SHARP

SUPPLEMENTAL HEALTHCARE ADVENTIST RETIREMENT PLAN

12501 Old Columbia Pike
Silver Spring, MD 20904

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SEVENTH-DAY ADVENTIST CHURCH

Retirement Plan
North American Division
Office of the Administrator

To: Retirees of the Seventh-day Adventist Retirement Plans
From: Del Johnson, Plan Administrator

The Retirement Plan of the Seventh-day Adventist Church in North America offers a healthcare assistance plan for eligible retirees and Joint & Survivor (J&S) spouses. This booklet introduces the Plan**,** and gives eligible retirees the opportunity to select Options of coverage.

IMPORTANT! -- PLAN DESIGN CHANGE FOR 2009

Effective January 1, 2009, selection of the Base Option is no longer required in order to select other Standard SHARP Options. Standard SHARP Options (Base, DVH, Rx, and MCx) can be selected individually or in combination with each other. The levels of coverage for the Base and MCx Options are exactly the same (except that MCx does not cover HMO or VA co-pays); **however** the Base Option has a large annual deductible and the MCx Option has no deductible. Thus, when making coverage choices members should not choose both the Base and the MCx Options. Those who, prior to January 1, 2009, selected both the Base and MCx Options will have their coverage converted to the MCx Option only and the cost of the Base Option will be removed.

Standard SHARP relies on Medicare to cover the cost of most medical services, with few exceptions. It provides options to supplement Medicare, as well as Options of coverage to assist with non-medical expenses not offered by Medicare. In addition, the Plan provides an Option of coverage for Pre-Medicare retirees and J&S spouses, as well as dependent children.

SHARP is not free. Based primarily on years of service credit with the church and the policies in place when retired, the Plan pays part of the costs.

SHARP calculates an "Earned Credit" for eligible retirees based on years of qualifying service. The personal Earned Credit is applied to the total cost of the Options selected. If the cost of the selections exceeds the Earned Credit, the balance will be withheld from the retiree's monthly benefits.

There are limited opportunities to change coverage. Therefore, it is important to read this booklet carefully to fully understand these limits and then select coverage Options that make sense for the retiree and J&S spouse.

Enrollment Form(s) are included in this booklet to select coverage Options. The coverage Options selected will become effective upon eligibility for healthcare benefits. There is no automatic enrollment. Retirees who do not enroll will not be eligible for assistance.

Healthcare in Retirement is a major concern for retirees today: there are many sources of coverage to consider and understand, costs are rising, Medicare rules and treatment rules change. The Retirement Plan continues to work to provide for the needs of retirees covered by SHARP.

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General Information

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

Changes To The Plan:
SHARP reserves the right to amend the plan based on financial considerations or other unanticipated circumstances such as changes to Medicare. This may result in changes in provisions, in contributions, and in earned credits.

Administration:
SHARP is governed by the North American Division (NAD) Retirement Office, and administered by the NAD Retirement Plans Committee. Claims are managed by Adventist Risk Management, Inc.

Affiliation:
SHARP is NOT a qualified 'Medicare supplement coverage' plan as administered by various insurance companies and regulated by states, generally designated as plans A through J. SHARP is a part of the Retirement Plans operated by the North American Division for retired employees of participating employers.

Lifetime and Other Maximums
The SHARP Plan has an overall limit of three (3) Million dollars per member, and has other limits as listed in the Schedules of Benefits.

Standard SHARP Providers:
The provisions of Standard SHARP (Base, DVH, Rx and MCx) do not restrict members to seeking services within a provider network.

Pre-Medicare and Non-Medicare Members Require PPO Participation
SHARP's Pre-Medicare/Non-Medicare provisions operate under a Preferred Provider Organization, Private Healthcare System (PHCS). Non-emergency services rendered outside of the PPO will be reimbursed at a reduced rate.

Eligibility

Retiree Eligibility: To be eligible to participate in SHARP, a retiree must:

1. Be a beneficiary of one of the Defined Benefit Retirement Plans operated by the North American Division of Seventh-day Adventists.
2. Have at least fifteen years of qualifying service in the NAD Retirement Plan. Service with an Adventist Hospital does not normally qualify a retiree for healthcare assistance under SHARP.
3. Otherwise be eligible for healthcare assistance, under special arrangements with foreign church entities for their resident retirees, or through other policy provisions.

An eligible retiree who:

- is less than age 65 may select coverage from any of the following: the Pre-Medicare Option, the DVH Option, and the Rx Option.
- Is less than age 65, *but is covered by Medicare because of a disability or some other reason*, may not select the Pre-Medicare Option. He/she may only select coverage from the Standard SHARP Options.
- is age 65 or older may select coverage only from the Standard SHARP Options.

SPOUSE ELIGIBILITY: To be eligible to participate in SHARP, a spouse must:

1. Be covered as a Joint and Survivor spouse by the retiree, and
2. Have been married to the current spouse for a year or more before retirement.

An eligible Joint and Survivor spouse who:

- is less than age 65 may select coverage from any of the following: the Pre-Medicare Option, the DVH Option and the Rx Option.
- Is less than age 65, *but is covered by Medicare because of disability or some other reason,* may not select the Pre-Medicare Option. He/she may only select coverage from the Standard SHARP Options.
- is age 65 or older may select coverage only from the Standard SHARP Options.

DEPENDENT CHILDREN ELIGIBILITY:

1. Dependents are eligible for healthcare assistance, under SHARP's Non-Medicare Option, based on the retiree's years of service credit.
2. Dependent children must be unmarried and less than 19 years of age that were born to or legally adopted by the retiree prior to the effective date of his/her retirement. Upon marriage or reaching age 19 (regardless of school attendance) the child ceases to be eligible for coverage.
3. Dependent children, determined to be disabled **and** also covered by Medicare Part A and Part B, may be determined eligible for participation in SHARP if he/she was determined to be eligible for healthcare on the retirement effective date of his/her retiree parent. Dependent children in this category are not covered under the Non-Medicare Option. The retiree parent must select coverage for such dependents from the Standard SHARP Options.
4. Upon the death of the retiree or Surviving Spouse, all dependent coverage is terminated.

ENROLLMENT AND CHANGES TO COVERAGE

Generally, the effective date for SHARP is the same as the retirement effective date. Eligible retirees must select for himself/herself, as well as for any eligible Joint and Survivor spouse, or eligible dependent child within 30 days of the retirement effective date. Without a signed enrollment form from the retiree, no healthcare assistance will be provided.

DELAYED ENROLLMENT – NEW RETIREES ONLY

A new, eligible retiree may choose to delay coverage for himself/herself, for an eligible Joint and Survivor Spouse, or for eligible dependent children because at effective date of retirement they had other coverage in place. If coverage is delayed, it can only be obtained under SHARP in the future if you meet one of the criteria below under 'Limits to Changes in Coverage.' If such delay is requested, the following must happen:

1. Document to the SHARP office within 30 days of the retiree's effective date of retirement

the name of each person with current coverage, along with the name of the provider.
2. Contact the SHARP office within 30 days when the previously documented coverage is no longer available to request coverage under SHARP.

Limits For Changes in Coverage

Other than what is noted in this section, each eligible person (retiree, J&S spouse, dependent child) has up to three opportunities to elect SHARP coverage.

1. Within 30 days of the retiree's effective date of retirement
2. One-time, Three-year Anniversary Open Enrollment – based on the retirees effective date of retirement.
3. Retirees and J&S spouses who select SHARP coverage prior to age 65 AND ALSO do not qualify for an Earned Credit, may make coverage changes within 30 days of reaching age 65.

Thus, it is important to note that with few exceptions, the coverage selected within these opportunities will be your coverage for life

Three-Year Anniversary Open Enrollment - Each retiree has a one-time opportunity to change coverage at the three-year anniversary of the retiree's retirement date, to become effective at the beginning of the next Plan Year. Example: If a retiree enrolled in SHARP during 2006, an open enrollment period occurs in 2009. Any changes selected become effective on January 1, 2010. Retirees will be notified of opportunity to change coverage. Retirees are not required to make a change. If no re-enrollment form is received, coverage will remain in force with the same coverage provided upon initial enrollment. This open enrollment period **occurs only once, not every three years.**

Special Enrollment due to High Inflation - Healthcare costs can increase significantly. SHARP 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 will allow a two-month special enrollment period in which retirees are permitted to permanently REDUCE coverage.

Special Enrollment due to Loss of Coverage - Retirees may have healthcare coverage from a Medicare Choice Health Maintenance Organization or supplemental plans provided by other organizations. Retirees who wish to remain on such coverage are welcome to do so. SHARP cannot assist with premiums paid for such coverage. If such coverage is dropped due to significant premium increases (over 25% per year), or a move from the company's covered territory, or the company withdraws from the market, SHARP will allow a special open enrollment.

If a spouse is currently covered under an employer healthcare plan, upon his/her retirement that spouse will probably suffer a Loss of Coverage and will be eligible for a special open enrollment.

Pre-Medicare Expiration: If a retiree or retiree's spouse is on the Pre-Medicare Plan, upon reaching age 65 that Pre-Medicare Plan will be terminated. An open enrollment is available for the retiree or spouse to select standard SHARP Options at that time.

Discretionary Special Enrollment: SHARP may find it necessary to make significant changes in the Plan. Should that occur, SHARP may provide an opportunity to change

specific or all elections. Example: Because of the 2006 Medicare Part D Prescription Drug Plans, SHARP adjusted the structure of the Base and Rx Options. Thus SHARP offered all participants an opportunity to adjust coverage effective January 1, 2006.

Re-Employment: Should a retiree or Joint & Survivor spouse return to employment subsequent to enrollment in SHARP and become eligible for an employer healthcare coverage, SHARP will allow the retiree and/or eligible spouse to terminate coverage in SHARP upon receipt of written verification of such employer-provided coverage.

Death of a Member - Upon the death of either the retiree or covered spouse SHARP will stop taking deductions for the deceased beneficiary. However coverage and deductions for a surviving beneficiary will continue without change.

Medicare Part D – While SHARP change limitations apply to all Options selected, including the Rx Option, this Plan also prohibits concurrent enrollment in SHARP's Rx Option and a Medicare Part D plan. If during the reconciliation process which takes place between SHARP and Medicare, 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 and will not be able to re-enroll.

STANDARD SHARP

The following four Options are offered to an eligible retiree and/or an eligible Joint & Survivor Spouse. For costs and limits, see *Schedule of Standard SHARP Benefits* on page 21.

BASE OPTION

The Base Option is a limited level of coverage leaving the retiree exposed to significant costs from Medicare deductibles and co-pays, as well as other expenses such as dental, vision, hearing and prescription drug costs. *Prior to 2009, members were required to select the Base Option before choosing any other Standard SHARP Options. Effective January 1, 2009, for new retirees, this is no longer required and new members may select the four Standard SHARP Options independently of each other.* The Base Option provides coverage for:

- **CATASTROPHIC MEDICAL COVERAGE:** ***After meeting the annual deductible***, coverage provides reimbursement for the Medicare Part A (In-Patient) deductible(s), and the Medicare Part B (Out-Patient) annual deductible as well as the 20% co-pays on Medicare-approved expenses determined to be the individual's personal responsibility.

Reportable Expenses include:	**2009 Medicare Examples**
• Medicare Hospitalization deductible	$1,068
• Medicare Out-Patient annual deductible	$135
• Out-Patient	20% co-pay
• Medicare co-insurance for hospital days 61-90	$267/day
• Medicare co-insurance for hospital days 91-150	$534/day
• Skilled Nursing Facility days 21-100	$133.50/day

The following costs are **NOT** covered by the Catastrophic Medical Coverage:

- Skilled Nursing Facility coinsurance for stays exceeding Medicare limits
- Hospitalization exceeding Medicare coverage limits of 150 days

- Portion of physician charge(s) that exceed Medicare approved amount
- Medical procedures not approved by Medicare
- Nursing Home expenses

Medicare Participation Required:
Reimbursement under the Catastrophic Medical Coverage category requires eligibility for traditional Medicare. Reimbursement for covered expenses requires that Medicare first approve the service and amount charged and then pay its portion. If Medicare does not approve an expense, this Plan will deny it as well. Thus, a retired minister who has opted out of Social Security and who will not become eligible for Medicare should not select this Option, as reimbursement requires a Medicare approval of any medical expense submitted. Current information about Medicare can be obtained at the Medicare web-site, www.medicare.gov.

Exceptions: The Base Option, SHARP will consider appeals for certain categories of denials by Medicare in the following areas:

- **Blood:** Medicare will usually deny the first three pints of blood each year. SHARP's Base Option will reimburse the retiree for this expense.
- **Orthopedic Shoes**: Medicare may deny assistance for orthopedic shoes, shoe inserts, or similar devices. Under the Base Option, a retiree can submit such Medicare denied expenses for assistance on an 80%/20% basis. Claims should include a physician's statement of medical necessity, fitting documentation and a copy of Medicare's denial of coverage. See *Schedule of Standard SHARP Benefits* on page 21 for the annual limit for Orthotics.
- **Miscellaneous Medical Supplies:** The Base Option provides assistance for colostomy and ileostomy on an 80%/20% basis but only if denied by Medicare. See *Schedule of Standard SHARP Benefits* on page 21 for annual limit for Miscellaneous Medical Supplies.

Claims submitted for reimbursement as an exception for blood, orthopedic shoes, or miscellaneous medical supplies as described above must include a copy of the Medicare denial AND a statement of medical necessity from a physician to be considered for reimbursement. However, if the Medicare denial is because the services were provided by a non-participating provider, SHARP will not provide reimbursement.

- **ONE DENTAL CLEANING/EXAM:** One annual dental exam including bite wing and cleaning paid at 100%. Additional dental coverage is available under the DVH Option (see page 9).

- **FOREIGN TRAVEL EMERGENCY MEDICAL COVERAGE** is:
  - Limited to unexpected medical expenses incurred during a personal trip lasting less than 60 days
  - Not available as coverage for denominationally sponsored mission trips. Short-term medical coverage should be purchased for denominationally sponsored trips and for personal trips expected to be for 60 days or longer.
  - Available from Adventist Risk Management, Inc. For information please contact them 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.

- **MEDICARE HMO AND VETERANS ADMINISTRATION (VA) CO-PAYS:** Medicare HMO and VA Co-Pays for In-Patient and Out-Patient expenses will be fully reimbursed to retirees who

send in appropriate documentation of payment of such co-pays to healthcare providers. Medicare HMO and VA co-pays for prescription drugs will not be reimbursed. HMO premiums will not be reimbursed. Co-pays for other Medicare Advantage plans such as PPOs will not be reimbursed.

- To be eligible for reimbursement of co-pays, members must:
- ***On an annual basis***, submit a copy of the front and back of your Medicare HMO or Veteran's Administration Identification Card to:

  Adventist Retirement Plans
  Attn: SHARP
  12501 Old Columbia Pike
  Silver Spring, MD 20904
  Fax: 301-680-6190
- The SHARP staff in the NAD Retirement office will verify your coverage and then notify both you and Adventist Risk Management, Inc., that you are eligible to receive reimbursement on the co-pay receipts you submit, or that it was determined you do not have a Medicare HMO or VA coverage. See 'Filing Claims' on page 18 for information on how to submit a claim and what should be included.

DVH Option

The Dental, Vision, Hearing Option provides:

- **Dental:** SHARP pays 80% of costs based on reasonable and customary fees for the area services are rendered. Retiree is responsible for 20% subject to an annual maximum dental payable benefit per participant per Plan Year. See *Schedule of Standard SHARP Benefits* on page 21. Unused benefits may not be rolled over into the next Plan Year.

Covered

- Two cleanings per year in addition to the one cleaning covered in the Base and MCx Options. (Up to two additional cleanings may be authorized if recommended by dentist for treatment of periodontal disease.)
- One set of bitewing x-rays per Plan
- Year
- Extractions and periodontal treatment
- Full mouth/panorex x-ray every 3 Plan Years
- Implants (Caution: one implant may take your full annual limit.)
- Application of fluoride twice per Plan Year
- Fillings
- Root canal therapy
- Crowns/Bridges/Partials/Dentures

Not Covered

- Orthodontic treatment (except for Non-Medicare participants, *see Schedule of Non-Medicare Benefits on page 24*)
- TMJ/TMD treatment
- Jaw surgery
- Temporary crowns or bridges
- Experimental treatment/procedures
- Cosmetic services
- Toothbrushes

- **Vision:** SHARP pays 80% of costs. Member is responsible for 20% subject to an annual maximum vision payable benefit per participant per Plan Year. See *Schedule of Standard SHARP Benefits* on page 21. Covered services include refraction, corrective lenses, frames and related expenses. Surgery or other procedures considered to be medical in nature are not covered under the Vision Option, but may be covered by Medicare. Unused benefits may not be rolled over into the next Plan Year.

- **HEARING:** SHARP pays 80% of costs. Retiree is responsible for 20% subject to an annual maximum hearing payable benefit per participant per Plan Year. See *Schedule of Standard SHARP Benefits* on page 21. Covered expenses include hearing tests, hearing aids, and the repair of hearing aids. The Hearing Option has a ***one year 'look-back' provision*** which allows the payment of any unused benefits from the previous Plan Year to be used in the current Plan Year.

RX OPTION

The Rx (Prescription Drugs) Option:

- The Rx Option provides prescription drugs with generic and brand name co-pays. The co-pay provides up to a 30-day supply of prescription drugs when purchased at a local participating pharmacy, or up to a 90-day supply when purchased through *Medco By Mail*, a home delivery program.
- SHARP provides an identification card which can be used at major pharmacies, as well as with the Medco Health Solutions *Medco By Mail* program.
- If the actual cost of medication is less than the co-pay, actual cost is paid.
- Home Health intravenous drugs and the supplies to administer such drugs are covered by the Plan at 80%. Claims are submitted to Adventist Risk Management, Inc.
- Certain prescription drugs, primarily ED drugs such as Viagra, require a 50% co-pay and have monthly limits. Call Medco Health Solutions at (800) 841-5396 for information on specific drugs.

SHARP's Rx Option includes a broad formulary, which is a list of prescription drugs preferred by the Plan because they help to control rising prescription drug costs. This list has a selection of generic and brand-name medications. Periodic changes are made to this list throughout the Plan Year without prior notice to retirees. For further information on this formulary, visit Medco at www.medco.com or call Medco toll free at (800) 841-5396. SHARP cannot advise retirees regarding the formulary.

COST CONTAINMENT RULES FOR PRESCRIPTIONS

- **Prior Authorization:** Certain medications will no longer be covered by the Plan without a coverage review (prior authorization). If special circumstances require that you continue on a medication that is no longer covered, you can ask your doctor to begin a coverage review by calling Medco toll-free at 1-800-841-5396. If approved, you will pay your normal co-payment for that medication. Coverage management programs make use of two authorization processes – Traditional and Smart Authorizations. Medications may fall under one or more programs.
    - **Traditional Prior Authorization:** Traditional Prior Authorization requires that pre-approval be obtained through a coverage review. The review will determine whether the Plan covers a prescribed medication. Examples of drugs subject to this protocol include: Beteseron, Ritalin/Adderal, Stadol, fertility, growth hormones.
    - **Smart Prior Authorization:** For some medications, an automated process called Smart Rules is used to determine whether the retiree qualifies for coverage. Using factors on file such as medical history, drug history, age and sex, Smart Rules can authorize or deny coverage. Contact Medco to learn if a medication qualifies for coverage using Smart Prior Authorization. Examples of drugs subject to Smart Rules include: Enbrel, Lamisil, Bextra, Zovirax, Zofran, Imitrex, Prilosec.
- **Member Pays the Difference:** If a generic medication is available but the doctor or patient insist on the brand name product, the member is charged the brand name co-pay plus the difference in cost between the brand name and generic medication.

- **Retail Refill Allowance:** You are limited to filling a prescription three (3) times for the same medication at a retail location. Beginning with the 4th time you fill that same prescription at a retail location, you will be charged, in addition to your regular co-pay, 50% of the actual retail cost of the prescription.

- **Dose Optimization:** Medco will request the doctor to re-write the prescription for the most cost-effective dose. There are only a limited number of drugs subject to this rule and it is applied only with your doctor's authorization.

- **Quantity Per Dispensing Event:** If the prescription as written exceeds the generally-accepted maximum quantity, the excess is not covered by the Plan.

- **Medicare Part B Prescriptions:** Medco offers a service through *Medco By Mail* where you fill Medicare Part B eligible prescriptions with the convenience of mail order. When using this service, you initially send your prescription to *Medco By Mail*. Then, depending on the type of medication or supply requested, *Medco By Mail* transfers your prescription information to one of two Medicare Part B–participating mail-order pharmacies—**Liberty Medical** or **Accredo Health Group,** Medco's specialty pharmacy. Both Liberty and Accredo have extensive experience with Medicare Part B and support the dispensing and billing of your prescriptions. You'll typically receive your order within 10 days from when your prescription arrives at the mail-order pharmacy. You or your doctor may be contacted by Medco, Liberty, or Accredo if there is a question about your prescription order.

  If you prefer, you can use a participating retail pharmacy to fill your prescriptions for Medicare Part B eligible medications and supplies. When using a retail pharmacy, you will be asked to present your Medicare ID card. The retail pharmacy will work with you to bill Medicare on your behalf. The pharmacy will also submit any other claims that may be eligible for additional coverage. Most independent pharmacies and national chains are Medicare providers.

  Following are medications and supplies typically eligible for Medicare Part B Coverage:
  - *Diabetic supplies* (test strips and meters only)
  - *Transplants* - certain medications to aid tissue acceptance from Medicare covered organ transplants
  - *Cancer* - certain oral medications used to treat cancer
  - *Kidney Failure* -- certain medications used in situations where the kidneys have completely failed
  - *Breathing* -- certain inhalants used in nebulizers (devices that deliver liquid medication in mist form)

  If your prescription is not eligible for Medicare Part B coverage, the mail-order or retail pharmacies will bill you the usual co-pay for your 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.

MCx Option

The MCx Option (Medicare Extension) provides the same coverage as the Base Option (see *Schedule of Standard SHARP Benefits* on page 21 for benefit details) – **EXCEPT:**

- There is **No Annual Deductible.**
- It **excludes** coverage for HMO and VA co-pay coverage. Generally someone, who has a Medicare HMO or VA coverage, would not select the MCx Option because the coverage overlaps significantly.

Standard SHARP Exclusions

1. Preventative Physical Exams -- Medicare authorizes one preventative physical examination within 12 months of enrollment with Medicare part B. Other than this one-time physical examination, SHARP does not provide assistance for Preventative Physical Examinations.
2. Medical expenses denied by Medicare or not presented to Medicare. The only exception to this is as described under the Base Option.
3. Vitamins and/or dietary supplements
4. Support stockings
5. Adult diapers or other similar items
6. Wigs

Pre-Medicare and Non-Medicare SHARP

Standard SHARP is designed to supplement Medicare. However, a pre-65 retiree, eligible spouse, or unmarried dependent child less than 19 years of age not eligible for Medicare can use the Pre-Medicare or Non-Medicare coverage to assist with In-Patient/Out-Patient medical services.

Preferred Provider Organization (PPO) Required for Pre-Medicare and Non-Medicare Members. Coverage is limited to a network of participating providers. Non-emergency out-of-network expenses will be paid at a lower rate unless there is no participating provider within twenty-five miles of residence. *See Schedule of Pre-Medicare Benefits on pages 22 & 23 for full disclosure on the PPO requirement.* Claims filed for a non-PHCS provider will be reimbursed at 65% rather than the standard 80% and will be subject to usual and customary limits.

To find a participating provider, contact PHCS (Private Healthcare System) at (866) 680-7427, or www.phcs.com

General Benefit Rules: Benefits are only paid for medical expenses if the expenses:

- are medically necessary.
- represent a commonly accepted form of treatment and meet professionally recognized national standards of quality, and are generally accepted by the American medical community.
- result from a non-occupational illness, injury or other even or cause.
- are not limited by Plan rules.
- Do not exceed Plan limits.

Medical Necessity: Medical necessity means a covered procedure, service, or supply that the Plan considers eligible for benefits and is:

- Appropriate and necessary for the symptoms, diagnosis, and direct care or treatment of an

illness or injury.
- Consistent with professionally recognized standards of health care and given at the right time and in the right setting.
- Not primarily for the convenience of the patient or provider.
- The most appropriate treatment for the diagnosis
- Expected to enable the member to make reasonable progress in treatment.

Acupuncture Treatment is covered by the Plan when services are performed in a clinical setting by a recognized provider, including physicians, osteopaths, chiropractors, and non-physician acupuncturists who have met all state license requirements. *See Schedule of Pre-Medicare Benefits on pages 22 & 23.*

Cardiac Rehabilitation is covered by the Plan; however **Prior-Authorization is required**.

Chiropractic Treatment is covered by the Plan for members age 10 and above, subject to Plan limits and payment amounts. See *Schedule of Pre-Medicare Benefits* on pages 23&24.

CT Scans are covered by the Plan; however **Prior-Authorization is required**.

Durable Medical Equipment: The Plan covers durable medical equipment that meets all of the following requirements. The equipment must:
- Be able to stand repeated use, and be of a type that could normally be rented and used by successive patients;
- be primarily and customarily used to serve a medical purpose
- generally not be useful to a person in the absence of an injury or illness;
- be appropriate for home use; and
- meet the guidelines used by the Center for Medicare and Medicaid Services (CMS), the agency that administers the Medicare, Medicaid and Child Health Insurance Programs.

DME Prior-authorization Requirements: To be eligible for benefits your physician must recommend the equipment or device. The Plan will determine if the requirements for eligibility have been met.
- **Rental Charges:** The Plan covers a portion of charges for the rental of DME. The prior-authorization process will determine if the purchase would be less expensive than rental depending on the likely length of time that the equipment will be needed.
- **Purchase Charges:** The plan will pay a percentage of the cost of the initial purchase of DME and accessories needed to operate it if the prior-authorization process determines that:
  - Long term use is planned and the equipment cannot be rented; or
  - It is likely to cost less to buy it than to rent it.
- **Repair and Replacement:** The Plan covers charges for repair of purchased equipment and accessories. Replacement of purchased equipment is covered only if the prior-authorization process determines that:
  - It is needed due to change in the person's physical condition; or
  - It is likely to cost less to buy or rent a replacement than to repair the excising equipment.

Home Health Care and Private Duty Nurse:

A Home Health Care Agency is an agency that:
- mainly provides skilled nursing and other therapeutic services;
- is associated with a professional group containing at least one physician and one

registered nurse who makes policy;
- has full-time supervision by a physician or an RN;
- keeps complete medical records on each person; and
- meets licensing standards.

Home Health Care covered Services and Expenses:

- part-time or intermittent care by an RN (or an LPN if an RN is not available)
- part-time or intermittent home health aide services for patient care
- physical, occupational and speech therapy; or
- the following to the extent the expenses would have been covered under this Plan if the person had stayed in the hospital:
    - medical supplies
    - laboratory services provided by or for a Home Health Care Agency

Prior-Authorization for Home Health Care or Private Duty Nursing is required.

Hospice Care is covered by the Plan. It is a care that offers a coordinated program of home care and inpatient care for a terminally ill patient and the patient's family. For purposes of this Plan, a terminally ill patient is someone who has a life expectancy of approximately six months or less, as certified in writing by the physician in charge of the patient's care and treatment. The Plan will assist on covered charges for:

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

Services must be provided by a qualified hospice program that meets the standards of the National Hospice Organization (NHO) and applicable state licensing requirement. **Prior-Authorization is required.**

Massage Therapy is covered by the Plan for members age 10 and above, subject to Plan limits and payment amounts noted in the *Schedule of Pre-Medicare Benefits on pages 22 & 23.*

Maternity/Obstetrics/Infertility:

- Maternity expenses are covered by the Plan for Pre-Medicare members, but not for Non-Medicare members unless required by state law.
- **Prior-Authorization is required** for all In-Patient maternity services, and also for ALL state required Non-Medicare In-Patient or Out-Patient maternity services
- Obstetric and infertility expenses are not covered by SHARP.

Organ/Tissue Transplants: The Plan covers necessary expenses relating to organ/tissue transplants. **Prior-Authorization is required** for services and expenses related to organ/tissue transplants. Once services and/or treatment have prior-authorization, the member will be directed to a facility for the necessary services and/or treatment. The type of transplant must not be experimental or investigative and must be from a human donor. Members may be eligible as a recipient or donor under this benefit. The Plan covers donor expenses the same as for the recipient, but only if the recipient is also eligible for participation in SHARP.

Skilled Nursing Facility: A skilled nursing facility must meet all of the following:

- Must be licensed to engage in providing 24-hours per day professional nursing services on an inpatient basis for persons recovering from injury or disease by an RN or an LPA under the direction of an RN.

- Physical restoration services must be provided to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
- A skilled nursing confinement must take place within 14 days of a hospital discharge and must represent care for the same condition for which the hospitalization was required.
- The care provided must not be custodial in nature.
- The skilled nursing facility must maintain a complete record on each patient
- The skilled nursing facility must have an effective utilization review plan.
- Limitation: 30 day stay per Plan Year.

Therapeutic Care is covered within Plan limits stated in the *Schedule of Pre-Medicare Benefits on pages 22 & 23.* **Prior Authorization is required** for all therapeutic care services below.

- Occupational Therapy
- Physical therapy
- Prosthetic Devices
- Speech therapy
- Vision Therapy

PRE-MEDICARE OPTION

This Option provides healthcare assistance for eligible retirees and J&S spouses who are not yet age 65 who are not yet eligible for Medicare. Once a member reaches age 65, regardless of whether he/she has obtained Medicare, coverage is terminated. Coverage provided is:

- In-Patient/Out-Patient medical services only.
- If coverage is desired for prescriptions, dental, vision, or hearing, it must be obtained by selecting the DVH and or the Rx Options under Standard SHARP.

There is an individual annual deductible per Plan Year. See *Schedule of Pre-Medicare Benefits on pages 22 & 23.*

NON-MEDICARE OPTION

This Option provides healthcare assistance for eligible Dependent Children. Coverage provided is:

- In-Patient/Out-Patient services.
- Prescription drugs
- Dental/Vision/Hearing

There is an individual annual deductible per Plan Year for In-Patient/Out-Patient Services. *See Schedule of Non-Medicare Benefits on page 24.*

PRE-MEDICARE/NON-MEDICARE SHARP EXCLUSIONS:

1. I*nfertility* and related treatment, artificial insemination, in vitro fertilization or embryo transfer procedures, reversal of any sterilization procedure
2. *Cosmetic* procedures
3. *Lasik* eye surgery
4. *Diet* foods, herbs and minerals, food supplements, vitamins
5. *Elective abortion* except when the mother's life is endangered or pregnancy is a result of rape or incest (including medical complications which arise from an elective abortion)
6. *Health enhancement programs* which are designed primarily to influence adoption of healthier lifestyle changes with only a secondary objective of providing necessary medical treatment.
7. *Obesity* treatment
8. *Pregnancies* with respect to a dependent child, unless otherwise mandated by state law

9. *Experimental* procedures
10. *School Requirement* – Services/supplies a school s required to provide under any law
11. *Sex change* surgery or any treatment related to gender identity
12. *Work related* injuries
13. *Auto Accident* exclusions include:
    a. Under private automobile insurance, the first $5,000 of medical expenses arising from an automobile accident, or
    b. Under "no-fault" automobile reparations insurance which is required under any law of a government and is provided on other than a group basis; but only to the extent of the level of benefits required by the no-fault law.

COORDINATION OF BENEFITS

Standard SHARP

As an employer sponsored trust fund, the Standard SHARP Options (Base, DVH, Rx and MCx Options) are considered secondary to *all other healthcare plans available to the member,* including other coverages that are secondary to Medicare.

- Medicare is primary for all Medical services for member who have reached age 65, regardless of whether or not the member has applied for and/or obtained Medicare Part A or Part B coverage. All medical services must first be approved and its portion paid by Medicare before they are considered by this Plan. Services not approved and paid by Medicare are not covered by the Base or MCx Options.

Pre-Medicare SHARP

As an employer sponsored trust fund, the Pre-Medicare SHARP Option is secondary to all other healthcare plans available to the member.

Non-Medicare SHARP

As an employer sponsored trust fund, the Non-Medicare SHARP Option is secondary to any other plan available to the member except in situations where the dependent child is also covered by a plan under a non-retiree parent. In such cases SHARP determines primary responsibility based on the parent whose birthday falls first in the year.

Coordination Rules for All SHARP Options

SHARP will coordinate with all other plans where it has secondary responsibility by paying up to 100% of approved balances, as long as the amount paid does not exceed what would have been paid if SHARP had primary responsibility.

Medicaid

Retirees or eligible spouses who are receiving Medicaid benefits should consult with the appropriate state agency to determine whether SHARP should be retained. SHARP will abide by state rules and regulations to determine primary responsibility.

Veterans Administration

Retirees who are veterans are often eligible for benefits from a Veterans Administration healthcare facility at very low costs. Such retirees would normally not select the MCx Option because they may not receive a Medicare summary statement for such procedures. If the retiree is enrolled in

SHARP's Base Option, VA co-pays (other than for prescription drugs) will be reimbursed 100% by SHARP. Additional information on this benefit is documented on pages 9 & 18.

HMOs - Health Maintenance Organizations

Medicare HMOs are a preferred option for many retirees, when available. If a retiree enrolls in both a Medicare HMO and SHARP's Base Option, Medicare HMO co-pays (other than for prescription drugs) will be reimbursed 100% by SHARP. Additional information on this benefit is available on pages 9 & 18.

FILING CLAIMS

TIMELY FILING REQUIREMENTS

All 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 claim. Claims filed late will not be reimbursed.

PAPER CLAIMS ADDRESS:

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

ELECTRONIC CLAIMS ADDRESS:

WebMD/Envoy Payor ID 75261 CMS Crossover Enabled

MEDICAL, DENTAL, VISION, AND HEARING CLAIMS

Upon enrollment, retirees will receive identification cards indicating the Options selected. Healthcare providers may bill Adventist Risk Management, Inc., directly.

- **Paper claims** should be sent to Adventist Risk Management, Inc., at the address listed on the member ID card.
- **Electronic claims** may be sent to Adventist Risk Management, Inc., using the electronic address listed on the back of the member ID card.
- **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, so that any balances can be considered for payment for those members who have Base or MCx coverage under Standard SHARP. All claims submitted by a member for reimbursement after Medicare must include a copy of the Medicare explanation of payment. Most providers will bill Medicare, so generally it will not be necessary for a member to submit balances for payment since Medicare submits these automatically to Adventist Risk Management, Inc.
- **Claims paid first by the member** should be submitted with clear proof of payment and a request for reimbursement back to the member. Such claims should be mailed to Adventist Risk Management, Inc., at the address listed on the back of the member ID card.

PRESCRIPTION DRUG CLAIMS

- **Home Delivery:** The preferred method of obtaining prescription drugs is via the *Medco By Mail*. Medco will arrange directly with the member the method of payment for this service.

- **Local Pharmacy:** Co-payment on a prescription drug claim will be paid to the local pharmacy. The SHARP identification card indicates eligibility for the purchase of prescription drugs. Although most pharmacies participate with Medco's pharmacy program, there are some that do not. If prescription drugs are purchased at a pharmacy that does NOT participate in the Medco system, members will have to pay for the full cost of the prescription filled. Contact Adventist Risk Management, Inc., at 1-800-447-5002, or Medco Health Solutions at 1-800-841-5396 to obtain a form for direct reimbursement. Direct reimbursement for a prescription obtained at a non-participating pharmacy will likely result in a higher cost to the member.
- **Home Health Intravenous Drug Claims** should be directed to Adventist Risk Management, Inc., either in the form of a paper or electronic claim to the address listed on the back of the member ID card. Only members who have selected the Non-Medicare Option or the Rx Option are eligible for Home Health Intravenous Drug benefits.

HMO Co-pay and VA co-pay Claims: should be directed to Adventist Risk Management, Inc., as a paper claim. Information that must be included when filing a claim:

- Patient name AND retiree name, if different
- Co-pay amount
- Retiree SSN
- Provider name and address
- Date of Service

Appeals

Questions about your claims can be resolved by contacting Adventist Risk Management, Inc., at 1-800-447-5002. In situations where you believe the Plan has improperly interpreted your claim or eligibility, you may appeal. The process is as follows:

When to Appeal: Appeals must be filed within 12 months of the date of service for the claim in questions. Appeals for services that have not yet been rendered may be filed at any time. The Plan does not allow exceptions on Plan limits or maximums for any reason, and therefore does not accept appeals for either of these reasons.

Appeal Process: Appeals must be submitted in writing. Information to include with your appeal may include a copy of the claim in question, information from a provider, background information from the retiree, or anything else that you wish to provide to support your request. Appeals should be addressed to the SHARP Administrator using any of the following methods:

Email: SHARP@nad.adventist.org
Fax: 301-680-6190

Mail: Adventist Retirement Plans
Attn: SHARP Appeal
12501 Old Columbia Pike
Silver Spring, MD 20904

Decision on Appeal: The SHARP Appeals Committee will review all documentation and return its decision to you in writing. Generally, except in extraordinary situations, this response will be within 60 days.

EARNED CREDITS – ELIGIBILITY & AMOUNTS

The Earned Credit is the monthly amount the Plan makes available to assist members with the costs of the Options selected. Each eligible person will receive his/her own Earned Credit. If eligible for an Earned Credit, a retiree or Joint and Survivor spouse who selects Options under both Standard SHARP and the Pre-Medicare SHARP, will receive one Earned Credit for Standard SHARP and another Earned Credit for Pre-Medicare. If the cost of your coverage choices is less than the Earned Credit you are eligible for, the amount left over is neither paid to you, nor can it be used to cover another family member's coverage choices. Also, if a person is eligible for an Earned Credit for more than one coverage, unused Earned Credits for one coverage cannot be used to cover the cost of another coverage (for example, the Standard SHARP Earned Credit cannot be used to cover the cost of Pre-Medicare coverage.)

DETERMINING YOUR EARNED CREDIT CATEGORY

The Category, in the Earned Credit Table (see page 20), is determined by the sum of qualified service in the following areas:

- Pre-2000 years under the Defined Benefit Retirement Plan
- Post 1999 years under the Defined contribution Retirement Plan
- 2000 to 2004 under the Career Completion Option
- Pre-2000 years under the Canadian Retirement Plan.
- Regional Retirement prior to January 1, 2000.
- Years of service with the Adventist hospital system generally do not count toward the SHARP Plan. The hospital plan provides a monthly cash benefit in lieu of healthcare assistance. Exceptions include those who retired prior to 1991 and those 'Grandfathered' employees who, on December 31,1991, were in denominational employment, were 55+ years of age with 25+ years of service credit.

ELIGIBILITY FOR EARNED CREDIT

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

- **For Retiree:**
  - Retiree is age 65+, or
  - Retiree is less than age 65 but has 40 years of denominational service
  - Retiree was eligible for early retirement prior to 2003, regardless of when retirement actually occurred, and was determined eligible for healthcare with 15 or more years of denominational service.
- **For Joint & Survivor Spouse:**
  - Retiree must be eligible for Earned Credit, and
  - No age requirement for eligible J&S spouse.
- **For Dependent Children:**
  - Retiree must be eligible for Earned Credit, and
  - Eligible dependents must be less than 19 years of age and been determined eligible to participate in SHARP on the effective date of the retiree's retirement.

FUTURE ELIGIBILITY FOR EARNED CREDIT

Retirees, who are less than age 65 and have fewer than 40 years of denominational service, who are not eligible for an Earned Credit may participate in SHARP at their own cost. The retiree's Earned Credit will apply once he/she meets Earned Credit eligibility as noted above. An eligible

Joint & Survivor spouse and/or eligible dependent(s) will qualify for an Earned Credit only when the retiree qualifies.

EARNED CREDIT TABLE

Retiree Qualifying Service Credit	35+ Yrs	30-34 Yrs	25-29 Yrs	20-24 Yrs	15-19 Yrs	8-14 Yrs**	5-7 Yrs**	Retiree not yet age 65 with less than 40 Yrs of Service	My Earned Credit
Category - - ->	**A**	**B**	**C**	**D**	**E**	**F**	**G**		
Standard SHARP For eligible Retirees and J&S Spouses	$190	$170	$150	$135	$115	$95	$75	**$0**	
Pre-Medicare SHARP For eligible Retirees and J&S Spouses	$399	$349	$299	$249	$200	$150	$100	**$0**	
Non-Medicare SHARP For eligible Dependent Children	$138	$121	$104	$86	$69	$52	$35	**$0**	

**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. A retiree with less than 15 years of qualifying service is not eligible for healthcare or an Earned Credit.

SCHEDULE OF STANDARD SHARP BENEFITS

For eligible Retirees and Spouses
January 1, 2009 to December 31, 2009

Lifetime Limit for All SHARP benefits: $3,000,000.00
2009 STANDARD SHARP COSTS: BASE.....$20 per person/month
DVH ..... $55 per person/month
Rx ..... $115 per person/month
MCx ..... $130 per person/month
Base Deductible: $2,100 – Applies to Catastrophic Medical
Foreign Travel Emergency Deductible: $1,000

Base	**Subject to Deductible**	**Plan Pays**	**Limits**
Catastrophic Medical - **($2,100 Deductible)**	Yes	100%	None
Medicare Part A Deductible(s)	Yes	100%	None
Medicare Part B Deductible	Yes	100%	None
Blood	No	100%	3 pints
Orthopedic Shoes/Orthotics	No	80%	$600/year
Durable Medical Equipment	No	80%	$1,100/year
Medical Supplies – colostomy and Ileostomy only	No	80%	None
One Dental Cleaning/Exam	No	100%	1 exam/cleaning
Foreign Travel Emergency	Yes	80%	$50,000/year
Medicare HMO/Veterans Co-pays	No	100%	None

DVH - *not subject to any deductible*	**Plan Pays**	**Limits**
Dental	80%	$2,200/year
Vision	80%	$400/year
Hearing (hearing has a one-year look back provision)	80%	$2,200/year

Rx - *not subject to any deductible*	**Member Co-Pay**	**Limits**
Purchased at a Retail Pharmacy		
Generic	$11	30 day supply
Brand	$22	30 day supply
Purchased through *Medco By Mail*		
Generic	$25	90 day supply
Brand	$50	90 day supply
Home IV Therapy	20%	none

MCx – No $2,100 Deductible	**Subject to Deductible**	**Plan Pays**	**Limits**
Catastrophic Medical – same as Base Option	No	100%	None
One Dental Cleaning/Exam	No	100%	1 exam/cleaning
Foreign Travel Emergency	Yes	80%	$50,000/year

SCHEDULE OF PRE-MEDICARE BENEFITS – PAGE 1 OF 2

For eligible Pre-65 Retirees and Spouses
January 1, 2009 to December 31, 2009

Lifetime Limit for All SHARP benefits:	$3,000,000.00
2009 Pre-Medicare Cost:	$399 per person/month
Annual Pre-Medicare Deductible:	$550 per person
Out of Pocket Maximum:	$5,000 per person/year

Preferred Provider Organization Required: The Pre-Medicare Option requires the use of the Preferred Provider Organization, Private Healthcare System (PHCS). Contact PHCS at (866) 680-7427 to locate network providers within 25 miles of retiree's residence. Amounts disallowed as over U&C will not be used to meet any Plan deductible, limit, or maximum.

- If in-network provider is not used for non-emergency services, reimbursement will be made at 65% of usual and customary (U&C) fees.
- If there is no in-network provider within 25 miles, non-emergency services will be reimbursed at 80% of U&C fees.
- Out-of-network emergency services will be reimbursed at 80% of U&C fees.

Usual and Customary (U&C) Fees are established based on what 90% of the providers in a specific area are charging for the same service.

PRIOR-AUTHORIZATION IS REQUIRED ON THE FOLLOWING SERVICES

Service	Penalty if no Prior-Authorization
Cardiac Rehabilitation	paid at 65% of U&C
CT Scan	paid at 65 of U&C
Durable Medical Equipment (over $1,000)	paid at 65 of U&C
Home Health Care Services/Private Duty Nurse	paid at 65 of U&C
Hospice	paid at 65% of U&C
Hospitalization – All In-Patient Admissions	$500 per day
Maternity – Non-Medicare	
(only covered if required by state law)	
Out-Patient	paid at 65%
In-Patient	$500 per day
Mental Health Services	
In-Patient	$500 per day
Out-Patient	paid at 65% of U&C
Midwife	paid at 65% of U&C
MRI	paid at 65% of U&C
Occupational Therapy	paid at 65 of U&C
Prosthetic Devices	paid at 65% U&C
Physical Therapy	paid at 65 of U&C
Skilled Nursing Facility	$500 per day
Speech Therapy	paid at 65% of U&C
TMJ Services	not covered
Transplant Services	not covered

SCHEDULE OF PRE-MEDICARE BENEFITS – PAGE 2 OF 2

For eligible Pre-65 Retirees and Spouses
January 1, 2009 to December 31, 2009

	Prior-Authorization Required	Plan Pays	Limits
Acupuncture	N	80%	18 visits/year
Ambulance	N	80%	none
Cardiac Rehabilitation	Y	80%	none
Chiropractic	N	80%	30 visits/year
CT Scan	Y	80%	none
Durable Medical Equipment	Y- over $1,000	80%	$12,000/year
Home Health Care/Private Duty Nurse	Y	80%	52 visits/year
Hospice	Y	80%	none
Hospitalization & In-Patient Surgery	Y	80%	none
International Health Services			
Emergency	N	80%	none
Non-Emergency			not covered
Massage Therapy	N	80%	30 visits/year
Maternity			
Pre-Medicare:			
In-Patient	Y	80%	none
Out-Patient	N	80%	none
Non-Medicare: **(only covered if mandated by state law)**	Y	80%	none
Mental Health Services	Y		
Out-Patient	Y	80%	30 visits/year
In-Patient	Y	80%	15 days/year
Partial Hospital/Out-Patient Day Treatment	Y	80%	20 days/year
Substance Abuse			
Out-Patient	Y	80%	30 visits/year
In-Patient	Y	80%	15 days/year
Partial Hospital/Out-Patient Day Treatment	Y	80%	20 days/year
Midwife – Pre-Medicare Only **(must be licensed AND insured)**	Y	80%	none
MRI	Y	80%	none
Obstetrics/Infertility			not covered
Out-Patient Services	N	80%	none
Orthotics/Orthopedic Shoes	N	80%	$600/year
Preventive Health Evaluations/Physicals	N	80%	none
Skilled Nursing Facility	Y	80%	30 days/year
Therapeutic Care			
Occupational Therapy	Y	80%	30 visits/year
Physical Therapy	Y	80%	30 visits/year
Prosthetic Devices	Y	80%	$10,000/year
Speech Therapy	Y	80%	30 visits/year
Vision Therapy	Y	80%	8 visits/year
TMJ Services			not covered
Transplants	Y	80%	$200,000/year

SCHEDULE OF NON-MEDICARE BENEFITS

For eligible Dependent Children
January 1, 2009 to December 31, 2009

Lifetime Limit for All SHARP benefits:	$3,000,000.00
2009 Non-Medicare Cost:	$138 for 1st dependent child, and then an additional $138 for any number of additional children combined.
Annual None-Medicare Deductible:	$550 per person
Out of Pocket Maximum:	$5,000 per person/year

Preferred Provider Organization Required: The Non-Medicare Option requires the use of the Preferred Provider Organization, Private Healthcare System (PHCS). Contact PHCS at (866) 680-7427 to locate network providers within 25 miles of retiree's residence. Amounts disallowed as over U&C will not be used to meet any Plan deductible, limit, or maximum.

- If in-network provider is not used for non-emergency services, reimbursement will be made at 65% of usual and customary (U&C) fees.
- If there is no in-network provider within 25 miles, non-emergency services will be reimbursed at 80% of U&C fees.
- Out-of-network emergency services will be reimbursed at 80% of U&C fees.

Usual and Customary (U&C) Fees are established based on what 90% of the providers in a specific area are charging for the same service.

Prior-authorization is Required – See *Schedule of Pre-Medicare Benefits on page 22* for list.

In-Patient/Out-Patient Services – see *Schedule of Pre-Medicare Benefits on page 24.*

DVH - *not subject to any deductible*	**Plan Pays**	**Limits**
Dental	80%	$2,200/year
Orthodontia	50%	$2,300/lifetime
Vision	80%	$400/year
Hearing (hearing has a one-year look back provision)	80%	$2,200/year

Rx - *not subject to any deductible*	**Member Co-Pay**	**Limits**
Purchased at a Retail Pharmacy		
Generic	$11	30 day supply
Brand	$22	30 day supply
Purchased through *Medco By Mail*		
Generic	$25	90 day supply
Brand	$50	90 day supply
Home IV Therapy	20%	none

SUPPLEMENTAL HEALTHCARE ADVENTIST RETIREMENT PLAN

PRE-MEDICARE/NON-MEDICARE ENROLLMENT FORM

(Instructions to complete form are on page 26)

This form is only for retirees who seek In-Patient/Out-Patient healthcare assistance for eligible family members who are not eligible for Medicare.

	Name	Relationship	Birth-Date	SS #	Cost/Month
1		**Retiree**			**$399**
2		**J&S Spouse**			**$399**
2		**Dependent Child**			**$138**
4		**Dependent Child**			**$138**
		Dependent Child			
		Dependent Child			
5	Total Cost per Month				
6	Retiree Pre-Medicare Earned Credit (if eligible)				
7	Spouse Pre-Medicare Earned Credit (if eligible)				
8	Non-Medicare Earned Credit -- Dependent Children				
9	Total Pre-Medicare & Non-Medicare Earned Credit (if eligible)				
10	Monthly Contribution by Retiree				

Please accept my signature below as a request for enrollment in Pre-Medicare/Non-Medicare SHARP coverage as stated above, and agreement to conditions below:

- I authorize SHARP to deduct monthly contributions based on my requests for coverage. If my pension is inadequate, I agree to make quarterly payments in advance.
- I hereby certify that any children listed were my unmarried legal dependents at my first SHARP enrollment and continue to be my legal dependents, below age 19 and eligible to participate in SHARP. I understand that my children become ineligible at either marriage or age 19, whichever comes first, and I will inform SHARP of such an event.
- I understand that Pre-Medicare or Non-Medicare cannot be cancelled until ineligibility (reaching Medicare eligibility, or for a dependent child, marriage or age 19.)
- I understand that there are annual deductibles before this Plan responds to claims.
- I understand that the Pre-Medicare/Non-Medicare Plan is part of a Preferred Provider Organization (PPO), Private Healthcare System (PHCS). Out-of-network services may be denied, or reimbursed at lower rates. Amounts denied do not go to meet Plan deductibles, limits, or maximums.
- I understand Pre-Medicare coverage is limited to In-Patient and Out-Patient expenses.

PRINTED NAME OF RETIREE _____ **EFFECTIVE DATE** _____

RETIREE SIGNATURE _____ **DATE SIGNED** _____

SIGN AND MAIL WITHIN 30 DAYS TO: Adventist Retirement Plan
Attn: SHARP
12501 Old Columbia Pike
Silver Spring, MD 20904-6000
Fax: 301-680-6190

QUESTIONS? Email: SHARP@nad.adventist.org
Phone: 301-680-5036

PRE-MEDICARE/NON-MEDICARE ENROLLMENT FORM INSTRUCTIONS

Line	
1	Enter retiree name, date of birth and SS number **ONLY IF** Retiree is not yet age 65. If retiree is covered by Medicare Part A and/or Part B, even if not yet age 65, he/she is not eligible for the Pre-Medicare Option -- only the Standard SHARP Option may be selected. This Option is only for In-Patient and Out-Patient medical assistance. It does not include prescription drugs, dental, vision, or hearing.
2	Enter J&S Spouse name, date of birth, and SSN number **ONLY IF** spouse is not yet age 65. If spouse is covered by Medicare Part A and/or Part B, even if not yet age 65, he/she is not eligible for the Pre-Medicare Option – only the Standard SHARP Option may be selected. This Option is only for In-Patient and Out-Patient medical assistance. It does not include prescription drugs, dental, vision, or hearing.
3	Enter Dependent Child name, date of birth and Social Security number of a Dependent Child. Coverage for eligible Dependent Children is only available until they marry or reach age 19, whichever comes first. Non-Medicare SHARP covers certain In-Patient/Out-Patient medical, prescription drugs, dental, vision, and hearing services as described by policy.
4	Enter names, dates of birth and SS numbers of additional Dependent Children as instructed under Line 3 above. Eligible dependent child 2, 3, or more are covered by one additional monthly charge.
5	Add selected monthly costs.
6	Enter the Earned Credit amount for retiree. Instructions for determining eligibly for and the amount of the Earned Credit is outlined on page 19 & 20.
7	Enter the Earned Credit amount(s) eligible J&S spouse. Instructions for determining eligibly for and the amount of the Earned Credit is outlined on pages 19 &20.
8	Enter the Earned Credit amount(s) for Dependent child (ren). Double the amount of the Earned Credit if two or more Dependent Children are seeking coverage. Instructions for determining eligibility for and the amount of Earned Credit(s) is outlined on pages 19 & 20.
9	Enter the Earned Credit total on Line 9, by adding the Pre-Medicare Earned Credits from Line 6 & 7, if any, to the Non-Medicare Earned Credit(s) on Line 8.
10	Subtract Total Earned Credit on Line 9 from the Total Monthly Costs on Line 5. This is the amount that will be deducted from the retiree's monthly benefits. If the total healthcare contributions exceed the total of the benefits, a quarterly payment in advance will be required.
	Read carefully the conditions of coverage noted below the form you completed. Sign and date the application and either mail or fax to SHARP office for processing. Without a signature, this application will NOT be processed.

SUPPLEMENTAL HEALTHCARE ADVENTIST RETIREMENT PLAN

STANDARD SHARP ENROLLMENT FORM

(Instructions to complete form are on page 28)

Base ($2,100 deductible) and MCx (no deductible) may not be selected together because coverage overlaps. See Base Option (page 7) and MCx Option (page 12) for more information.

1	**Retiree Name:**	**SS#**	**Date of Birth:**
2	**Joint & Survivor Spouse Name:**	**SS#**	**Date of Birth:**
Options & Costs		**Retiree**	**J&S Spouse**
3	**Base** -- $20 per person/month		
4	**Dental, Vision, Hearing (DVH)** – $55 per person/month		
5	**Prescription Drugs (Rx)** -- $115 per person/month		
6	**Medicare Extension (MCx)** -- $130 per person/month		
7	**Total Cost of Selected Items**		
8	**Less the Earned Credit (If any)**		
9	**Net Monthly Retiree Contribution (Enter '0' if Earned Credit exceeds the cost of selected Options)**		

Please accept my signature below as a request for enrollment in Standard SHARP coverage as stated above, and acceptance of the conditions documented below:

- I authorize SHARP to deduct monthly contributions as calculated by SHARP based on my requests for coverage. If my pension is inadequate for the monthly contributions, I agree to make quarterly payments in advance.
- Attached are copies of our Medicare cards. If not yet eligible, I will send copies of the Medicare cards upon eligibility upon receipt of cards.
- I understand that I am limited in changing Options, and that the first opportunity to make a change in coverage would normally be at the one-time three-year anniversary of my enrollment unless already expired.
- I understand the deductibles and maximums for Options selected.
- I understand that if I do not list my J&S spouse above, he/she will be ineligible for any healthcare benefits until applied for during an open enrollment as described in this document such as 'Loss of Coverage,' or the 'One-time Three Year Anniversary.'

PRINTED NAME OF RETIREE _____ **EFFECTIVE DATE** _____

RETIREE SIGNATURE _____ **DATE SIGNED** _____

Sign and Mail within 30 days to: Adventist Retirement Plan
Attn: SHARP
12501 Old Columbia Pike
Silver Spring, MD 20904-6000
Fax: 301-680-6190

Questions? Email: SHARP@nad.adventist.org
Phone: 301-680-5036

STANDARD SHARP ENROLLMENT FORM INSTRUCTIONS

Line	
1	Enter retiree name, Social Security number and date of birth.
2	Enter eligible Joint & Survivor spouse name, Social Security number and date of birth. In order to be a J&S spouse, the retiree must have selected J&S upon retirement, and have been married to the spouse for at least one year prior to retirement. If spouse is covered by an employer healthcare plan, and retiree does not want him/her covered under any provisions of this Plan at this time, do NOT enter Spouse's name. The retiree must document the spouse's Loss of Coverage to provide coverage for a J&S Spouse in the future, if the retiree elects NOT to cover him/her at this time.
3	Enter the cost for the Base Option in the box beside the Base Option for retiree and, if desired, for eligible J&S spouse. See pages 7 & 8 for description of Base Option.
4	Enter the cost for the DVH Option in the box beside the DVH Option for retiree and, if desired, for eligible J&S spouse. See pages 9 & 10 for description of DVH Option.
5	Enter the cost for the Rx Option in the box beside the Rx Option for retiree and, if desired, for eligible spouse. See pages 10 & 11for description of Rx Option.
6	Enter the cost for the MCx Option in the box beside the MCx Option for retiree and, if desired, for eligible J&S spouse. See page 12 for description of MCx Option.
7	Add the costs of the Options selected in the retiree and J & S spouse columns, where applicable. These amounts are monthly costs for each person.
8	Enter the Earned Credit amount(s) for retiree and eligible J&S spouse. Instructions for determining eligibly for and the amount of the Earned Credit(s) is outlined on pages19 & 20.
9	Subtract the Standard SHARP Earned Credit you entered on Line 8 from the Total Cost you entered on Line 7, and enter the difference on Line 9 for retiree and J&S spouse. If the difference is a negative number, enter a '0.' This would mean there is no monthly cost. If the difference is more than zero, this amount represents the monthly cost for the coverage selected. The sum of both the retiree and J&S amounts will be deducted from the retiree's monthly benefit check.
	Read carefully the conditions of coverage noted below the form you completed. Sign and date the application and either mail or fax to SHARP office for processing. Without a signature, this application will NOT be processed.

Contact Information

SHARP Office - NAD Retirement Plans:

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

- Reasons to contact NAD Retirement SHARP office for:
  - Enrollment Questions
  - Appeals
  - Request replacement ID card

Adventist Risk Management, Inc. (ARM)

Phone -- Customer Service & Prior-Authorization ..... (800) 447-5002
Claims Address: Adventist Risk Management, Inc.
PO Box 1928
Grapevine, TX 76099-1928

- Reasons to contact ARM:
  - All claims payment issues
  - Verification of benefits to providers
  - Prior-authorization on required services

Medco

Phone and Prior-Authorization ..... (800) 841-5396
Web site ..... www.medco.com
Claims Address (must have claim form to submit paper claim)
Medco Health Solutions, Inc.
PO Box 14711
Lexington, KY 40512

- Reasons to contact Medco:
  - Prior-authorization for certain required drugs
  - Inquire about lost prescription
  - Obtain a 'Prescription Drug Reimbursement Form' or a *Medco By Mail* order form

PHCS

Phone ..... (866) 680-7427
Web site ..... www.phcs.com

- Reasons to contact PHCS:
  - Pre-Medicare/Non-Medicare – to find a physician within 25 miles of your home

Other

Medicare ..... www.medicare.gov