SHARP

January 1

2011

Supplemental Healthcare Adventist Retirement Plan

12501 Old Columbia Pike Silver Spring, MD 20904

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Supplemental Healthcare Adventist Retirement Plan

January 1 to December 31, 2011

General Information

The Retirement Plans operated by the North American Division of Seventh-day Adventists offers a healthcare assistance plan for eligible retirees and Joint & Survivor (J&S) spouses. This document introduces the North American Division (NAD) Supplemental Healthcare Adventist Retirement Plan (SHARP), and gives eligible retirees the opportunity to select Options of coverage. The SHARP healthcare plan is offered to retired employees of participating NAD employers.

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.

Plan Year

The SHARP Plan Year is January 1 to December 31. All benefit limits and deductibles are based on the Plan Year. A member who enrolls in SHARP during the Plan Year will have access to full limits and will be subject to full 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.

Important Plan Changes for 2011

- The Lifetime Limit for all SHARP benefits has been removed.
- The Shingles vaccine has been added to the Rx Option.
- The annual deductible for the Pre-Medicare/Non-Medicare Options has been removed.
- The Standard SHARP Option costs have changed**:** see page 27 on the SHARP enrollment form.
- The Earned Credit Table has been adjusted to reflect the cost changes for all SHARP Options.

Affiliation

SHARP is NOT a qualified 'Medicare supplemental coverage' plan as administered by various insurance companies and regulated by states, generally designated as plans A – N of Medicare. The Base and MCx Options rely on Medicare to cover the cost of most medical services, with few exceptions. Standard SHARP provides Options to supplement Medicare, as well as Options of coverage to assist with non-medical expenses not offered by Medicare such as DVH (Dental, Vision and Hearing) and Rx (prescription).

SHARP Options

SHARP Options can be selected individually or in combination with each other. Members may not choose both the Base and the MCx Options. The levels of coverage for the Base and MCx Options are the same except in one area. The Base Option has an *annual* deductible. The MCx Option has *no* deductible. The provisions of Standard SHARP do not restrict members to seeking services within a provider network. The Pre-Medicare Option is offered to a pre-65 retiree and J&S spouse. The Non-Medicare Option is offered for eligible dependent children.

SHARP Pre-Medicare and Non-Medicare Require PPO Participation

The SHARP Pre-Medicare/Non-Medicare Options operate under a Preferred Provider Organization (PPO), Private Healthcare System (PHCS/MultiPlan). Non-emergency services rendered outside of the PPO will be reimbursed at a reduced rate.

SHARP is not free

The Plan pays part of the cost for SHARP coverage. This is based primarily on years of qualifying church service credit and the policies in place at retirement.

Enrollment Forms

Enrollment forms are included in this booklet on pages 27 & 29. 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.

SHARP Earned Credit

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 the retiree selects. If the costs of the selections exceed the Earned Credit, the balance will be withheld from the retiree's monthly benefits. The rules regarding Earned Credit are described on pages 7-9 of this booklet.

Limits for change in coverage

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

Medicare

Traditional Medicare is required for participation in the Base or MCx Option. The Base and MCx Option are described on page 10 of this booklet. A retired minister who has opted out of Social Security and who will not become eligible for Medicare should not select the Base or MCx Option, as reimbursement requires Medicare approval of any medical expense submitted. Current information about Medicare can be obtained at the Medicare website, www.medicare.gov.

Eligibility

Retiree Eligibility

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

1. be a beneficiary of the Defined Benefit or Defined Contribution Plans operated by the North American Division of Seventh-day Adventists.
2. be a beneficiary in the Canadian Retirement Plan operated by the Seventh-day Adventist Church in Canada and have eligible service in either the Defined Benefit or Defined Contribution Plans operated by the North American Division.
3. have at least 15 years of qualifying service in the NAD Retirement Plans. Service with an Adventist Hospital does not normally qualify a retiree for healthcare assistance under SHARP.
4. otherwise be eligible for healthcare assistance, under special arrangements with foreign Seventh-day Adventist church entities for their resident retirees, or through other policy provisions. 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 North American Division after 1999.

An eligible retiree who:

1. is less than age 65 may select coverage from any of the following Options: Pre-Medicare, DVH and Rx.
2. is less than age 65, *but is covered by Medicare because of a disability or for some other reason,* may not select the Pre-Medicare Option. He/she may only select coverage from the Standard SHARP Options.
3. 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 J & S spouse by the retiree, and
2. have been married to the current spouse for one year or more prior to the retiree's retirement date.

An eligible Joint & Survivor spouse who:

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

Dependent Children Eligibility:

1. Dependents are eligible for healthcare assistance, based upon the retiree's years of service. Only the Non-Medicare Option may be selected for dependents except as noted in number 3 below.
2. Dependent children must be less than 19 years of age and have been born to or legally adopted by the retiree *prior* to the effective date of the retiree's retirement

date. The participation in the SHARP Plan ends on the last day of the month in which the dependent child turns 19 years of age.

3. Dependent children who have been determined to be disabled **and** are also covered by Medicare Part A and Medicare Part B, may be determined to be eligible for participation in Standard SHARP if he/she was eligible for healthcare on the retiree's effective date of retirement. 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 J & S spouse, whichever is later, all dependent coverage is terminated.

Eligibility Exclusions

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

Enrollment and Changes to Coverage

The effective date for SHARP is generally the same as the retirement effective date. Eligible retirees must select SHARP Options for himself/herself, as well as for any eligible Joint and Survivor spouse or eligible dependent children, within 30 days of the retirement effective date. Without a signed enrollment form from the retiree, healthcare assistance *will not* be provided.

Limits for Changes in Coverage

Other than what is noted in this section, each eligible person (retiree, 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. Onetime, Three-year Anniversary Open Enrollment. This is based upon the retiree's retirement effective date.
3. Retiree and eligible 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.

Delayed Enrollment –New Retiree Only

A new, eligible retiree may choose to delay ALL Standard SHARP coverage, for himself/herself, for a Joint & Survivor spouse, or for eligible dependent children, because at the effective date of retirement other coverage was in place. If Standard SHARP coverage is delayed, it can only be obtained in the future if one of the criteria listed under 'Limits for Changes in Coverage' are met. If such a delay is requested the following must occur:

1. The retiree must document to the SHARP Plan office within 30 days of retirement
    a. the name of each person with current other coverage
    b. the name and address of the other coverage

2. The retiree must contact the SHARP office within 30 days of the loss of other coverage and provide a copy of the termination letter and complete all enrollment forms for SHARP.

Discretionary Special Enrollment:

The SHARP Plan may find it necessary to make significant changes in the Plan. Should this 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.

High Inflation Special Enrollment:

Healthcare costs can increase significantly. The SHARP Plan 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.

Loss of Coverage Special Enrollment:

A retiree, spouse, or dependent children may have other healthcare coverage. SHARP does not assist with the premiums for such other coverage. If one of the participants discontinues such other coverage due to significant premium increases (over 25% per year), moves from the company's covered territory, or the company withdraws from the market, SHARP will allow a special open enrollment for that participant. Proof of one of these events will be required by the Plan prior to enrollment in SHARP. The retiree must request coverage under SHARP within 30 days of one of these events. If an eligible spouse is currently covered under an employer healthcare plan, upon his/her retirement the spouse may suffer a Loss of Coverage, he/she will be eligible for a special open enrollment.

Medicare Part D:

This Plan also prohibits concurrent enrollment in SHARP's Rx Option and a Medicare Part D plan. If during a reconciliation between SHARP and Medicare Part D, 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.

Re-Employment:

In situations where 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. To be reinstated into SHARP coverage a written request must be submitted to SHARP within 30 days of the loss of other coverage.

Three-year Anniversary Open Enrollment

1. **Standard SHARP:** Each retiree and eligible spouse who has an Earned Credit has the opportunity to change coverage at a onetime three-year anniversary open enrollment. Retirees will be notified of the opportunity to change coverage but are not required to make a change. Any changes become effective at the beginning of the next Plan year.
   Example: If a member enrolled in Standard SHARP during 2010, an open enrollment period occurs in 2013. Any changes selected become effective on January 1, 2014.
   If the SHARP office does not receive a re-enrollment form the same coverage will remain in force as was selected at the initial enrollment. **This open enrollment period occurs only once, not every three years.**
   a. The three-year anniversary Open Enrollment opportunity will be calculated from the retiree's retirement effective date for both the retiree and/or eligible Joint & Survivor spouse.
2. **Pre-Medicare SHARP:** No three-year anniversary open enrollment is available with the Pre-Medicare Option. This coverage option is in force until the coverage is requested to be terminated (see rules under Termination of Coverage) or when the member turns age 65 and becomes eligible for an open enrollment under the Pre-Medicare Expiration rule outlined in this section.
3. **Non-Medicare SHARP:** No three-year anniversary open enrollment is available with the Non-Medicare Option. The Non-Medicare coverage is in force until the coverage is requested to be terminated (see rules under Termination of Coverage) or when the dependent child turns age 19 and is no longer eligible.

Termination of Coverage:

If any of the retiree, eligible spouse or dependant child's benefits are discontinued at the request of the retiree, the termination of benefits will be considered permanent and will not be reinstated even if the person otherwise meets the requirements under the Limits for Changes in Coverage section.

1. Upon the death of either the retiree or covered spouse SHARP will stop taking deductions for the deceased beneficiary. However coverage and deductions for an eligible J & S spouse will continue.

Pre-Medicare Expiration:

If a retiree or eligible J & S spouse, is enrolled in the Pre-Medicare Option, upon reaching age 65 the Pre-Medicare Option will be terminated. An open enrollment is available to the individual turning age 65 to select from the Standard SHARP Options.

Earned Credits-Eligibility & Amounts

The Earned Credit is the monthly amount the Plan makes available to assist a retiree with the costs of the SHARP Options selected. Each eligible retiree will receive his/her own Earned Credit. If eligible for an Earned Credit, a retiree or J & S spouse who selects

coverage under both Standard SHARP and the Pre-Medicare SHARP will receive two Earned Credits, one for Standard SHARP and another Earned Credit for Pre-Medicare SHARP.

If the cost of your SHARP options are 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. Standard SHARP Earned Credit may only be used for the Standard SHARP Option. This is true for the Pre-Medicare Option and the Non-Medicare option as well. Pre-Medicare and Non-Medicare may only use the Earned Credit for that category.

Determining Your Earned Credit Category

The Category, in the Earned Credit Table (see page 9) is determined by the sum of qualified service in the following areas:

- Pre-2000 years under the NAD Defined Benefit Retirement Plan
- Post 1999 years under the NAD Defined Contribution Retirement Plan
- 2000-2004 under the Career Completion Option
- Canadian Retirement Plan
- 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 North American Division after 1999.
- Years of service with the Adventist hospital system generally do not count toward the SHARP Plan. The hospital plan provided 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 qualifying denominational service, or
  - 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 qualifying denominational service.
- **For Joint & Survivor Spouse:**
  - retiree must be eligible for Earned Credit, and
  - no age requirement for eligible spouse.
- **For Dependent Children:**
  - retiree must be eligible for Earned Credit, and
  - eligible dependent children 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 qualifying denominational service, who are not eligible for an Earned Credit may participate in SHARP Pre-Medicare, DVH or Rx, at their own cost. The retiree's Earned Credit will apply once he/she meets the Earned Credit eligibility as noted above. An eligible J & S spouse and/or eligible dependent children will qualify for an Earned Credit *only* when the retiree qualifies.

Earned Credit Table for 2011

A retiree with less than 15 years of qualifying denominational service is not eligible for healthcare or an Earned Credit. A retiree not yet age 65 with less than 40 years of qualifying denominational service has no Earned Credit.

Retiree Qualifying Service Credit	**35 Yrs**	**30-34 Yrs**	**25-29 Yrs**	**20-24 Yrs**	**15-19 Yrs**	**8-14 Yrs****	**5-7 Yrs****
Category	**A**	**B**	**C**	**D**	**E**	**F**	**G**
Standard SHARP (eligible Retiree and Spouse)	**$200**	**$180**	**$160**	**$140**	**$120**	**$100**	**$80**
Pre-Medicare SHARP (eligible Retiree and Spouse)	**$399**	**$349**	**$299**	**$249**	**$200**	**$150**	**$100**
Non-Medicare SHARP (eligible dependent children)	**$138**	**$121**	**$104**	**$86**	**$69**	**$52**	**$35**

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

Medicare Part B Premium Reimbursement

The Retirement Plan reimburses the retiree and eligible J & S spouse for a percentage of the regular Medicare Part B premium if the retiree meets age requirements and has 15 or more years of service credit in the NAD Defined Benefit and/or NAD Defined Contribution Plans. Medicare Part B premium reimbursement is based on $96.40 for 2011. A copy of the Medicare Health Insurance card must be submitted to the Retirement 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 NAD Retirement effective date but for no more than 12 months.

Participants in both the NAD and Canadian retirement plans 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 Premium Reimbursement 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
Years of Service Credit:	35+	30-34	25-29	20-24	15-19
Reimbursement:	90%	80%	70%	60%	50%

Standard SHARP

The following four Options (Base, MCx, DVH and Rx) are offered to an eligible retiree and an eligible Joint & Survivor spouse. *Members may select from the four Standard SHARP Option independent of each other.*

The Base and MCx Standard SHARP Options Require Eligibility for Traditional Medicare. Medicare must first approve the medical service and the amounts charged and pay its portion for SHARP reimbursement to be made. If Medicare does not approve an expense, this Plan will deny the expense as well. Current information about Medicare can be obtained at the Medicare web-site; www.medicare.gov.

Base Option and MCx Option

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

These two Options provide a limited level of medical coverage. For costs and limits, see the Schedule of Standard SHARP Benefits on page 24.

Medical Coverage

1. Provides reimbursement for the Medicare Part A (hospital) deductible and the Medicare Part B (medical/outpatient) annual deductible as well as the 20% co-pays on Medicare approved medical expenses determined to be the individual's personal responsibility.
2. Reportable Expenses include:
    a. Medicare hospitalization deductible
    b. Medicare outpatient annual deductible
    c. Medicare co-insurance for hospital days 61 – 90
    d. Medicare co-insurance for hospital days 91 – 150
    e. Skilled Nursing Facility days 21 – 100

3. Expenses **not** covered by Medical Coverage include:
    a. expenses not approved by Medicare,
    b. expenses that exceed Medicare limits and maximums,
    c. expenses for Nursing Home care and Custodial care
    d. expenses for Skilled Nursing Facility charges for stays exceeding Medicare limits.

Base and MCx Exceptions

1. **Blood:** Medicare will usually deny the first 3 pints of blood each calendar year. The Base and MCx Option will reimburse the retiree for this expense.
2. **Durable Medical Equipment:** The Base and MCx Option provides limited assistance for Durable Medical Equipment such as crutches or non-motorized wheelchairs.
3. **Colostomy/ileostomy Supplies:** The Base and MCx Option provide assistance for colostomy and ileostomy supplies on an 80%/20% reimbursement basis but only if denied by Medicare.
4. **Incontinence Supplies:** not covered.
5. **Orthopedic Shoes:** Medicare may deny assistance for orthopedic shoes, shoe inserts or similar devices. Under the Base and MCx Option, a retiree can submit such Medicare denied expenses for assistance on an 80%/20% reimbursement basis. The claim must include a doctor's written statement of medical necessity, fitting documentation and a copy of the Medicare denial
6. **Support stockings:** not covered.
7. **Wigs:** not covered.

(See the Schedule of Standard SHARP Benefits on page 24 for annual limits on each of these benefits)

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

One Dental Cleaning/Exam

One annual dental exam including bite wing and cleaning paid at 100%. Additional dental coverage is available under the DVH Option.

Foreign Travel Emergency Medical Coverage

Foreign travel emergency medical coverage is a benefit provided under both the Base and MCx Options of SHARP. This benefit has a $1,000 per person/year deductible. Claims are paid at 80% with a $50,000 per year maximum payable benefit.

- is limited to unexpected/emergency medical expenses incurred during a personal trip lasting less than 60 days
- does not cover denominationally sponsored or volunteer mission trips.

You may contact Adventist Risk Management Inc. for information regarding short-term medical coverage that can be purchase for denominationally and volunteer sponsored trips or personal trips lasting longer than 60 days. 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.

Dental, Vision, Hearing (DVH) Option

The Dental benefit provides coverage for dental services based upon reasonable and customary fees for the area the services are rendered. SHARP will pay 80% of reasonable and customary fees. The retiree is responsible for 20% subject to an annual maximum. Unused benefits may not be rolled over into the next Plan year. Prior Authorization is not required. See the Schedule of Standard SHARP Benefits on page 24.

Covered

- Two cleanings per Plan 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 a dentist for treatment of periodontal disease.
- One set of bite wing 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

Dental Exclusions

- Orthodontic treatment (except for Non-Medicare participants/see Schedule of Non-Medicare Benefits on page 25 for limits).
- TMJ/TMD treatment
- Jaw surgery
- Temporary crowns or bridges
- Experimental treatment/procedures
- Cosmetic services
- Toothbrushes

The Vision benefit provides coverage for services including refraction exam, corrective lenses, frames and related expenses. SHARP will pay 80% of the costs. The retiree is responsible for 20% subject to an annual maximum. See the Schedule of Standard SHARP Benefits on page 24. 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.

The Hearing benefit provides coverage for services including hearing tests, hearing aids and the repair of hearing aids. SHARP will pay 80% of the costs. The retiree is responsible for 20% subject to an annual maximum. See the Schedule of Standard SHARP Benefits on page 24. 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.

Prescription Drug (Rx) Option

The prescription drug program requires that you pay a portion of the cost of medications in the form of a copayment. Non-compliance with the cost containment rules described in this section may result in additional out-of-pocket costs to the member.

The Rx benefit provides:

1. 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. If the actual cost of a medication is less than the co-pay, you will pay the actual cost.
2. a SHARP identification card which can be used at local pharmacies, as well as with the Medco Health Solutions *Medco By Mail* program.
3. coverage for Home Health Intravenous medications and the supplies to administer them. The Plan pays these claims at 80%. Claims are submitted to Adventist Risk Management, Inc.
4. certain prescription drugs, primarily ED drugs such as Viagra, require 50% co-pay but have no other limit. Call Medco Health Solutions at (800) 841-5396 for information on specific drugs.
5. coverage for self-administered drugs. These medications are given in a hospital outpatient setting and are not covered by Medicare Part B. The medication must be a part of the SHARP drug formulary. Reimbursement will be at 80%. Claims are submitted to Adventist Risk Management, Inc.
6. coverage for the Shingles (Herpes Zoster) vaccine. Reimbursement will be at 80%. Claims are submitted to Adventist Risk Management, Inc.

SHARP's Rx Option includes a broad formulary. A formulary is a list of preferred, both generic and brand name, drugs. The list is used as a guide for prescribing and dispensing. The formulary used by the Plan is incentive-based. Medications both on and off the formulary are covered but at differing rates. The Plan in most instances pays higher benefits when you use drugs on the formulary list. Periodic changes are made to this list throughout the Plan Year without prior notice to retirees. **For further information on this formulary, visit the Medco website at www.medco.com or call Medco toll free at (800) 841-5396.** SHARP cannot advise members regarding the formulary and specific drug choices. Always discuss your medications with your treating doctor.

Cost Containment Rules for Prescriptions

1. **Prior Authorization:** Certain medications are not covered by the Plan without a coverage review (Prior Authorization). If special circumstances require that you continue a medication that is not covered, you can ask your doctor to begin a coverage review by calling Medco toll-free at (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 program.

a. **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: Beterson, Ritalin/Adderal, Stadol, fertility and growth hormones.
b. **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, medication 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 medications subject to Smart Rules include: Enbrel, Lamisil, Bextra, Zovirax, Zofran, Imitrex and Prilosec.

2. **Member Pays the Difference:** If a generic medication is available but the doctor or member insist on the brand name medication, the member will be charged the brand name co-pay in addition to the difference in cost between the brand name medication and the generic medication.
3. **Retail Refill Allowance:** At a retail pharmacy location, you are limited to filling a prescription three (3) times for the same medication. Beginning with the fourth (4^{th}) refill you will be charged 50% of the actual retail cost of the medication in addition to your regular retail co-pay.
4. **Preferred Drug Step Therapy:** This program provides cost containment measures. Certain brand name medications used to treat conditions such as depression, ulcers, osteoporosis, hypertension, insomnia, allergies and headaches, will not be covered. However, there are *preferred* brand and generic medications that can be used in their place. Medco will work with the member and their doctor to identify the medications covered by the Plan. In some cases, over-the-counter alternatives will be required whenever clinically appropriate.
5. **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.
6. **Quantity per Dispensing Event:** If the prescription as written exceeds the generally accepted maximum quantity, the excess is not covered by the Plan.
7. **Medicare Part B Prescriptions:** Medco offers a service through *Medco By Mail* where you fill Medicare Part B eligible prescriptions through mail order. You initially send your prescription to *Medco By Mail*. Depending on the type of medication or supply requested, *Medco By Mail* transfers your prescription 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 questions arise about your prescription.
    a. 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 identification card. The retail pharmacy will work with you to bill Medicare on

your behalf. The retail pharmacy will also submit any other claims that may be eligible for additional coverage. Most independent pharmacies and national chains are Medicare providers.

b. Medications and Supplies typically eligible for Medicare Part B coverage are:
    i. Diabetic supplies (test strips and meters only)
        1. Insulin and syringes for the treatment of diabetes are obtained through Medco Health. The mail-order or retail co-pay will apply
    ii. Transplants – certain medications to aid tissue acceptance for Medicare- approved organ transplants
    iii. Cancer – certain oral medications used to treat cancer
    iv. Chronic Renal Failure – certain medications used in situations where the kidneys have completely failed
    v. Respiratory– certain inhaled medications used in a device such as a nebulizer to receive the medication in mist form
    vi. Colostomy/iIeostomy supplies

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.

Rx Exclusions

1. Compound Medications: without FDA approval (NDC number)
2. Vitamins and/or dietary supplements

Pre-Medicare and Non-Medicare SHARP

Standard SHARP is designed to supplement Medicare. Pre-Medicare and Non-Medicare Options for inpatient/outpatient medical services are available for the pre-65 retiree, eligible spouse or unmarried dependent child less than 19 years of age who is not eligible for Medicare. (See Schedule of Benefits on page 25)

Pre-Medicare Option

This Option provides healthcare assistance for an eligible retiree and spouse who are not age 65 and 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 under the Pre-Medicare Option is:

- Inpatient/Outpatient medical services only
    - If coverage for DVH or Rx is needed the member must make the selection for these additional coverage options under Standard SHARP at the time of enrollment into the Pre-Medicare Option. The DVH and Rx options do not apply to the annual deductible or the out-of-pocket maximum. (See Schedule of Benefits on page 25)

Non-Medicare Option

This Option provides healthcare assistance for eligible dependent children. Coverage provided is *(*See Schedule of Benefits on page 25):

- Inpatient/Outpatient medical services
- Prescription drug coverage
- Dental/Vision/Hearing services

Preferred Provider Organization (PPO) is required for Pre-Medicare and Non-Medicare Members.

Coverage is limited to a network of participating providers. The provider network used by SHARP is PHCS (Private Healthcare System). To find a participating provider, contact PHCS at 1-866-680-7427 or www.phcs.com.
Non-emergency out-of-network expenses will be paid at a lower rate unless there is no participating provider within 25 miles of the member's residence. See the Schedule of Pre-Medicare/Non-Medicare Benefits on page 25 for a full disclosure on the PPO requirement. Claims filed for a participating PHCS provider will be reimbursed at 80%. If there is no participating provider within 25 miles of the member's residence, non-emergency claims will reimbursed at 80% of U&C. Claims filed for a non-PHCS provider will be reimbursed at 65% and will be subject to Usual and Customary (U&C) limits. Amounts disallowed as over U&C will not be used to meet any Plan out-of-pocket maximum.

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 event 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.

Prior Authorization

- You do not need to obtain prior authorization for health care performed in a provider's office, urgent care center, or emergency room.

- It is your responsibility to obtain appropriate prior authorization for diagnostic testing, outpatient procedures, etc., as per Plan guidelines. Your provider can initiate this by calling the number on the back of your SHARP identification card.
- If your care results in a hospital admission your provider must call the prior authorization department no later than the next business day after the admission. When you know in advance that you need to be hospitalized, your doctor must contact the prior authorization department prior to admission at the number on the back of your SHARP identification card.
- In case of an emergency hospital admission or surgery, you or your doctor must notify the prior authorization department within 24 hours of the admission or on the next business day following admission by calling the number on your SHARP identification card.

Pre-Medicare/Non-Medicare Covered Services and Treatments

See Schedule of Benefits on page 25 for a description of all coverage percentages, limits and prior authorization requirements.

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.

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

Chiropractic Treatment is covered by the Plan for members age 10 and above, subject to Plan limits and payment amounts. Services are limited to spinal manipulation only and appropriate billing codes (CPT) must be included for each charge. There is only one covered office visit and x-ray service per Plan year.

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

Durable Medical Equipment (DME): The Plan covers durable medical equipment that meets all of the following requirement. The equipment must:

- be able to withstand 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 doctor must recommend the medical equipment or device. The Plan will determine if the requirements for eligibility have been met. See the Schedule of Benefits on page 25.
    - **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 a change in the member's physical condition; or
  - it is likely to cost less to buy or rent a replacement than to repair the existing equipment.

Home Health Care and Private Duty Nurse: Prior Authorization is required.
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 doctor and one registered nurse who makes policy;
- has full-time supervision by a doctor or an RN;
- keeps complete medical records on each patient; 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 patient had stayed in the hospital:
  - medical supplies
  - laboratory services provided by or for a Home Health Care Agency.

Hospice Care is covered by the Plan. **Prior authorization is required for Inpatient or Respite Hospice care**. Hospice is 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 doctor in charge of the patient's care and treatment. The Plan will assist on charges for:

- services of a doctor; and
- health care services as an inpatient or at home, including part-time nursing care, part-time or intermittent home health care aide, 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 requirements.

Massage Therapy is covered by the Pre-Medicare/Non-Medicare Option for members age ten and above, subject to the limit of 30 visits per Plan year. Massage therapy must be provided by a licensed massage therapist (LMT) per regulatory requirements of the state in which services were rendered.

Maternity/Neonatal/Infertility:

- Maternity expenses are covered by the Plan for Pre-Medicare members.
- Maternity expenses are not covered for Non-Medicare members unless required by state law. This must be documented to the Plan prior to claim payment.
- Midwife services are covered but only for providers that are licensed AND insured.
- Infertility expenses are not covered by the Plan.
- Postnatal care (after mothers discharge) and Neonatal care and services are not covered. See eligibility rules for dependent children on page 4 of this document.

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. All claims will be denied without this authorization. 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 investigational 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 hour per day professional nursing services, on an inpatient basis for persons recovering from injury or disease, by an RN or an LPN 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. **Prior Authorization is required** for all therapeutic care services listed below.

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

Pre-Medicare/Non-Medicare SHARP Exclusions

1. **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 that is required under any law of a government and is provided other than a group basis; but only to the extent of the level of benefits required by the no-fault law.
2. **Cosmetic** procedures.
3. **Custodial Care and Services** Custodial Care and services are services and supplies that are furnished mainly to train or assist a person in personal hygiene and other activities of daily living rather than to provide therapeutic treatment. The Plan also considers any care or services to be custodial if they are or would be considered custodial for Medicare purposes.
4. **Diet** foods, herbs, and minerals, food supplements and 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. **Experimental** procedures.
7. **Health enhancement programs, Life Style Center programs and Residential Diabetic treatment programs** which are designed primarily to influence adoption of healthier lifestyle changes with only a secondary objective of providing necessary medical treatment.
8. **Infertility** and related treatment, artificial insemination, in vitro fertilization or embryo transfer procedures and reversal of any sterilization procedure.
9. **Lasik** eye surgery.
10. **Obesity** treatment.
11. **Pregnancies** with respect to a dependent child, unless otherwise mandated by state law.
12. **School Requirement –** services/supplies a school is required to provide under any law.
13. **Sex change surgery** or any treatment related to gender identity.
14. **Work** related injuries.

Coordination of Benefits

Standard SHARP

As an employer sponsored trust fund, the Standard SHARP Options (Base, MCx, DVH and Rx Options) are considered secondary to *all other healthcare plans available to the member*, including other coverage's that are secondary to Medicare. (Refer to Coordination Rules for All SHARP Options listed below for more information).

- Medicare is primary for all medical services for a member who has 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 for payment by this Plan. Services not approved and paid by Medicare are not covered by the Standard SHARP 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. (Refer to Coordination Rules for All SHARP Options listed below for more information).

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-retired parent. In such cases SHARP determines primary responsibility based on the parent whose birthday falls first in the year. (Refer to Coordination Rules for All SHARP Options listed below for more information).

Coordination Rules for All SHARP Options
SHARP is not insurance. It is a retirement medical benefit available to those who have met vesting requirements under a NAD defined benefit and/or defined contribution retirement plan. Thus it cannot be required to be primary by any insurance plan whether it is an employer insurance plan, a retiree supplemental insurance plan, a retiree supplemental reimbursement program for Medicare Part B premium, an auto policy or Worker's Compensation, etc. SHARP will coordinate with all other plans where it has secondary or tertiary responsibility by paying up to 100% of 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 Standard SHARP should be retained. Standard SHARP will abide by state rules and regulations to determine primary responsibility.

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 claims. 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 Payer ID 75261 CMS Crossover Enabled

Medical, Dental, Hearing and Vision Claims:

Upon enrollment, members will receive a SHARP identification card 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 above and on the SHARP identification card.
- **Electronic claims** may be sent to Adventist Risk Management, Inc. using the electronic address listed on the back of the SHARP identification 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 the Base or MCx Option 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 above or on the back of the SHARP identification card.

Prescription Drug Claims:

- **Home Delivery:** Claims are automatically filed through the *Medco By Mail* program.
- **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 the full cost of the prescription filled. Contact Adventist Risk Management, Inc., at 1-800-447-5002.You may contact 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 Medication:** 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 SHARP identification card. Only members who have selected the Non-Medicare Option or the Rx Option are eligible for Home Health Intravenous Medication benefits.

Appeals

The following measures have been adopted to ensure that your appeal of a claim will be handled promptly and in a fair, reasonable, and consistent manner. If you think that your claim denial was incorrect, you may have your claim reconsidered by submitting an appeal in writing. Questions about your claims can be resolved by contacting Adventist Risk Management, Inc., at P.O. Box 1928 Grapevine, TX 76099-1928. The customer service

number is 1-800-447-5002. Any appeal must be submitted within the timeline of 12 months from the date of service for the claim.

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: 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. Appeals for services that have not yet been rendered may be filed at any time.

Appeal Process: The appeal must be submitted in writing stating clearly why you feel the claim should be handled differently. Information to include with your appeal may include a copy of the claim in question, information from a provider, and 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 Plan
Attn: SHARP Appeals
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. If your appeal is denied in whole or in part, the decision will include specific reasons and specific references to the Plan provisions upon which it is based. Generally, except in extraordinary situations, this response will be within 60 days of receipt of your written appeal.

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 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 (North American Division Committee). 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*, call **301-680-6249.**

Schedule of Standard SHARP Benefits

January 1, 2011 to December 31, 2011

Services	Medicare Pays	SHARP Pays		You Pay	
		Base Option	MCx Option	Base Option	MCx Option
Deductibles	**Medicare pays approved services after a deductible** Medicare Part A (Inpatient): $1,132 Medicare Part B (Outatient): $ 162	All Medicare approved services after member $2,100 annual deductible	Balance of Medicare approved expenses	$2,100 Annual Deductible	$0
Hospital Expenses					
General Nursing & Miscellaneous	days 1-60 -- 100%	$0*	$0	$0*	$0
Semi-Private Room & Board,	days 61-90 -- all but $283/day	$283*	$283	$0*	$0
Services & supplies	days 91-150 -- all but $566/day	$566*	$566	$0*	$0
	days over 150 -- $0	$0*	$0	all costs	all costs
Skilled Nursing Facility* **					
General Nursing & Miscellaneous	days 1-20 -- 100%	$0	$0	$0*	$0
Semi-Private Room & Board,	days 21-100 -- all but $141.50/day	$141.50/day*	141.50/day	$0*	$0
Services & supplies	days over 100 -- $0	$0	$0	all costs	all costs
Outpatient Medical Service					
Outpatient Services	80%	20%*	20%	$0*	$0
Blood (first 3 pints)	$0	100%	20%	$0	$0
Colostomy/ileostomy Supplies	$0	80%	80%	20%	
Durable Medical Equipment (crutches/non-motorized wheelchairs)	$0	80% up to $1,100/year	80% up to $1,100/year	$0	$0
Hospice Care****	100%	$0	$0	$0*	$0
Foreign Travel - $1000 deductible		80% up to $50,000/yr	80% up to $50,000/yr	20%	20%
Orthotics/Orthopedic Shoes	$0	80% up to $600/year	80% up to $600/year	20%	

* $2,100 deductible applies

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

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

**** Physician must certify as a terminal illness

Services	Annual Limit	SHARP Pays		You Pay	
DVH - Dental, Vision, Hearing					
Dental	$2,200/person/year	80%		20%	
Vision	$400/person/year	80%		20%	
Hearing	$2,200/person/year	80%		20%	
Rx - Prescription Drug		**Retail**	**Mail order**	**Retail**	**Mail order**
Generic	None	Cost of medication		$11*****	$25*****
Brand Name		Cost of medication		$22*****	$50*****
Home IV Therapy		80%		20%	
Self-Administered Drugs******		80%		20%	
Shingles Vaccine		80%		20%	

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

****** Drugs given during Outpatient Hospital or Urgent Care visit that are denied

Pre-Medicare and Non-Medicare Schedule of Benefits

January 1, 2011 to December 31, 2011 - Out of Pocket Maximum: $5500.00/member

NOTE: Refer to Pre-Medicare and Non-Medicare Benefit Rules on page 16 for other important informaiton on PPO requirements, U&C fees, and Prior Autorizaiton requirements and Penalties.

Service	Prior Authorization	SHARP Pays	Limits
Acupuncture	No	80%	18 visits/year
Ambulance	No	80%	none
Cardiac Rehabilitation	Yes	80%	none
Chiropractic	No	80%	30 visits/year
CT Scan	Yes	80%	none
Durable Medical Equipment	Yes - over $500	80%	$8,000/year
Home Health Care/Private Duty Nurse	Yes	80%	52 visits/year
Hospice & Inpatient/Respite Hospice	Yes	100%	none
Hospitalization/Inpatient Surgery	Yes	80%	none
Infertility treatment		Not Covered	
International/Emergency Serivces	No	80%	none
International/Non-Emergency Services		Not Covered	
Massage Therapy	No	80%	30 visits/year
Maternity			
Pre-Medicare	No	80%	none
Non-Medicare(only as mandated by state law)	Yes	80%	none
Midwife - Pre-Medicare only	No	80%	none
Mental Health Services/Outpatient	No	80%	none
Mental Health/Inpatient	Yes	80%	none
Substance Abuse Services/Outpatient	No	80%	none
Substance Abuse Services/Inpatient	Yes	80%	none
MRI	Yes	80%	none
Postnatal/Neonatal care & services		Not Covered	
Outpatient Services/Peventative Services	No	80%	none
Orthopeadic Shoes/Orthotics	No	80%	$600/year
Skilled Nursing Facility	Yes	80%	30 days/year
Therapeutic Care			
Occupational Therapy	Yes	80%	30 visits/year
Physical Therapy	Yes	80%	30 visits/year
Prostheic Devices	Yes	80%	$10,000/year
Speech Therapy	Yes	80%	30 visits/year
Vision Therapy	Yes	80%	8 visits/year
Transplant Services (transplant services are not	Yes	80%	$200,000/year
covered if prior authorization is not abtained)			

Standard SHARP Options - Included in Non-Medicare - Optional choice for Pre-Medicare members

Service	SHARP Pays	You Pay	Limits
DVH			
Dental	80%	20%	$2,200/year
Orthodontia (Non-Medicare Only)	50%	50%	$2,300/lifetime
Vision	80%	20%	$400/year
Hearing	80%	20%	$2,200/year
Rx			
Retail Pharmacy			
Generic		$11 co-pay	30 day supply
Brand		$22 co-pay	30 day supply
Medco By Mail			
Generic		$25 co-pay	90 day supply
Brand		$50 co-pay	90 day supply
Home IV Therapy	80%	20%	none

Instructions for Completing the SHARP Forms

1. The SHARP form completion depends upon meeting the eligibility requirement for either the Standard SHARP or the Pre-Medicare/Non-Medicare Options. Refer to the Eligibility section on page 4 of this document to determine which coverage is the correct one for you. **All Medicare eligible** individuals may only choose from the Standard SHARP Option.

2. For each individual you are seeking healthcare benefits for 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 Form for age 65 and younger and dependent children. The forms are found on pages 27 & 29. Enter the dollar amount for the options you have selected.

3. Pre-Medicare: Remember inpatient & outpatient medical benefits are separate from DVH & Rx benefits. If you wish to also have dental, vision, hearing and prescription benefits you *must enroll separately* for each.

4. Non-Medicare: This coverage includes Medical inpatient and outpatient expenses, dental, vision, hearing and prescription drugs as described within the policy. See page 25 for the Schedule of Benefits.

5. Total ALL monthly selections.

6. If you meet the eligibility requirements refer to page 9 for the Earned Credit Table. Enter the Earned Credit for yourself, your spouse and your dependent child(ren). If there is more than one dependent child enter double the Earned Credit amount.

7. Add the total cost of all options selected. Subtract your Earned Credit if eligible. The "Total" will be your monthly cost for your 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. Without a signature the application and enrollment will NOT be processed.

10. For assistance at any time with the enrollment process you may contact the SHARP office at 301-680-5036: Monday –Thursday 8 a.m. – 5 p.m. EST.

Standard SHARP Form

Retiree Name: _____ **SSN:** _____

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

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

Standard SHARP

Base - $25/month/person		
MCx - $135/month/person		
DVH - $60/month/person		
Rx - $115/month/person		
Gross Standard SHARP Cost	**$**	**$**
Minus Standard SHARP Earned Credit	**-**	**-**
Total Standard SHARP Cost:	**$**	**$**

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

* I authorize SHARP to deduct monthly contributions based on the options I selected. If the cost of my options is greater than my monthly pension, I agree to make quarterly payments in advance.
* I understand that I and my eligible joint and survivor spouse are allowed to join SHARP or request changes to SHARP at specific times. (SHARP document, page 5 "Limits for Change in Coverage")
* I understand that there are deductibles and maximums in SHARP.
* I understand that the options selected and associated costs must be reviewed/authorized by the Retirement Office.
* I understand that to receive reimbursement of a percentage of Medicare Part B premiums, I must submit a copy of Medicare cards for myself and eligible joint and survivor spouse. (SHARP document pages 9 & 10)

Retiree Signature _____ **Date** _____

Effective Date of Options Selected: _____

Please sign & return within 30 days to: Adventist Retirement Plans
12501 Old Columbia Pike
Silver Spring, MD 20904

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

Pre-Medicare / Non-Medicare SHARP Form

Retiree Name: _____ **SSN:** _____

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

Pre-Medicare

Pre-Medicare - $399/month/person		
Minus Pre-Medicare Earned Credit	-	-
Net Pre-Medicare Cost	$	$

Standard SHARP

DVH - $60/month/person		
Rx - $115/month/person		
Gross DVH and/or Rx Cost	$	$
Minus Standard SHARP Earned Credit	-	-
Net DVH and/or Rx Cost	$	$
Total Pre-Medicare/DVH/Rx:	$	$

Non-Medicare

Note: 1st and 2nd child will be charged $138 each. No addt'l charge for 3 or more children

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

Total Cost for All Options Selected	$

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

* I authorize SHARP to deduct monthly contributions based on the options I selected. If the cost of my options is greater than my monthly pension, I agree to make quarterly payments in advance.
* I understand that I and my eligible joint and survivor spouse are allowed to join SHARP or request changes to SHARP at specific times (SHARP document page 5 "Limits for Change in Coverage")
* I understand that there are deductibles and maximums in SHARP.
* I hereby certify that child(ren) listed meet eligibility requirement (SHARP document pages 4 & 5), and that I am responsible to notify SHARP when my child(ren) become(s) ineligible.
* I understand that the Pre-Medicare/Non-Medicare SHARP **requires** participation in PHCS (a PPO) and are limited to inpatient and outpatient medical expenses only. I must select the DVH or Rx options if I wish to have benefits for those types of services. (SHARP document pages 15 & 16)
* I understand that the options selected and associated costs must be reviewed/authorized by the Retirement Office.
* I understand that to receive reimbursement of a percentage of Medicare Part B premiums, I must submit a copy of Medicare cards for myself and eligible joint and survivor spouse. (SHARP document pages 9 & 10)

Retiree Signature _____ **Date** _____

Effective Date of Options Selected: _____

Please sign & return within 30 days to: Adventist Retirement Plans
12501 Old Columbia Pike
Silver Spring, MD 20904

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

Notes

Notes

NOTES

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
Fax 301-680-6190
Address: Adventist Retirement Plans
Attn: SHARP
12501 Old Columbia Pike
Silver Spring, MD 20904

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

Adventist Risk Management, Inc. (ARM)

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

- Reasons to contact ARM:
  - All claims payment issues
  - Verification of benefits
  - 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 a paper claim)
Medco Health Solutions, Inc.
PO Box 14711
Lexington, KY 40512

- Reasons to contact Medco:
  - Prior-Authorization required for certain medications
  - 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