Standard SHARP-Ex

January 1

2017

12501 Old Columbia Pike
Silver Spring, MD 20904

Supplemental
Healthcare
Adventist
Retirement
Plan

Table of Contents

Page

Introduction 1
- Important Plan Changes for 2017 1
- Retirees Share in SHARP Cost 1
- Timely Enrollment is Important 2
- Limited Options for Changing Benefits 2

Eligibility 2
- Retiree Eligibility 2
- Spouse Eligibility 3
- Dependent Children Eligibility 4
- Eligibility Exclusions 4

Enrollment and Enrollment Changes 5
- Limits for Enrollment Changes 5
- Delayed Enrollment Due to Other Coverage - New Retiree Only 5
- Loss of Other Coverage 6
- Special Enrollment Rights 6
- Discretionary Special Enrollment 7
- High Inflation Special Enrollment 7
- Pre-Medicare SHARP Expiration 7
- Re-Employment 7
- Surviving Retiree or Eligible Spouse 7
- Requested Termination of Benefit 8
- Your Responsibility to Report Family Changes 8

Health Reimbursement Account (HRA) and Earned Credit – Eligibility and Amounts 8
- Sharp Ex HRA and Earned Credit 8
- Determining Earned Credit Category 9
- Eligibility for HRA or Earned Credit 9
  - Eligible Retiree 9
  - Eligible Spouse 10
  - Eligible Dependent 10
  - Future Eligibility for Earned Credit 10
- 2017 HRA Table for 2017 11
- SHARP DVH Earned Credit Table 11

Page

Medicare Part B Premium Reimbursement 12
- Medicare Part B Premium Reimbursement Table 12

Dental, Vision, Hearing (DVH) Option 13
- Covered Dental Benefits 13
- Dental Exclusions 13
- Vision 14
- Hearing 14
- Schedule of DVH Benefits ....

Coordination of Benefits 15
- DVH Coordination Rules 15
- Medical Coordination Rules 15
- Medicaid 15

Filing DVH Claims 16
- Timely Filing Requirements 16
- Paper Claims Address 16
- Claims Paid First by Covered Member 16

Appeals of Denied DVH Claims 17
- Adventist Retirement Appeals Procedures 17
- Review Process 18
- Level I Appeal 19
- Level II Appeal 19
- Level III Appeal 20
- External Claim Appeal Process 21

HIPPA 22

Notice of Privacy Practices 23

Medicare Prescription Drug Plan Info 29

General Information 32
- Administration 32
- Changes to Standard SHARP 32
- Plan Year 32

Glossary 33

Appendix A: Preventive Care List 35
- Adults 35
- Women 36
- Children 37
- Prescription 38

Instructions for Completing SHARP Form 41
- Standard SHARP Form........................42

Contact Information (Back Cover)
- SHARP Office
- Aon Retiree Health Exchange
- Adventist Risk Management (ARM)
- Medicare
- SHARP Privacy Officer

Supplemental Healthcare Adventist Retirement Plan Standard Program

January 1 to December 31, 2017

Introduction

The North American Division of Seventh-day Adventists (NAD) offers a healthcare assistance plan for certain Eligible Retirees and their Eligible Spouses and Eligible Dependent children through the Adventist Retirement Plans office. This document describes the Standard Supplemental Healthcare Adventist Retirement Plan (SHARP-Ex) for the 2017 Plan Year. Capitalized terms used in this document are defined in the Glossary.

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

- Medical and Prescription Drug plans for those age 65 and older will be chosen from the private Medicare Exchange Marketplace vendor, Aon Retiree Health Exchange, and

- SHARP DVH Option (Dental, Vision and Hearing)

Other healthcare assistance programs are available to certain retirees, eligible spouses and dependent children who are not entitled to Medicare. Refer to the 2017 SHARP Pre-Medicare / Non-Medicare document, and the Standard SHARP document for participants eligible for Social Security Disability and Medicare Part A and Part B, for information about those programs.

Important Plan Changes for 2017

- Aon Retiree Health Exchange assists each Medicare age Eligible Retiree and their Medicare age Eligible Spouse with enrollment in a healthcare plan to supplement Medicare Part A, Part B and Part D

Retirees Share in SHARP Cost

The Adventist Retirement Plan pays part of the cost for SHARP DVH 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.

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 Dependent children.

Eligibility

Retiree Eligibility

To be an Eligible Retiree in the SHARP-Ex Option and to enroll through the Aon Retiree Health Exchange, the Eligible Retiree must be enrolled in Medicare Parts A and B. 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 will not be eligible to enroll through Aon Retiree Health Exchange because Medicare Part A and B enrollment is required to participate. 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 Social Security disability,* may select coverage only from the Standard SHARP Base, Rx and DVH Options. Refer to the Standard SHARP with Disability document.

3. age 65 or older may select coverage only from the Standard SHARP-Ex Option.

Spouse Eligibility

To be an Eligible Spouse in Standard SHARP-Ex, 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 Adventist Retirement Office), or be eligible under the special rules described in the section on Special Enrollment Rights – Family Status Changes.

An Eligible Spouse who is:

1. less than age 65 may select 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 Social Security disability,* may select coverage only from the Standard SHARP Options as found in the Standard SHARP with Disability document.

3. age 65 or older may select coverage only from the Standard SHARP-Ex Option.

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 requirement for 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 the current 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, until the child attains age 26.

An Eligible Dependent described above shall remain an Eligible Dependent for 60 days following the death of the Eligible Retiree (or the second to die of both the Eligible Retiree and Eligible Spouse), and shall remain covered by the then existing coverage options until the end of such 60 days, unless an earlier termination of coverage is requested in writing on behalf of the Eligible Dependent. 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 Options are not available to individuals who have primary residence outside of the United States.

Enrollment and Enrollment Changes

The effective date for Standard SHARP-Ex coverage is generally the same as the retirement effective date for the Eligible Retiree. An Eligible Retiree must select Standard SHARP-Ex Options for himself/herself, as well as for any Eligible Spouse or Eligible Dependent, within 30 days of the retirement effective date. The SHARP-Ex Option requires 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 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). This is the only opportunity to enroll in SHARP benefits. If SHARP benefits are declined, it is considered a permanent opt-out of benefits.

2. An Eligible Retiree or Eligible Spouse, who selects Pre-Medicare SHARP or Standard Sharp with Disability prior to age 65, may enroll in Standard SHARP - Ex within 30 days of reaching age 65. The Eligible Retiree or Eligible Spouse will then be entitled to select any of the Standard SHARP-Ex Options.

    - **Important Note**: With very limited exceptions as 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 is 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

    c. the effective date of the other coverage

2. Within 30 days of the loss of other coverage, the Eligible Retiree must contact the SHARP Office and complete all required SHARP enrollment forms.

Loss of 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), or
(ii) loss of healthcare benefits from VA, TriCare, Medicaid, state/federal plan and other retirement plan healthcare coverage.
(iii) any insurance carrier issues involving a move by an ARHE participant, requires the Retiree to work directly with Aon Retiree Health Exchange.

“Loss of Other Coverage” does not include the voluntary decision of an Eligible Retiree or Eligible Spouse to terminate other healthcare coverage.

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. (Refer to the Glossary for the definition and rules regarding a non-eligible spouse)

Discretionary Special Enrollment

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

High Inflation Special Enrollment

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

Pre-Medicare SHARP Expiration

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

Re-Employment

If an Eligible Retiree or Eligible Spouse returns to full-time employment subsequent to enrollment in Standard SHARP-Ex and becomes eligible for an employer healthcare coverage, SHARP requires the Eligible Retiree and/or Eligible Spouse to terminate benefits in Standard SHARP-Ex. To be reinstated into Standard SHARP-Ex, a written request, with documentation of loss of coverage, must be submitted to the SHARP Office within 30 days of the loss of 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 need to contact the Aon Retiree Health Exchange Benefit Advisor at 1-844-360-4714 for assistance with continuation of medical or prescription drug benefits.

Requested Termination of Benefit

If, at the request of the Eligible Retiree or Eligible Spouse, SHARP-Ex or DVH benefits are discontinued, 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-Ex 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, disability status, loss of disability status of a dependent child, change in address/telephone number, eligibility for Medicaid assistance.

Health Reimbursement Account and Earned Credit Eligibility and Amounts

SHARP-Ex Health Reimbursement Account (HRA) and Earned Credit

The Adventist Retirement Board has established a Health Reimbursement Account (HRA) to be administered through the SHARP-Ex Option. An HRA is a tax-free reimbursement account established for each Eligible Retiree and Eligible Spouse based upon the rules as stated below. An HRA and Earned Credit is calculated for Eligible Retirees based on years of Retirement Plan Service. The HRA and Earned Credit is the monthly amount that is made available to assist an Eligible Retiree with the costs of the Standard SHARP DVH Option if selected and provide the HRA amount for the SHARP-Ex Option.

Each Eligible Retiree and each Eligible Spouse will receive his/her own HRA or Earned Credit. That means that both the Eligible Retiree and Eligible Spouse who are covered under Standard SHARP-Ex, will each receive an HRA or Earned Credit for Standard SHARP-Ex and SHARP DVH. To receive the HRA, you must enroll in a medical, prescription drug, dental or vision plan through the Aon Retiree Health Exchange.

If eligible for a Pre-Medicare SHARP Earned Credit, an Eligible Retiree or Eligible Spouse who selects benefits under the Pre-Medicare SHARP will receive two Earned Credits: an Earned Credit for Pre-Medicare SHARP and another Earned Credit for Pre-Medicare DHV and Rx SHARP. The Non-Medicare SHARP receives a separate Earned Credit.

The Standard SHARP DVH Earned Credit is applied to the total cost of the DVH Option. If the cost of the SHARP DVH selection exceeds 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 DVH Option 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 DVH Earned Credit may only be used for Standard SHARP DVH. This applies to 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 Benefit Plan
- Pre- 2000 years under the Canadian Retirement Plan
- Non-NAD service in foreign divisions for certain of those who transferred to and began employment in the NAD before 2000.
- Pre-2000 years under the Bermuda Retirement Plan

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 the HRA or Earned Credit

Those eligible to participate in SHARP are eligible for an HRA or 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 Eligible Retiree must be eligible for an HRA or 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 an HRA or 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 or meet the rules of Special Enrollment Rights-Change in Family Status requirements.

- **Future Eligibility for Earned Credit**

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

  An Eligible Retiree will become entitled to an HRA or Earned Credit once he/she meets the HRA and Earned Credit eligibility as described above.

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

2017 HRA TABLE

2017 HRA Table							
Church 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**
Annual HRA Contribution	$2,400.00	$ 2,160.00	$ 1,920.00	$ 1,680.00	$1,440.00	$1,200.00	$ 900.00
Less SHARP DVH Earned Credit	$ 780.00	$ 696.00	$ 612.00	$ 528.00	$ 444.00	$ 360.00	$ 276.00
Net Annual HRA Contribution	$1,620.00	$1,464.00	$1,308.00	$1,152.00	$ 996.00	$ 840.00	$ 624.00

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

SHARP DVH Option Earned Credit Table

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
DVH Cost/Month	$ 90.00	$ 90.00	$ 90.00	$ 90.00	$ 90.00	$ 90.00	$ 90.00
Minus the DVH Credit/Month	$ 65.00	$ 58.00	$ 51.00	$ 44.00	$ 37.00	$ 30.00	$ 23.00
Total DVH Cost /Member /Month	$ 25.00	$ 32.00	$ 39.00	$ 46.00	$ 53.00	$ 60.00	$ 67.00

****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 January 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 was frozen January 1, 2015 and 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 Adventist 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.

SHARP 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 on approved charges. Fees above the annual SHARP maximum paid amount and any charges above reasonable and customary fees are the responsibility of the member. 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 billed costs subject to a calendar year SHARP maximum paid amount of $400. Any expenses above this SHARP maximum amount are not eligible expenses.

The covered member is responsible for the 20% coinsurance on approved charges. Fees above the calendar year SHARP maximum paid amount are the responsibility of the member. 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 billed costs subject to a calendar year SHARP maximum paid amount of $2,200. Any expenses above this SHARP maximum amount are not eligible expenses.

The covered member is responsible for the 20% coinsurance on approved charges. Fees above the calendar year SHARP maximum paid amount are the responsibility of the member. 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.

Schedule of Standard SHARP DVH Benefits			
January 1, 2017 - December 31, 2017		**SHARP**	**You**
Dental	$2,200 person/year*	80%	20%
Vision	$400 person/year*	80%	20%
Hearing	$2,200 person/year*	80%	20%

Note: * refers to the payment rules as noted above.

Coordination of Benefits

Standard SHARP DVH is an employer-sponsored plan for retirees. A member who enrolls in Standard SHARP DVH during the Plan year will have access to full limits and will be subject to full deductibles without pro-ration. Total payments will not exceed SHARP's payment responsibility as if SHARP had been primary.

SHARP DVH Coordination Rule:

SHARP DVH Option is considered the primary DVH benefit for the member and does not coordinate with other DVH plans.

SHARP Medical Coordination Rules:

SHARP-Ex medical and prescription drug coordination of benefit rules are determined by the insurance carrier the member enrolled with through the Aon Retiree Health Exchange. SHARP-Ex does not participate in medical or prescription drug coordination of benefits with these carriers.

SHARP is *not* insurance. It is a retirement healthcare benefit available to those who have met certain requirements described in this document and cannot be required to be primary for any other healthcare benefits the retiree may be enrolled in (including a retiree supplemental reimbursement program for Medicare Part B premium, an auto policy or Worker's Compensation, etc.). Total Payments will not exceed SHARP's payment responsibility as if SHARP had been primary.

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.

Medicaid

Covered members who are receiving Medicaid benefits should consult with the appropriate state agency to determine whether Standard SHARP-Ex should be retained. The Medicaid program may be dual-eligible with the Medicare program. Standard SHARP-Ex will abide by state rules and regulations to determine primary responsibility and may terminate SHARP benefits. Please contact the Aon Retiree Health Exchange for assistance with coordinating Medicare and Medicaid benefits.

Filing Claims

All claims for the SHARP-Ex Option will be managed by the insurance carrier the member is enrolled with.

Timely Filing Requirements – SHARP DVH Option:

All dental, vision and hearing claims must be filed within one year of the date of service.

Dental, Vision and Hearing providers may bill ARM directly.

Paper Claims Address (on the SHARP ID card):

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

- Adventist Risk Management, Inc. will be providing an explanation of benefits for how services were approved and paid.

- **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 as shown on the back of the SHARP ID card.

Appeals of Denied Claims - Standard SHARP DVH

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

The Eligible Retiree or Eligible Spouse enrolled through the SHARP-Ex Option, must follow the appeal process as listed by the insurance carrier they enrolled with through the Aon Retiree Health Exchange. The Aon Retiree Health Exchange provides and advocacy service to assist the retiree with disputes. Call 1-844-360-4714 option #3 or contact your Aon Benefit Advisor directly. SHARP will not be involved in medical or prescription drug claim disputes.

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

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 SHARP DVH 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 dental, vision or hearing 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.

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

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

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

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

Review Process

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

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

Level I Appeal

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

Attn: Administrative Appeal
Adventist Retirement 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 SHARP DVH member ID 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 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

MEDICARE PRESCRIPTION DRUG PLAN INFORMATION

Important Notice about the SHARP 2017 Commercial Prescription Drug Coverage (Rx Option) and the Medicare Prescription Drug Coverage

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

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

1. Medicare prescription drug coverage is available to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. This coverage is sometimes referred to as Medicare Part D prescription drug coverage. In general Medicare Part D provides coverage for prescription drugs not covered under Medicare Part A and Part B. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some Medicare plans may also offer more coverage for a higher monthly premium.

2. The Supplemental Healthcare, Adventist Retirement Plan has determined that the prescription drug coverage offered under its Commercial Rx Option is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage under Medicare. Because your prescription drug coverage under SHARP’s Commercial Rx Option is, on average, at least as good as standard Medicare prescription drug coverage, you can keep (or enroll in) SHARP’s Commercial Rx Option coverage (instead of enrolling in a Medicare prescription drug plan) and not pay a higher premium (a penalty) if you later decide to join a Medicare prescription drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you also will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

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

Under SHARP Commercial Rx, you are not allowed to receive prescription drug coverage under both Medicare prescription drug coverage and the SHARP Commercial Rx Option. You must

choose one or the other. Therefore, it is important to make an informed, deliberate decision. Do not enroll in Medicare prescription drug coverage "just in case."

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

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

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

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

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

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

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

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

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

For More Information about This Notice or Your Current Prescription Drug Coverage:
Read the SHARP booklet carefully. Then, for further questions contact our office (email and phone listed below) for further information regarding SHARP Commercial Rx Option. However, please note that our office cannot assist you with information about a Medicare Prescription Drug Plan.

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

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

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

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

For more information about Medicare prescription drug coverage:
• Visit www.medicare.gov
• Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
• Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov,or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	October 1, 2016
Name of Entity/Sender:	Supplemental Healthcare, Adventist Retirement Plan
Contact--Position/Office:	Administrator
Address:	12501 Old Columbia Pike, Silver Spring MD 20904
Phone Number:	301-680-5036

General Information

Administration

SHARP is governed by the Adventist Retirement Board, and administered by the Adventist Retirement Board. Claims for SHARP DVH 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.

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

"Aon" means Aon Retiree Health Exchange.

"ARM" means Adventist Risk Management, Inc.

"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.

“HRA” means Health Reimbursement Account set up for certain Eligible Retiree or Eligible Spouse, based upon qualifying years of church service rules. These rules are explained in the HRA and Earned Credit section of 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.

“Plan Year” means the calendar year.

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

“Retirement Plan Service” means the service credited under the 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 service records are maintained in the eAdventist Personnel database. Service under the Seventh-day Adventist Hospital Plan does not count as Adventist 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-Ex” means the medical and prescription drug benefits offered through the private Medicare Exchange Marketplace vendor, Aon Retiree Health Exchange.

“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 your supplemental insurance plan. Any of the preventive services listed below which are not covered by Medicare Part B may be reimbursed under insurance carrier the Retiree or Spouse has enrolled with.

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-Ex 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.

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 not 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.

SHARP DENTAL/VISION/HEARING Enrollment Form – 2017

Retiree Name: **SSN:**

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	Retiree Name	Spouse Name
	DOB:	**DOB:**
	SSN:	**SSN:**
SHARP DVH (age 65+)		
DVH - $90/month/person		
Gross SHARP DVH Cost	$ -	$ -
Minus SHARP Earned Credit	-	-
Total SHARP DVH Cost:	$ -	$ -
Total:		$ -

Please enroll me in the SHARP DVH coverage as requested above. I authorize SHARP deduct monthly contributions from my pension. If there are no monthly pension funds to cover this amount, I will make advance monthly payments. I understand that:

- SHARP provides Medical and Prescription Drug assistance for age 65+ enrollees only through funding into a Healthcare Reimbursement Account (HRA). I will work with Aon Retiree Health Exchange to enroll in the plan(s) that best meet my needs separately from this SHARP enrollment.
- For age 65+ enrollees, SHARP only provides a Dental/Vision/Hearing option. I can opt out of DVH now, resulting in a larger contribution to my HRA. I will not have a future DVH open enrollment.
- My non-eligible spouse may participate in SHARP, but will receive no financial assistance towards options selected.
- SHARP's DVH option includes calendar year deductibles and maximums, neither of which will be prorated during enrollment year.
- Age 65+ enrollees must also enroll directly in Medicare A and B. Medicare rules regarding delayed enrollment in Medicare B (outpatient) or Medicare D (prescription drug coverage) may result in a Medicare premium penalty. It is my responsibility to enroll with Medicare on a timely basis.
- All service credit and other information will be reviewed by the Retirement Office before finalization. A SHARP employee will contact me to step through my selections.
- SHARP does not provide annual or three-year anniversary open enrollments.

Retiree Signature **Date**

ffective Date of Options Selected:

Please sign & return within 30 days to:

Adventist Retirement Plans Phone: 301-680-5036
12501 Old Columbia Pike Fax: 301-680-6190
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
- Eligibility Appeals

Aon Retiree Health Exchange 1-844-360-4714 (TTY use 711 Relay)
www.retiree.aon.com/adventistretirement

Adventist Risk Management, Inc. (ARM)

Customer Service – DVH Option	1-800-447-5002 www.webtpa.com
DVH Claims Address:	Adventist Risk Management, Inc. PO Box 1928 Grapevine, TX 76090-1928

Reasons to contact ARM:

- DVH claim payment issues
- DVH Verification of benefits

Medicare:	www.medicare.gov 1-800-633-4227
Contact for the SHARP Privacy Officer	1-301-680-6249