure of PHI inconsistent with this Article of which the Sponsor becomes aware.
e. Make available PHI in accordance with the access requirements in 45 CFR Section 164.524 and for amendment in accordance with 45 CFR Section 164.526; and incorporate any amendments to PHI in accordance with the requirements of 45 CFR Section 164.526.
f. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528.
g. Make the Sponsor's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's administrative simplification requirements. No attorney-client, accountant-client, or other legal privilege or the work product rule shall be or shall be deemed to have been waived by complying with this provision.
h. If feasible, return or destroy all PHI received from the Plan that the Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Sponsor shall limit further uses and disclosures to those purposes that meet the requirements of HIPAA and that make the return or destruction of the information infeasible.
i. Ensure that there is adequate separation between the Plan and the Sponsor by implementing the terms of Section of this Article.

Adequate Separation between the Plan and the Sponsor

Any officer or employee of the Sponsor who serves as a fiduciary with respect to the Plan, and any officer or employee of the Sponsor (including, but not limited to, benefits, audit, legal, accounting, and systems personnel) who, from time to time in the ordinary course of business of the Sponsor, perform Plan Administration Functions related to the Plan, may be given access to PHI received from the Plan, subject to the following restrictions:

a. These persons may only have access to, and use and disclose, PHI for Plan Administration Functions that are performed by the Sponsor for or on behalf of the Plan; and
b. These persons shall be subject to disciplinary action and sanctions in accordance with the policies of the Sponsor, up to and including termination of employment, for any use or disclosure of PHI in

breach of, or in violation of, or in noncompliance with, the provisions of this Article or the law. The Sponsor shall arrange to maintain records of such violations, as well as disciplinary and corrective measures taken with respect to each incident.

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 North American Division of Seventh-day Adventist Retirement Committee). The permitted disclosures to and uses by the Plan Sponsor of medical information are as follows:

1. The Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary information for the purpose of a) obtaining premium bids for providing insurance coverage; or b) modifying, amending, or terminating the Plan ("Summary Information"). The Plan Sponsor may use Summary Information so received from the Plan only for these two listed purposes.
2. The Plan may disclose to the Plan Sponsor, and the Plan Sponsor may use, information on whether an individual is participating in the Plan or is enrolling or dis-enrolling in the Plan.
3. The Plan may disclose PHI to the Plan Sponsor and/or the Plan Sponsor may use such PHI if you have specifically authorized in writing such disclosure and/or use.
4. The Plan may disclose PHI to the Plan Sponsor, and the Plan Sponsor may use PHI, to carry out plan administration functions, such as activities relating to:
    a. obtaining 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 retiree. All Participants should be aware that the Plan and the Plan Sponsor will be providing PHI concerning all dependents of an employee to the employee as part of the Explanation of Benefits and when reimbursing the employee for covered services under the Plan. If there is some reason why a dependent (spouse or child) of an retiree does not want the retiree to receive PHI, the dependent should so inform his or her healthcare provider and should also contact the Plan Administrator

c. determining eligibility for the Plan or eligibility for one or more types of coverage or benefits provided under the Plan
d. coordination of benefits or determinations of co-payments or other cost sharing mechanisms
e. adjudication and subrogation of claims, billing, claims management, collection activities and related 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 employee benefit plan of the Plan Sponsor.
4. The Plan Sponsor will report to the Plan any use or disclosure of the PHI that is inconsistent with the permitted uses and disclosures of which the Plan Sponsor becomes aware. The Plan Sponsor will report to the Plan any security incident of which the Plan Sponsor becomes aware.
5. The Plan Sponsor will 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, 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.
11. 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 (NAD Retirement Plans Office)
    c. Plan Sponsor's designated Benefit Coordinator and Controlling Committee
12. 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.
13. 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 Retirement Plans
Privacy/Security Officer
12501 Old Columbia Pike
Silver Spring, MD 20904

General Information

Administration

SHARP is governed by the Adventist Retirement Board, and administered by the Adventist Retirement Board. Claims are managed by Adventist Risk Management, Inc. (ARM).

Changes to Standard SHARP

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

Plan Year

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

Glossary

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

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

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

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

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

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

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

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

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

"Non-Medicare SHARP" means the health care plan offered to a child of an Eligible Retiree who is under age 26.

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

"Open Enrollment" means the Eligible Retiree who has an Earned Credit has the opportunity to change selected benefits at a onetime three-year anniversary open enrollment. The Eligible Retiree is not required to make a change in benefits. If the SHARP office does not receive a re-enrollment form the same benefits will remain in place as were selected at the initial enrollment. This Open Enrollment occurs in November of each Plan year.

"Plan Year" means the calendar year.

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

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

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

"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 this document.

Appendix A: Preventive Care Services

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

Covered Preventive Services for All Adults

- **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin** use for men and women of certain ages
- **Blood Pressure** screening for all adults
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults over 50
- **Depression** screening for adults
- **Type 2 Diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at higher risk for chronic disease
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults--doses, recommended ages, and recommended populations vary:
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza (Flu Shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
- **Obesity** screening and counseling for all adults

- **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
- **Tobacco Use** screening for all adults and cessation interventions for tobacco users
- **Syphilis** screening for all adults at higher risk
- **Vitamin D** for individuals over age 65 who are at increased risk for falls

Covered Preventive Services for Women

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

- **Well-Woman Visits** to obtain recommended preventive services

Covered Preventive Services for Children

- **Alcohol and Drug Use** assessments for adolescents
- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages (coverage for each child is for one screening during each of the age categories shown):
    - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Blood Pressure** screening for children (one screening during each of the age categories shown):
    - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Cervical Dysplasia** screening for sexually active females
- **Congenital Hypothyroidism** screening for newborns
- **Depression** screening for adolescents
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders (one screening during each of the age categories shown):
    - Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Fluoride Chemoprevention** supplements for children without fluoride in their water source
- **Gonorrhea** preventive medication for the eyes of all newborns
- **Hearing** screening for all newborns
- **Height, Weight and Body Mass Index** measurements for children (one screening during each of the age categories shown):
    - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Hematocrit or Hemoglobin** screening for children
- **Hemoglobinopathies** or sickle cell screening for newborns
- **HIV** screening for adolescents at higher risk
- **Immunization** vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis
    - Haemophilus influenza type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus

- Inactivated Poliovirus
- Influenza (Flu Shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella

- **Iron** supplements for children ages 6 to 12 months at risk for anemia
- **Lead** screening for children at risk of exposure
- **Medical History** for all children throughout development (one screening during each of the age categories shown):
  - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Obesity** screening and counseling
- **Oral Health** risk assessment for young children (one screening during each of the age categories shown):
  - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI)** prevention counseling for adolescents at higher risk
- **Tuberculin** testing for children at higher risk of tuberculosis (one screening during each of the age categories shown):
  - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Vision** screening for all children

PREVENTIVE CARE SERVICES – PRESCRIPTION

The Plan pays benefits for Preventive Care Prescriptions as required by health care reform. These Prescriptions are summarized below. The Plan pays 100% of the cost of these Covered Services, without co-payments, and the Plan deductibles do not apply. Claims for prescriptions drugs in this category will be submitted directly to Express Scripts for reimbursement. You may obtain a claim submission form by contacting Express Scripts.

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 (including all over-the-counter 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

1. **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
2. **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
3. **Female Contraception Methods** – all FDA-approved methods of contraception for women; hormonal, barrier, emergency, and implanted devices including over-the-counter contraceptive methods, oral contraceptives, and contraceptive devices
    a. Women up to age 50 years
4. **Folic Acid**; Folic acid tablet 0.4 MG and 0.8 MG; prenatal vitamins with folic acid; multivitamins with folic acid
    a. Women through age 50 years
5. **Iron Supplements**; Iron (various strengths) drops, liquid, suspension, granules; chewable 0.25 MG and 0.5 MG; drops 0.25 MG and 0.5MG; suspension
    a. Children ages 6 to 12 months who are at risk for iron deficiency anemia
6. **Oral Fluoride**; Fluoride chewable tablet 0.25 MG and 0.5 MG; Fluoride drops 0.125 MG, 0.25 MG and 0.5 MG
    a. Children older than 6 months of age through age 5
7. **Smoking Cessation**; Bupropion SR 150 MG; Chantix; Nicotine gum, lozenge, and patch (OTC products only)
    a. Men and women ages > 18 who use tobacco products
8. **Vitamin D**; Vitamin D 1,000 units or less per dose u nit; calcium with vitamin D
    a. Men and women ages >65 who are at risk of falls
9. **Breast Cancer Primary Prevention**; Tamoxifen, raloxifene, and Soltamox (Tamoxifen liquid). When prescribed for use in primary prevention of invasive breast cancer in women at high risk.

Instructions for Completing the SHARP Forms

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

1. The SHARP form completion depends upon meeting the eligibility requirement for the Standard SHARP or the Pre-Medicare/Non-Medicare Options. Refer to the Eligibility section of this document to determine which coverage is the correct one for your needs. **All Medicare-eligible** individuals may only choose from the 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 Pre-Medicare/Non-Medicare SHARP form for those less than age 65, not Medicare eligible and dependent children. Enter the dollar amount for the options 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* using the Pre-Medicare/Non-Medicare form. Refer to the Pre-Medicare/Non-Medicare document Schedule of Benefits.

4. Non-Medicare: This coverage includes medical inpatient and outpatient expenses, dental, vision, hearing and prescription drugs as described within the policy. Refer to 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. Special enrollees are <u>not</u> eligible for 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. If there is no signature, the application and enrollment will NOT be processed.

10. For assistance with the enrollment process please contact the SHARP Office at: 301-680-5036 / Monday–Thursday / 8 a.m. – 5 p.m. Eastern Standard Time.

Standard SHARP Form -- 2016

You may select either Base or MCx, but not both:	• Base Option: $2,100 deductible/ year/person • MCx Option: No deductible

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

Standard SHARP		
Base - $35/month/person		
MCx - $175/month/person		
DVH - $75/month/person		
Rx - $120/month/person		
Gross Standard SHARP Cost	**$**	**$**
Minus Standard SHARP Earned Credit	**-**	**-**
Total Standard SHARP Cost:	**$**	**$**

Please accept my signature below as agreement to the following conditions:

- 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 enrollment.
- 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 understand that any child listed meets eligibility requirements. I am responsible to notify SHARP when my child become(s) ineligible.
- I understand that the options selected and associated costs must be reviewed and authorized by the Retirement Office.
- I understand that to review SHARP Base, MCx and Rx Options, as well as reimbursement of a percentage of Medicare Part B premiums (if eligible), I must submit a copy of Medicare Part A and B cards for myself and my spouse.
- Medicare rules regarding delayed enrollment in Medicare Part B or prescription drug coverage (Medicare D) may result in a Medicare premium penalty.

Retiree Signature: _____ Date: _____

Effective Date of options selected: _____

Please sign and return within 30 days to:

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

Pre-Medicare / Non-Medicare SHARP Form – 2016

Retiree Name: _____ **SSN:** _____

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

Pre-Medicare		
Pre-Medicare - $450/month/person		
Minus Pre-Medicare Earned Credit(see Bullet #5 below)		
Net Pre-Medicare Cost	**$**	**$**

Standard SHARP		
DVH - $75/month/person		
Rx - $120/month/person		
Gross DVH and/or Rx Cost		
Net DVH and/or Rx Cost		
Total Pre-Medicare/DVH/Rx:	**$**	**$**

Non-Medicare $130/month/child	Dependent Child Name	Dependent Child Name	Dependent Child Name
	DOB:	DOB:	DOB:
	SSN:	SSN:	SSN:
Non-Medicare -$130/month/child			
Minus Earned Credit			
Net Non-Medicare Cost:	$		

Total Cost for All Options Selected:	**$**

Please accept my signature below as agreement to the following conditions:

- I authorize SHARP to deduct my 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/survivor spouse, non-eligible spouse or 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 enrollment.
- I understand that the non-eligible spouse is not eligible for the Earned Credit.
- I understand that there are deductibles and maximums in SHARP, and that upon my enrollment in SHARP Pre-Medicare/Non-Medicare I will have access to full limits and be subject to the full deductible without proration as of my effective date.
- I certify that any child listed meets eligibility requirements and that I am responsible to notify SHARP when my child become(s) ineligible.
- I understand that Pre-Medicare SHARP **requires** participation in Aetna ASA PPO and is 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 and return within 30 days to:
Adventist Retirement Plans, 12501 Old Columbia Pike, Silver Spring, MD 20904

NOTES

Contact Information

SHARP Office – Adventist Retirement Plans

Email (preferred method of contact):	SHARP@nadadventist.org
Phone:	1-301-680-5036
Web site:	www.adventistretirement.org
Fax:	1-301-680-6190
Address:	Adventist Retirement Plans Attn: SHARP 12501 Old Columbia Pike Silver Spring, MD 20904

Reasons to contact the SHARP Office:

- Enrollment questions
- Appeals
- Request replacement SHARP ID card

Adventist Risk Management, Inc. (ARM)

Customer Service, Claims	1-800-447-5002
Benefits & Prior-Authorization	www.webtpa.com
Claims Address:	Adventist Risk Management, Inc. PO Box 1928 Grapevine, TX 76090-1928

Reasons to contact ARM:

- All claim payment issues
- Verification of benefits

Express Scripts

Phone and Prior-Authorization:	1-866-838-3974
Web site:	www.express-scripts.com
Claims Address: (Must use a Prescription Drug Reimbursement Form)	PO Box 66577 St Louis, MO 63166-8838

Reasons to contact Express Scripts:

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

Other

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

Contact for the SHARP Privacy Officer 1-301-680-6249