ADVENTIST RETIREMENT

SHARP

Supplemental Healthcare Adventist Retirement Plan

2025

Standard

Less than Age 65 with Medicare as Primary Coverage

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Supplemental Healthcare Adventist Retirement Plan SHARP less than age 65 with Medicare as primary coverage January 1 to December 31, 2025

Introduction

The North American Division of Seventh-day Adventists (NAD) offers a healthcare assistance plan for certain Eligible Retirees, their Eligible Spouses and Eligible Dependent children through its Adventist Retirement Plans office. This document describes the Supplemental Healthcare Adventist Retirement Plan (SHARP) for those less than age 65 with Medicare as primary healthcare coverage for the 2025 Plan Year. Capitalized terms used in this document are defined in the Glossary.

Under SHARP, retirees who qualify may choose among the following SHARP Options:

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

Other healthcare assistance programs are available to certain retirees, eligible spouses and dependent children who are not entitled to Medicare. Refer to the 2025 SHARP Pre-Medicare/Non-Medicare documents for information about those programs. Those age 65 and over should refer to the SHARP–Ex document for benefits.

Eligible Retirees and Eligible Spouses or Eligible Dependent children, who qualify for Social Security disability and are less than age 65, will choose from three SHARP options: Base Option, Rx Option and DVH Option. The age change eligibility rules of age 65 and age 26 will apply (see the Eligibility section of this document).

Coordination with Medicare

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

The Base and MCx Options are described later in this booklet. The Rx Option is also described in more detail in the prescription drug section of this document.

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

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

This Plan document describes the Plan's provisions for the period January 1, 2025, through December 31, 2025. All benefit limits and deductibles are based on the Plan Year. A member who

enrolls in SHARP during the Plan Year will have access to full limits and will be subject to full deductible without pro-ration.

Retirees Share in SHARP Cost

Adventist Retirement subsidizes a portion of the cost for SHARP coverage, based primarily on years of qualifying church service credit and the policies in place at retirement (See Earned Credit section). Eligible Retirees pay the remainder of the cost.

Timely Enrollment is Important

There is no automatic enrollment in SHARP. Retirees who do not enroll within thirty days of their eligibility will not be eligible for assistance with health care costs. An enrollment form is included at the end of this booklet.

Limited Options for Changing Benefits

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

Alight Retiree Health Solutions: Alight Retiree Health Solutions assists each Medicare age eligible retiree (age 65 or older) and their Medicare age eligible spouse (age 65 or older) with enrollment in a healthcare plan to supplement Medicare Part A, Part B and Part D. The SHARP-Ex policy determines who is eligible for the Alight Retiree Health Solutions.

Eligibility

Retiree Eligibility

To be an Eligible Retiree in SHARP-less than age 65 with Medicare primary coverage and to enroll in the Base and Rx Options, a retiree must be enrolled in Medicare Parts A and B. An Eligible Retiree must have at least 15 years of qualifying service by July 1, 2020, and be:

1. a beneficiary of one of the Seventh-day Adventist Retirement Plan of the North American Division and Auxiliary Benefits Z 15, The Seventh-day Adventist Hospital Retirement Plan section Article I section 1.26, 1.33, 1.34 (see page 10 the Retirement Plan for reference to years of service policy) or the Adventist Retirement Plan (Defined Contribution Plan), or

2. a beneficiary in the Pre-2000 Canadian Retirement Plan operated by the Seventh-day Adventist Church in Canada and have a retirement benefit resulting from Retirement Plan Service in either the Pre-2000 Defined Benefit Plan or the Adventist Retirement Plan Defined Contribution Plan.

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

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

1. less than age 65 may select coverage under Pre-Medicare SHARP, which offers choices of medical, DVH and Rx options. The Pre-Medicare SHARP Options are described in a separate document.
2. Less than age 65 but is enrolled for Medicare Parts A and B because of Social Security disability status, may select coverage only from the SHARP – Less than Age 65 with Medicare as Primary Coverage Option described in this document.
3. Age 65 or older may select coverage only from the SHARP-Ex Option.

Spouse Eligibility

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

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

An Eligible Spouse who is:

1. less than age 65 may select coverage under Pre-Medicare SHARP, which offers choices of medical, DVH and Rx Options. The Pre-Medicare SHARP Options are described in a separate document.
2. less than age 65 *but enrolled for Medicare Parts A and B because of Social Security Disability status*, may select coverage only from the SHARP – less than age 65 with Medicare as primary coverage option as described in this document.
3. age 65 or older may select coverage only from the SHARP-Ex Option.

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

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

The Plan reserves the right to review and approve spouse eligibility in the year of the retiree's retirement. Retirees who have been married less than one year prior to retirement, may enroll their spouse in SHARP at full cost at their retirement effective date. No earned credit is applied. Retirees

who marry after their retirement effective date have a limited opportunity (30 days from date of marriage) to enroll their new spouse in SHARP-Ex or Pre-Medicare benefits. The new non-Eligible Spouse is not eligible for Earned Credit, Additional Accrued Pension Supplement, or the Health Reimbursement Account benefits (See section on Special Enrollment Rights).

Dependent Children Eligibility

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

An Eligible Dependent is:

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

2. under age 26;

3. a child who is covered under Medicare Disability benefits, until the child attains age 26.

An Eligible Dependent described above shall remain an Eligible Dependent for 60 days following the death of the Eligible Retiree (or the second to die of both the Eligible Retiree and Eligible Spouse) and shall remain covered by the then existing coverage options until the end of such 60 days, unless an earlier termination of coverage is requested in writing on behalf of the Eligible Dependent. If there is no monthly pension benefit to cover healthcare enrollment costs, payment will be required in advance for the remaining enrollment period.

Eligibility Exclusions

1. Beneficiaries who elect or receive healthcare benefits from the Regional Retirement Plan are not eligible to participate in SHARP.

    a. Policy Z 10 25 & Z 20 05 of the North America Division Working policy.

2. The SHARP Pre-Medicare/Non-Medicare Options are not available to individuals who have primary residence outside of the United States.

3. Employees hired on or after July 1, 2020 are not eligible to participate in SHARP upon retirement.

Enrollment and Enrollment Changes

The effective date for SHARP-less than age 65 with Medicare as primary coverage is generally the same as the retirement effective date for the Eligible Retiree. An Eligible Retiree must select SHARP Options for himself/herself, as well as for any Eligible Spouse or Eligible Dependent, within 30 days of the retirement effective date. The Base and MCx Options of SHARP require eligibility for and enrollment in original Medicare (Parts A and B).

Without a timely submitted and signed enrollment form from the Eligible Retiree, healthcare assistance will *not* be provided under SHARP – less than age 65 with Medicare Primary.

Limits for Enrollment Changes

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

1. Within 30 days of the Eligible Retiree's effective date of retirement (or loss of coverage as described under the new retiree Delayed Enrollment provision below). When the member attains age 65, they will be offered an enrollment in the SHARP-Ex option. SHARP abides by the Medicare enrollment rules for medical and prescription drug coverage. If SHARP-Ex benefits are declined at age 65, it is considered a permanent opt-out of benefits.

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

   - **Important Note**: With very limited exceptions as identified below, the coverage selected during the above-listed enrollment opportunities will remain in effect during the life of the Eligible Retiree and the Eligible Spouse.

Delayed Enrollment Due to Other Coverage – New Retiree Only

A newly Eligible Retiree may choose to delay ALL SHARP coverage, for himself/herself or an Eligible Spouse or Eligible Dependent, if at his or her retirement effective date, other healthcare coverage (VA, TriCare, Medicaid, state/federal plan, other retirement plan healthcare coverage) is in place. If SHARP coverage is delayed for this reason, it can only be obtained in the future if one of the criteria listed in the section 'Loss of Coverage' are met.

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

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

   a. the name of each person with current other coverage
   b. the effective date of the other coverage

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

Loss of Coverage

For the purposes of this section, a "loss of coverage" means an involuntary loss of other coverage in any one of the following events:

(i) loss of eligibility for coverage due to termination of employment (such as an Eligible Spouse's termination of employment), or

(ii) loss of healthcare benefits from VA, TriCare, Medicaid, state/federal plan and other retirement plan healthcare coverage.

(iii) loss of healthcare benefits by an Eligible Retiree or Eligible Spouse as a result of legal separation, divorce or death.

"Loss of Coverage" does not include the voluntary decision of an Eligible Retiree or Eligible Spouse to terminate other, primary healthcare coverage except as described above.

The Eligible Retiree must notify SHARP of a "loss of coverage" within 30 days of the loss.

Special Enrollment Rights – Changes in Family Status

An Eligible Retiree may enroll his/her newly married non-Eligible Spouse or any other Eligible Dependent in SHARP as a "special enrollee" if any one of the qualifying events happens:

1. Marriage
2. Birth of a newborn
3. Adoption or placement of a child in the home for adoption
4. Loss of other healthcare coverage as described under the Loss of Coverage section of the plan.

If any one of these events happens, the Eligible Retiree **must enroll** the newly acquired non-Eligible Spouse and/or Eligible Dependent **promptly**, within 30 days of the qualifying event.(Refer to the Glossary for the definition and rules regarding a non-eligible spouse.)

Discretionary Special Enrollment

The Adventist Retirement Board may find it necessary to make significant changes in SHARP-less than Age 65 with Medicare as primary coverage. Should this occur, SHARP may provide an opportunity to change some or all elections previously made under SHARP-less than Age 65 with Medicare as primary coverage.

High Inflation Special Enrollment

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

Pre-Medicare SHARP Expiration

If an Eligible Retiree or Eligible Spouse is enrolled in SHARP – less than age 65 with Medicare as primary coverage or Pre-Medicare SHARP, upon reaching age 65, these SHARP coverages will be terminated. An open enrollment is available to the individual turning age 65 to enroll in the SHARP-Ex Option.

Re-Employment

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

Surviving Retiree or Eligible Spouse

Upon the death of either the covered Eligible Retiree or Eligible Spouse/Eligible Dependent, SHARP will cease deductions for the deceased beneficiary. However, a surviving Eligible Retiree or Eligible Spouse will need to contact SHARP for assistance with continuation of medical or prescription drug benefits.

A surviving Eligible Retiree, Eligible Spouse enrolled in SHARP DVH benefits or SHARP less than age 65 benefits, will have a 30-day open enrollment period during which he/she may amend the coverages which were in place at the covered beneficiary's date of death.

If an Eligible Retiree dies prior to retirement, the surviving Eligible Spouse may enroll in SHARP options upon the deceased Eligible Retiree's 65th birthday and the completion of a retirement application.

A surviving non-Eligible or non-Joint and Survivor spouse's SHARP benefits terminate 30 days following the death of the Eligible Retiree.

Requested Termination of Benefit

If, at the request of the Eligible Retiree or Eligible Spouse, SHARP Base, MCx, Rx or DVH benefits are discontinued, the termination of benefits will be considered permanent and will not be reinstated. This termination rule applies until age 65 and the open enrollment for SHARP-Ex.

If an Eligible Retiree or Eligible Spouse currently enrolled in the SHARP DVH Option then terminates the SHARP DVH Option, the termination will be a permanent and lifetime stop of the benefit. This includes requests to temporarily stop the benefit while residing outside of the United States.

If coverage is terminated due to a return to employer healthcare coverage, the Eligible Retiree, Eligible Spouse and Eligible Dependent will be eligible to re-enroll upon meeting the Loss of Coverage rules outlined in this document.

Your Responsibility to Report Family Changes

Since SHARP may be unaware of family changes that might affect you and your family member's eligibility for the Plan or the proper administration of the Plan, it is your responsibility to report changes in eligibility of general family or other status to SHARP within 30 days of the change. Failure to do so may hamper SHARP's ability to effectively administer benefits under the Plan. Examples of the types of changes that you must report are marital status changes such as divorce, return to full time employment, loss of disability status, change in address/telephone number, eligibility for Medicaid assistance.

Earned Credit – Eligibility and Amounts

SHARP – less than age 65 with Medicare as primary coverage Earned Credit – In General

An Earned Credit is calculated for Eligible Retirees based on years of Retirement Plan Service credit. The Earned Credit is the monthly amount that is made available to assist an Eligible Retiree with the costs of the SHARP – less than age 65 with Medicare as primary coverage Base, Rx and DVH Options selected. The eligibility rules for the Earned Credit are outlined below.

Each Eligible Retiree and each Eligible Spouse and/or Eligible Dependent will receive his/her own Earned Credit.

The Earned Credit is applied to the total cost of the Options selected by an individual. If the costs of the selections exceed the Earned Credit, the balance will be withheld from the Eligible Retiree's monthly retirement benefits (or SHARP billing arrangements are made if no retirement benefit is available). If the cost of the SHARP – less than age 65 with Medicare as primary coverage Option is less than the Earned Credit, the amount left over is neither paid to the Eligible Retiree, nor can it be used to cover another family member.

SHARP Earned Credit may only be used for SHARP – less than age 65 with Medicare as primary coverage. This is true for Pre-Medicare SHARP and Non-Medicare SHARP as well. Pre-Medicare and Non-Medicare SHARP covered members may only use their Earned Credit for that category of coverage.

Determining the Earned Credit Category

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

- Pre-2000 years under the Defined Benefit Plan
- Post-1999 years under the Defined Contribution Plan for employees hired before January 1, 2000
- Years from January 1, 2000 through June 30, 2020 under the Defined Contribution Plan for employees hired on or after January 1, 2000. Employees with only Defined Contribution Plan service cease accruing service credit for SHARP healthcare assistance beginning July 1, 2020.
- 2000-2004 under the "career completion option" under the Defined Contribution Plan
- Pre-2000 under the Canadian Retirement Plan
- Non-NAD service in foreign divisions for those who transferred to and began employment in the NAD before 2000.
- Pre-2000 years under the Bermuda Retirement Plan
- Pre-2000 years under the Kettering College of Medical Arts

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

Eligibility for Earned Credit

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

- **For an Eligible Retiree:**

The Eligible Retiree is at least age 65, or
The Eligible Retiree is less than age 65 but has 40 years of qualifying Retirement Plan Service, or
The Eligible Retiree was eligible for early retirement prior to 2003, regardless of when retirement occurred, and was determined eligible for healthcare assistance with 15 or more years of Retirement Plan Service.
The Eligible Retiree's primary residence is within the United States.

- **For an Eligible Spouse:**

The Eligible Retiree must be eligible for Earned Credit,
The Eligible Spouse must have been an Eligible Spouse as of the Eligible Retiree's retirement effective date, and
No age requirement applies for the Eligible Spouse.
The Eligible Spouse's primary residence is within the United States.

- **For an Eligible Dependent:**

The Eligible Retiree must be eligible for Earned Credit,
The Eligible Dependent must be under age 26, and
The child must have been determined to be an Eligible Dependent as of the Eligible Retiree's retirement effective date or meet the rules of Special Enrollment Rights-Change in Family Status requirements.
The Eligible Retiree and Eligible Dependent's primary residence is within the United States.

- **Future Eligibility for Earned Credit**

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

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

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

2025 Pre-Medicare/Non-Medicare EC Table*							
Years of qualifying church service	**35+**	**30-34**	**25-29**	**20-24**	**15-19**	**8-14***	**1-7***
Category	**A**	**B**	**C**	**D**	**E**	**F**	**G**
Pre-Medicare Medical	$440	$385	$330	$275	$220	$170	$110
Pre-Medicare Rx/DVH	$200	$180	$160	$140	$120	$100	$80
Non-Medicare	$130	$115	$100	$80	$65	$50	$35

2025 EC Table for less than age 65 with Medicare primary*							
Years of qualifying church service	**35+**	**30-34**	**25-29**	**20-24**	**15-19**	**8-14***	**1-7***
Category	**A**	**B**	**C**	**D**	**E**	**F**	**G**
SHARP	$220	$200	$175	$155	$130	$110	$90

***Based on eligibility**

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

Additional Accrued Pension Supplement

The Eligible Retiree or Eligible Spouse with combined Defined Benefit and Defined Contribution service credit is eligible to receive reimbursement for a percentage of the regular Medicare Part B premium if the individual is at least age 65 and the Eligible Retiree has 15 or more years of Retirement Plan Service and is eligible for an Earned Credit, as defined in the Glossary under Retirement Plan Service, and is eligible for an Earned Credit (Pre-65 retirees must have 40 years of service credit to be eligible for an Earned Credit, which would then grant the Eligible Spouse over age 65 partial reimbursement for Medicare Part B premiums). Notwithstanding the foregoing, neither (i) a retiree who receives a benefit from the Adventist Retirement Plan in the form of a lump sum, nor (ii) any spouse in respect of such a retiree, shall receive an Additional Accrued Pension Supplement under SHARP.

If the effective retirement date is January 1, 2015, or later, and the Eligible Retiree has only post-1999 service (Defined Contribution), there is no Additional Accrued Pension Supplement benefit for the Eligible Retiree or Eligible Spouse.

The Additional Accrued Pension Supplement was frozen January 1, 2015 and is based on $104.90. A copy of the Medicare Health Insurance card must be submitted to the SHARP Office for the reimbursement to be included in the monthly retirement benefits. Cards submitted after the Medicare Part B effective date will be retroactively reimbursed to the later of the Medicare Part B effective date or the Eligible Retiree's retirement effective date, but for no more than 12 months of retroactive reimbursement per covered member.

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

Additional Accrued Pension Supplement Table*							
SHARP Category	**A**	**B**	**C**	**D**	**E**	**F**	**G**
Years of Retirement Plan Service	35+	30-34	25-29	20-24	15-19	8-14**	1-7**
Reimbursement	90%	80%	70%	60%	50%	40%	30%
Monthly Reimbursement	$94.41	$83.92	$73.43	$62.94	$52.45	$41.96	$31.47

*based on $104.90

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

Dental, Vision, Hearing (DVH) Option

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

A retiree must make the decision to enroll in the SHARP DVH Option within 30 days of the retirement effective date or the Loss of Coverage effective date. If the retiree/spouse will be billed by SHARP for the monthly cost of the DVH Option, the ACH Authorization Form must be completed before the DVH Option will be activated. Once enrolled the retiree/spouse must remain enrolled in the benefit for the full calendar year* and make the required monthly payments. Non-payment of the SHARP DVH Option monthly costs may impact access to other benefits. If a retiree/spouse terminates the SHARP DVH Option during a non-open enrollment period, the termination will be a permanent and lifetime stop of the benefit.

A retiree or eligible spouse who enrolls in the SHARP DVH Option at any time during a plan year must remain in the benefit and pay the premiums for the benefit, for the full year. Failure to pay premiums will result in a permanent termination of the benefit.

The Dental benefit provides coverage for dental services based upon reasonable and customary fees for the geographical area in which the services are rendered. SHARP will pay 80% of reasonable and customary fees, subject to a calendar year SHARP maximum paid amount of $2,200. Any expenses above this maximum amount are not eligible expenses under SHARP. Unused dental benefits may not be rolled over into the next calendar year. Services that begin in one calendar year will have a date of service in that calendar year. Prior authorization is not required.

The covered member is responsible for the 20% coinsurance on approved charges. Fees above the annual SHARP maximum paid amount and any charges above reasonable and customary fees are the responsibility of the member.

*NOTE: Enrollment in Hospice and/or Medicaid allows for a mid-year termination of benefits with the option to re-enroll should the Eligible retiree/spouse lose the Hospice and/or Medicaid benefit.

Covered Dental Benefits

- Two cleanings per calendar year
- One set of bite wing x-rays per calendar year
- Extractions and periodontal treatment
- Full mouth or panorex x-ray every 3 calendar years
- Implants (*Caution: one implant may take your full annual limit*)
- Application of fluoride twice per calendar year
- Fillings
- Root canal therapy
- Crowns/bridges/partials/dentures
- Anesthesia, if medically necessary

Dental Exclusions

- Orthodontic treatment
- TMJ/TMD treatment
- Jaw surgery

- Temporary crowns or bridges
- Experimental treatments/procedures
- Cosmetic services
- Toothbrushes
- Treatment by Household Members. The Plan does not cover services of a person who ordinarily resides in the home of the patient.

The Vision benefit provides coverage for services including refraction exam, corrective lenses, frames and related expenses. SHARP will pay 80% of the billed costs subject to a calendar year SHARP maximum paid amount of $400. Any expenses above this SHARP maximum amount and Medicare disallowed amounts, are not eligible expenses.

The covered member is responsible for the 20% coinsurance and charges. Fees above the calendar year SHARP maximum paid amount are the responsibility of the member. Surgery or other procedures considered to be medical in nature are not covered under the Vision benefit but may be covered by Medicare. Unused Vision benefits may not be rolled over into the next calendar year.

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

The covered member is responsible for the 20% coinsurance and charges. Fees above the calendar year maximum paid amount are the responsibility of the member. The Hearing benefit has a **one year 'look-back' provision** which allows the payment of any unused benefits from the previous calendar year to be used in the current calendar year.

Schedule of SHARP DVH Benefits			
January 1, 2025 – December 31, 2025		**SHARP**	**You**
Dental	$2,200 person/year*	80%	20%
Vision	$400 person/year*	80%	20%
Hearing	$2,200 person/year*	80%	20%

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

2025 DVH Table*							
Years of qualifying church service	**35+**	**30-34**	**25-29**	**20-24**	**15-19**	**8-14***	**1-7***
Category	**A**	**B**	**C**	**D**	**E**	**F**	**G**
DVH Cost/Month	$107	$107	$107	$107	$107	$107	$107
(less EC)	($65)	($58)	($51)	($44)	($37)	($30)	($23)
Total Cost	$42	$49	$56	$63	$70	$77	$84
*based on eligibility							

SHARP Billing

SHARP deducts the monthly cost for the SHARP coverage selected, from the retiree pension. If there are no monthly pension funds or the pension funds are insufficient to cover the cost, the retiree must make advance monthly payments to SHARP. This payment must be received by SHARP department prior to the start of coverage. If there is a default on payment of the monthly cost, the SHARP coverage will be terminated. This will be a lifetime termination of the coverage.

Retirees are required to participate in an ACH/Automatic Debit payment to be enrolled in SHARP Billing. Upon enrollment, the retiree will provide the SHARP office with a signed enrollment form including bank information for the ACH withdrawal. (See the attached Authorization Agreement for Recurring Direct Payments (ACH Debits)

Retirees are billed monthly. Payments must be made by the 15th of the month prior to coverage. If the initial enrollment is such that a retroactive payment is required, the retroactive payment will be separate from the regular monthly or annual payment.

An enrollment letter will provide the retiree with the guidelines and the ACH process. See the attached Instructions for Completing the SHARP Forms for additional information.

Schedule of SHARP Standard Pre-65 Medicare Benefits

January 1, 2025 – December 31, 2025

BASE MEDICAL BENEFITS

Service	Medicare Pays	SHARP Pays		You Pay	
		Base Option	MCx Option	Base Option	MCx Option
DEDUCTIBLE Services subject to deductible beyond standard Medicare deductibles are marked with (D). Separate deductibles apply to Rx Option benefits.	Medicare pays on approved services after a deductible: Medicare Part A (Inpatient) $1,676 Medicare Part B (Outpatient) $257	All Medicare approved services after member $2,100 annual deductible	Balance of Medicare approved expenses	$2,100 Annual Deductible	$0
Hospital Expenses Semi-Private Room & Board, General Nursing & Miscellaneous Services & supplies[1]					
• Days 1-60	100%	$0(D)	$0	$0(D)	$0
• Days 61-90	all but $419/day	$419(D)	$419	$0(D)	$0
• Days 91-150	all but $838/day	$838(D)	$838	$0(D)	$0
• Days over 150	$0	$0	$0	All costs	All costs
Skilled Nursing Facility Semi-Private Room & Board, General Nursing & Miscellaneous Services & supplies (Custodial Care and Nursing Home Expenses not covered)					
• Days 1-20	100%	$0(D)	$0	$0(D)	$0
• Days 21-100	All but $209.50/day	$209.50(D)/Day	$209.50/Day	$0(D)	$0
• Days over 101	$0	$0(D)	$0	All costs	All costs
Outpatient Medical Services					
• Outpatient services	80%	20%(D)	20%	$0(D)	$0
• Blood (first 3 pints)	$0	100%	100%	$0	$0
• Colostomy/Ileostomy Supplies	$0	80%	80%	20%	20%
• Medical Supplies	$0	80% up to $500/year	80% up to $500/year	20% (100% over $500 limit)	20% (100% over $500 limit)
• Mental Health	80%	20%(D)	20%	$0(D)	$0
• Hospice Care (physician must certify as a terminal illness)	100%	$0(D)	$0	$0(D)	$0
• Foreign Travel Emergency ($1000 separate deductible)	Not Covered	80% up to $50,000/year(D)	100% up to $50,000/year(D)	20% (100% over $50,000 limit)(D)	$0 (100% over $50,000 limit)(D)
• Orthotics/Orthopedic Shoes	$0	80% up to $600/year	80% up to $600/year	20% (100% over $600 limit)	20% (100% over $600 limit)
• Home IV Therapy	80%	20%(D)	20%	$0(D)	$0

[1] Services not approved by Medicare will be denied by the Plan.

DVH (Dental, Vision, and Hearing) Option Benefits

Service[2]	Annual SHARP Payment Limit	SHARP Pays	You Pay
		DVH Option	DVH Option
Dental	$2,200 per person per year	80%	20%
Vision	$400 per person per year	80%	20%
Hearing	$2,200 per person per year	80%	20%

[2] Subject to the payment restrictions described in the Dental, Vision, Hearing (DVH) Option section of this document.

Rx (Prescription Drug) Option Benefits

Prescription Drug	
Annual Deductible – Individual/Family	$400 / $800
Annual Out-of-Pocket Maximums – Individual/Family	$1,600 / $3,200
Prescription copayment responsibility	
30-Day Supply – Short-Term Drugs Tier 1 – Generics $12 Tier 2 – Preferred Brand $29 Tier 3 – Non-Preferred Brand $45 Specialty Drugs – prior authorization required	90-Day Supply – Long-Term Maintenance Drugs (via Walgreen's Smart90, Express Scripts Home Delivery, or Accredo Specialty Pharmacy) Tier 1 – Generics $29 Tier 2 – Preferred Brand $70 Tier 3 – Non-Preferred Brand $110 Specialty Drugs – prior authorization required

- The Rx Option only covers formulary supplies/services received from Express Scripts, Inc. (ESI) or from a pharmacy contracted with ESI.

- Maintenance prescriptions up to 90-day supply are available only via Walgreen's smart 90 program, Express Scripts home delivery, or Accredo specialty pharmacy.

- Preventive prescriptions drugs are 100% covered by the plan provided by ESI or a pharmacy contracted with ESI (as described in the section of this document entitled Preventive Care Services – Prescription Drugs in Appendix A).

- Specialty drugs can only be filled via mail order through Accredo Specialty Pharmacy (see www.accredo.com for details). The copayment for specialty drugs is the same as other traditional prescription drugs as listed in the chart above, with the exception for drugs available through the SaveonSP specialty drugs program.

- SaveonSP Specialty Drug list may be found at www.saveonsp.com/adventistrisk. Coinsurance for Saveon SP drugs is set at 30%. However, if members sign up for the SaveonSP Program, their out-of-pocket cost will be set by the Plan at $0 and they will not be required to pay anything for the drug. If members do not sign up for the SaveonSP Program, then they will not have their out-of-pocket cost set by the Plan at $0 and will have to pay a high coinsurance (30%) for the drug (which is eligible for assistance from the drug manufacturer), and any

amount you pay will not apply to your *Plan* deductible or your *Plan* prescription drug out-of-pocket maximum.

- Shingles Vaccines are 100% covered by the Rx Option (you pay $0).

SHARP Less than Age 65 with Medicare as Primary Coverage Options and Costs

SHARP – less than age 65 with Medicare as primary coverage Option is only available to members who have met the eligibility requirements as noted in the Eligibility section of this document. SHARP – less than age 65 with Medicare as primary coverage can be selected in combination with each other (Base Option, DVH Option and Rx Option)

The deductibles, payment percentages and other limits for each SHARP Option are illustrated on the Schedule of SHARP – less than age 65 with Medicare as primary coverage benefits on the preceding page.

The Base Option has an ***annual*** deductible of $2,100 per person. The provisions of SHARP – less than age 65 with Medicare as primary coverage do not restrict members to seeking services within a provider network.

The following four SHARP Options with 2025 costs are:

- Base (Medicare Extension) Option: $60/month/person
- DVH (Dental, Vision and Hearing) Option: $107/month/person
- MCx (Medicare Extension) Option (no new enrollments): $225/month/person
- Rx (Prescription Drug) Option: $159/month/person

Married members, who meet the SHARP – less than age 65 with Medicare as primary coverage eligibility requirements may select from the three SHARP-less than age 65 with Medicare as primary coverage Option independently of each other.

The SHARP Base and MCx Options require enrollment in original Medicare Part A and Part B. A retiree who does not enroll in Medicare Part B is not eligible to enroll in the Plan. Except in the case of certain preventive care services described in Appendix A, Medicare must first approve the medical service and the amounts charged and pay its portion before SHARP reimbursement will be made. **If Medicare does not approve an expense, SHARP – less than age 65 with Medicare as primary coverage does not cover the expense.**

Current information about Medicare can be obtained at the Medicare website; www.medicare.gov or by calling Medicare at 1-800-633-4227.

Medical Benefits: Base and MCx Options

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

- Base Option is subject to an annual deductible

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

For payment percentages and limits, see the SHARP – less than age 65 with Medicare as primary coverage Schedule of Benefits.

Covered Expenses

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

SHARP – less than age 65 with Medicare as primary coverage generally provides reimbursement for Medicare Part A (hospital) deductible and the Medicare Part B (medical/outpatient) deductible and coinsurance for Medicare-approved medical expenses, including:

a. Medicare hospitalization deductible
b. Medicare outpatient annual deductible
c. Medicare coinsurance for hospital days 61 – 90
d. Medicare coinsurance for hospital days 91 – 150
e. Skilled nursing facility days 21 – 100
f. Preventive Services described in Appendix A

Excluded Expenses

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

a. Expenses not approved by Medicare,
b. Expenses that exceed Medicare limits and maximums,
c. Expenses for nursing home care and custodial care, and
d. Expenses for skilled nursing facility charges for stays exceeding Medicare limits.

Base and MCx Option – Coverage Exceptions:

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

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

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

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

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

statement of medical necessity, shoe-fitting documentation and a copy of the Medicare denial.

6. **Support stockings**: not covered.
7. **Wigs**: SHARP will cover only under specific conditions with a plan year maximum of $1,000.
8. **Preventive Care**: SHARP will cover certain preventive care services not otherwise covered by Medicare as described in Appendix A.

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

Foreign Travel Emergency Medical Benefit

Foreign travel emergency medical benefit is provided under both the Base and MCx Options of SHARP-less than age 65 with Medicare as primary coverage. All claims must be translated into English and be submitted to the ARM claims office address found on the back of the SHARP ID card.

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

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

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

- 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

SHARP Rx (Prescription Drug) Option

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

The Rx Option benefit provides coverage for the following:

- Prescription drugs, which under applicable state law, may only be dispensed by written prescription of a physician or dentist and are included in the formulary of your pharmacy benefit manager (see below).
- Diabetic supplies, including syringes and test strips.
- Compounds with National Drug Code (NDC) ingredients. (Compounds without NDC ingredients are not covered.)

Formulary, Pharmacy Levels and Drug Tiers

ESI uses a national preferred formulary. The formulary encourages members to use clinically appropriate drugs while helping to manage costs. A formulary is a list of drugs covered through the pharmacy benefit and presented in different therapy classes used to categorize or group the drugs on the formulary. The classes group drugs which are considered similar by the disease they treat or by the effect they have on the body.

Prescription drug coverage under the SHARP Plan is offered through two different pharmacy levels: 30-day for short term drugs; and 90-day Mail Order or Walgreens Smart90 retail program for long term maintenance drugs. Your copayments will be lowest if you use 90-day Mail Order or the Walgreens Smart90 retail program. If you choose to purchase long-term maintenance drugs at retail pharmacies for 30 days' supply at a time rather than via mail order or Walgreen Smart 90 retail program, after three purchases of the same drug, you will have to pay the difference in the cost between the price of the drug at the retail pharmacy and the price of the drug charged by the mail order home delivery program (and this difference will not accrue toward your plan year out of-pocket maximums or deductibles). For a list of long-term maintenance drugs that are subject to this rule, please contact the ESI Member Services Department at 800-841-5396.

Within each formulary category, there are three drug tiers, or levels:

Generic (Tier 1):
A generic drug is a safe, effective drug approved by the U.S. Food and Drug Administration (FDA) that also costs less. You pay the lowest copayment for generic drugs.

Preferred Brand (Tier 2):
Preferred formulary brand drugs cost less than the non-preferred brand drugs. The copayment for the preferred brand drugs is higher than it is for generic drugs.

Non-Preferred Brand (Tier 3):
Non-preferred formulary brand drugs are brand name drugs that have the highest copayment under the ESI national preferred formulary.

The ESI formularies are developed to be clinically sound and cost effective. Clinical appropriateness is the foremost consideration; however, **the prescribing physician has the final decision regarding a patient's drug therapy**. If your physician believes you should use a non-formulary drug because of medical necessity, he or she can request a coverage review by visiting Express Scripts' online portal, esrx.com/PA.

Cost Containment Rules for Prescriptions

1. **Prior Authorization**: As part of the SHARP RX Option prescription drug plan, Express Scripts needs to ensure that medications are dispensed in a safe and appropriate manner. As a result, certain medications may not be covered under SHARP without a review (referred to as "prior authorization"). SHARP participates in Express Scripts' utilization management program which manages the list of drugs with prior authorization requirements. The select drugs with prior authorization requirements are subject to a review for medical necessity criteria, and/or any Plan restrictions set by Express Scripts or the plan administrator. If you are prescribed a drug that requires prior authorization, your pharmacy will be notified when processing your prescription. Please work with your provider to submit the additional clinical information to Express Scripts for the prior authorization review. The list of drugs that require prior authorization is subject to change at any time. Please call Express Scripts' Member Services, (800) 841-5396, or visit Express Scripts' website www.express-scripts.com for further details.

2. **Member Pays the Difference for Brand Name Drugs**: If a generic medication is available and the covered member insists on the brand name medication, the covered member will be charged the brand name co-pay in addition to the difference in cost between the brand name medication and the generic medication.

3. **Step Therapy**: SHARP participates in Express Script's' Step Therapy program which requires the covered member to first try one or more specified drugs to treat a particular condition before SHARP will cover another (usually more expensive) drug that the doctor may have prescribed. Step therapy is intended to reduce costs to the covered member and to SHARP by encouraging use of medications that are less expensive but can still treat a condition effectively.

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

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

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

Preventive Prescription Drugs

Preventive prescription drugs include the prescription drugs listed in (or included in the services listed in) 26 CFR § 54.9815-2713, or any successor regulation or statute. Such preventive prescription drugs include prescription drugs included in the following:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;

(ii) Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(iii) With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(iv) With respect to women, to the extent not described in (i) above, evidence informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive prescription drugs will not include any items or services specified in any recommendation or guideline described in (i)-(iv) above after the recommendation or guideline is no longer described in (i)-(iv) above. See Appendix A for additional information about specific preventive care services and drugs. Preventive prescription drugs may be subject to the same prior authorization and step therapy requirements as other covered prescription drugs (described above).

Smoking cessation drugs that are prescribed by a physician and approved by the plan administrator are covered with no copayment and no deductible (if received from an in-network pharmacy).

If prescribed by a physician and received directly from ESI or a pharmacy contracted with ESI, the preventive services covered under this section are covered with no cost-sharing required on your part (that is, no copayment, no coinsurance, and no deductible; this is often referred to as “first-dollar coverage”).

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

- **Express Scripts Home Delivery**: Claims are automatically filed through the Express Scripts home delivery program.

- **Retail Pharmacy**: Claims are automatically filed through the retail pharmacy. The co-payment on a prescription drug claim will be paid to the local pharmacy. The Express Scripts identification card indicates eligibility for the purchase of prescription drugs. Although most pharmacies participate with Express Script’s pharmacy program, there are some that do not. If prescription drugs are purchased at a pharmacy that does NOT participate in the Express

Scripts system, members will have to pay the full cost of the prescription filled. If member needs to file a claim that did not processed through Express Scripts at a participating pharmacy, contact Express Scripts at 800-841-5396 to obtain a form for direct reimbursement.

- **Home Health Medication Infusions**: Generally, these claims are covered through Medicare as primary claims as medical services. These claims should be directed to be billed to Medicare first, then remaining balance to be billed to the ARM claim office, either in the form of a paper or electronic claim, to the address listed on the back of the SHARP ID card (Refer to claim filing section below).

Coordination of Benefits

SHARP is an employer-sponsored plan for retirees. A member who enrolls in the SHARP benefits (Base, MCx, DVH and Rx Options) during the Plan year will have access to full limits and will be subject to all deductibles without pro-ration. SHARP is paid secondary to *other healthcare plans available to the member*, as indicated below:

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

SHARP DVH Coordination Rule:

SHARP is not insurance. It is a retirement healthcare benefit available to those who have met certain requirements described in this document and cannot be required to be primary for any other dental/vision/hearing benefits the retiree/spouse/dependent may be enrolled in.

SHARP Medical Coordination Rules

SHARP is *not* insurance. It is a retirement medical benefit available to those who have met certain requirements described in this document and it cannot be required to be primary for any other healthcare benefits the retiree may be enrolled in (including an employer insurance plan, a retiree supplemental insurance plan, a Medicare Advantage or HMO plan, a retiree supplemental reimbursement program for Medicare Part B premium, an auto policy or Worker's Compensation, etc.). SHARP will coordinate with all other plans where it has secondary or tertiary responsibility. Total payments between SHARP and another plan will not exceed SHARP's 80% payment responsibility as if SHARP had been primary.

Medicare is primary for all medical services for a covered member who is less than age 65 and has qualified for Medicare Part A and Part B under Social Security disability rules. Each medical service must first be approved, and its portion paid by Medicare before it is considered for payment by SHARP. Except for certain preventive services described in Appendix A, services not approved and paid for by Medicare are generally not covered by either the Base or MCx Option.

Medicaid

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

Filing Claims

Timely Filing Requirements

All medical, prescription drug, dental, vision and hearing claims must be filed within one year of the date of service. Misplaced or uncashed reimbursement checks are not re-issued after more than 12 months after the date of issue. Claims that are first submitted to Medicare and are delayed by Medicare claims processing will be considered to have been filed on a timely basis if they are received within one year from the date that Medicare pays the claims. Claims filed late will not be reimbursed. Upon enrollment, the Eligible Retiree will receive a SHARP ID card indicating the medical Options selected. Healthcare providers may bill ARM directly.

Paper Claims Address (on the SHARP ID card):

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

Electronic Claims Address (on the SHARP ID card):

WebMD/Envoy Payer ID 75261 CMS Crossover Enabled

Prescription Claims must be submitted per the guidelines of Express Scripts. You can contact them at 1-800-841-5396 for more information.

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

DVH Claims must be filed within one year of the date of service. Misplaced or uncashed reimbursement checks are not re-issued after more than 12 months after the date of issue. DVH providers may bill ARM directly.

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

Appeals Process

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

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

Questions about claims can be resolved by contacting Adventist Risk Management, Inc. (ARM), at P.O. Box 1928 Grapevine, TX 76099-1928. The customer service number is 1-800-447-5002.

Any appeal must be submitted within the timeline of 12 months from the date of service for the claim.

Adventist Retirement Appeals Procedures

The following appeal procedures apply to SHARP eligibility or SHARP – less than age 65 with Medicare as primary coverage claims denied for benefits under SHARP. Plan information may be downloaded[1] by Eligible Retirees and Eligible Spouses. The documents are maintained and amended from time to time by the Adventist Retirement Board, under authority delegated to it by the NAD.

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

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

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

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

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

- Need-based enhancement of benefits

Review Process

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

- Level I: Plan Administrator
- Level II: SHARP Committee
- Level III: Retirement Appeals Committee

Level I Appeal

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

Attn: Administrative Appeal
Adventist Retirement
9705 Patuxent Woods Drive
Columbia, MD 21046

The appeal request should include the claimant's name, address, contact phone number, email address and last four digits of the covered member's social security number. If a claimant is an authorized representative of the Eligible Retiree or Eligible Spouse/Eligible Dependent, the claimant must present evidence of his or her authority to act on behalf of the Eligible Retiree or Eligible Spouse/Eligible Dependent.

The claimant should also include a copy of SHARP's initial claim or eligibility determination and the basis upon which the appeal is being made. If appropriate, this information will include a reference to SHARP or policy provisions which the claimant believes supports his or her claim for benefits. The claimant may also submit any other information to the Plan Administrator in support of the claimant's position.

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

Level II Appeal

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

Secretary, SHARP Committee
Adventist Retirement

9705 Patuxent Woods Drive
Columbia, MD 21046

The appeal must be sent in writing to the applicable address above within 45 days of the date of the Level I appeal determination notification. The appeal must include a description of the basis of SHARP policy upon which the appeal is being made.

A claimant may submit any additional written documentation in support of his or her claim but is not permitted to appear in person before the committee. The SHARP Committee generally will not consult an independent medical examiner to review a claim; however, a claimant may submit any additional evidence in support of his or her position with respect to the claim, including the opinion of a medical examiner.

The SHARP Committee generally meets on a quarterly basis and will review the facts of the determination to determine whether the Level I response was appropriate and in accordance with the terms of SHARP. The SHARP Committee will consider the appeal at the next scheduled meeting which occurs so long as the appeal information is received at least 10 days prior to the date of the regularly scheduled meeting.

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

Level III Appeal

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

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

Chairman, Retirement Appeals Committee
Adventist Retirement
9705 Patuxent Woods Drive
Columbia, MD 21046

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

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

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

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

The external claim appeal process for SHARP is administered through Adventist Risk Management, Inc.

Health Insurance Portability and Accountability Act Provisions (HIPAA Privacy Policy)

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"). In this HIPAA Privacy Policy, certain terms are used differently than in other Sections of the SPD:

- The terms "you" and "your" refer to the Plan member/enrollee (including a dependent enrollee).
- "Plan sponsor" means the North American Division of Seventh-day Adventists (NAD).
- "Plan Administrator" means ARM.
- 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 healthcare to you or
    3. past, present, or future payment for healthcare.

HIPAA allows medical information, including PHI, to be disclosed by the Plan to the plan sponsor and to be used by the plan sponsor in certain circumstances. The permitted disclosures are as follows:

1. The Plan may disclose to your employer (the plan sponsor), and your employer may use, information on whether your or your dependents are participating in the Plan or enrolling or dis-enrolling in the Plan.

2. The Plan may disclose to your employer de-identified claims information (e.g., information that is stripped of all information that could be used to identify the individual incurring the claim) in order to facilitate your employer's obligation to fund claims incurred you or your dependents under the Plan.

3. The Plan may disclose summary health information (information that summarizes claims history, claims expenses or types of claims experienced by Plan members) to the employer if they request the summary information for the purpose of

    a. obtaining premium bids for providing insurance coverage; or

    b. modifying, amending, or terminating the Plan ("Summary Information").

    The employer may use Summary Information so received from the Plan only for these two listed purposes.

4. While the Plan is permitted to disclose PHI to the your employer (the Plan sponsor), and your employer may use PHI, to carry out plan administration functions, such as activities described below, the Plan generally does not disclose PHI to the your employer. Rather, ARM carries out these functions:

    a. obtaining employee-share contributions or to determining or fulfilling responsibility for coverage and provision of benefits under the Plan

    b. payment for or obtaining or providing reimbursement for healthcare services – Payments under this Plan generally are made either to the healthcare provider or to the employee. All Members should be aware that the Plan will be providing PHI concerning all dependents of an employee to the employee as part of the Explanation of Benefits and when reimbursing the employee for covered services under the Plan. If there is some reason why a dependent (spouse or child) of an employee does not want the employee to receive PHI, the dependent should so inform his or her healthcare provider and should also contact the plan administrator

    c. determining eligibility for the Plan or eligibility for one or more types of coverage or benefits provided under the Plan

    d. coordination of benefits or determinations of copayments or other cost sharing mechanisms

    e. adjudication and subrogation of claims, billing, claims management, collection activities and related healthcare data processing

    f. payment under a contract for reinsurance

    g. review of healthcare services with respect to medical necessity, coverage under the health plan, appropriateness of care, or justification of charges

h. utilization review activities, including pre-certification and preauthorization of services and concurrent and retrospective review of services

i. disclosure to consumer reporting agencies of any of the following PHI regarding collection of premiums or reimbursement: name and address, date of birth, Social Security Number, payment history, account number and name and address of the health plan

j. medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs

k. business planning and development, such as conducting cost-management and planning-related analyses relating to managing and operating the Plan, including formulary development and administration and/or the development or improvement of methods of payment

l. resolution of internal grievances

m. prosecution or defense of administrative claims or lawsuits involving the Plan or plan sponsor

n. conducting quality assurance and improvement activities, case management and care coordination

o. evaluating healthcare provider performance or Plan performance

p. securing or placing a contract for reinsurance of risk relating to healthcare claims, other activities relating to the renewal or replacement of stop-loss or excess of loss insurance

q. contacting healthcare providers and patients with information about treatment alternatives.

These uses and disclosures are consistent with HIPAA Regulations.

As the plan sponsor, NAD has agreed to the following restrictions:

1. The plan sponsor will not use or further disclose the PHI except as described above or as otherwise required by law.

2. Any agents or subcontractors of the plan sponsor to whom the plan sponsor provides PHI will agree to the same restrictions and conditions on the use and disclosure of PHI that apply to the plan sponsor. Any agents or subcontractors of the plan sponsor to whom the plan sponsor provides electronic PHI must agree to implement reasonable and appropriate security measures to protect the information.

3. The plan sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

4. The plan sponsor will report to the Plan any use or disclosure of the PHI that is inconsistent with the permitted uses and disclosures of which the plan sponsor becomes aware. The plan sponsor will report to the Plan any security incident of which the plan sponsor becomes aware.

5. The plan sponsor will (or will cooperate with the plan administrator to) give you access and provide copies to you of your PHI in accordance with the HIPAA Regulations.

6. The plan sponsor will (or will cooperate with the plan administrator to) allow you to amend your PHI in accordance with the HIPAA Regulations.

7. The plan sponsor will (or will cooperate with the plan administrator to) make available PHI to you in order to make an accounting of PHI in accordance with the HIPAA Regulations.

8. The plan sponsor will (or will cooperate with the plan administrator to) make available its internal practices, books and records relating to the use and disclosure of PHI received from the Plan to the Secretary of Health and Human Services (or the Secretary's designee) for determining compliance by the Plan with the HIPAA Regulations.

9. The plan sponsor will, if feasible, return or destroy all protected PHI received from the Plan and retain no copies of the PHI when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

10. The plan sponsor will ensure that adequate separation between the Plan and plan sponsor is established. Only the following employees or classes of employees or other persons under the control of the plan sponsor will be given access to the PHI to be disclosed:

    a. The following officers of the plan administrator: CEO/President, VP/Chief Healthcare & Benefits Officer

    b. Employees of the plan administrator in the Healthcare & Benefits Team only

    c. The following officer of NAD: Treasurer (or his or her single designee)

11. The plan sponsor will ensure that this adequate separation is supported by reasonable and appropriate security measures to the extent that these individuals have access to electronic PHI.

12. The plan sponsor will (and will cooperate with the plan administrator to) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the plan sponsor creates, receives, maintains or transmits on behalf of the Plan, except enrollment/disenrollment information and Summary Information, which are not subject to these restrictions.

The access to and use by the employees described above is limited to the Plan administration functions that ARM (the plan administrator) performs for the Plan. This may involve sharing Plan enrollment information or de-identified information with your employer in connection with the employer's role as a plan sponsor in relation to financial liability for its employees under the Plan, but employers will not have access to any other PHI. Employees who violate this section are subject to disciplinary action by the plan sponsor, including, but not limited to, reprimands and termination.

The Plan has issued a Privacy Notice that explains the Plan's privacy practices and your rights under HIPAA. This Notice is available by contacting the Plan's Privacy/Security Officer, ARM's Vice-President, Chief Healthcare & Benefits Officer, at the following address: **Adventist Risk Management, 12501 Old Columbia Pike, Silver Spring, MD 20904 or email, privacyofficer@adventistrisk.org. The Privacy Notice is also available at http://www.AscendtoWholeness.org.**

Release of Medical Information

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

Furnishing Information

A person covered by the Plan must furnish all information needed to effect coverage under the Plan and termination or changes in such coverage. The plan administrator may require that a Member provide certain personal data (including reasonable proof of the accuracy of the data) necessary for the determination of the person's benefits. Failure to furnish the data (or proof of its accuracy) may delay the payment of benefits. Benefit payments may be adjusted to reflect correction of inaccurate or incomplete information, and an employee, other Member and/or medical provider may be required to make up any overpayments, and the Plan may make up any underpayments.

Plan Information

No Assignment of Benefits

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

Legal Actions

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

No Waiver

Failure of the Plan Administrator or SHARP to insist upon compliance with any provision of this Plan at any given time or times or under any given set or sets of circumstances shall not operate to waive

or modify such provision or in any manner whatsoever to render it unenforceable, as to any other time or times or as to any other occurrence or occurrences, whether the circumstances are, or are not, the same.

Foreign Language Notice

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

Other Plan Information

Plan Name

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

Plan Sponsor

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

Plan Documents

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

Medicare Prescription Drug Plan Information

Important Notice about the SHARP 2025 Prescription Drug Coverage (Rx Option) and the Medicare Prescription Drug Coverage

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

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

1. Medicare prescription drug coverage is available to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug

plans provide at least a standard level of coverage set by Medicare. Some Medicare plans may also offer more coverage for a higher monthly premium.

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

When Can You Join a Medicare Drug Plan?

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

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

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

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

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

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

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

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

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

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

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

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

If you go 63 continuous days or longer without prescription drug coverage that's creditable coverage (at least as good as Medicare's prescription drug coverage), your monthly premium for Medicare prescription drug coverage may go up at least 1% per month of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

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

Contact Express Scripts at 1-800-841-5396. NOTE: you will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Plan changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	December 1, 2024
Name of Entity/Sender:	Adventist Risk Management
Contact--Position/Office:	Administrator
Address:	12501 Old Columbia Pike, Silver Spring MD 20904
Phone Number:	443-391-7338

General Information

Administration

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

Plan Amendment and Termination

The Standard SHARP less than age 65 with Medicare as primary coverage Plan may be amended at any time without prior notice by a resolution of the Adventist Retirement Board. The right to amend includes the right to curtail or eliminate coverage for any treatment, procedure, or service, regardless of whether any covered employee is receiving such treatment for an injury, defect, illness, or disease contracted prior to the effective date of the amendment. Amendments may be made retroactively.

The Plan may be terminated by action of the North American Division Committee.

Plan Year

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

Glossary

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

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

"ARM" means Adventist Risk Management, Inc.

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

"Canadian Retirement Plan" means the retirement plan sponsored by the Seventh-Day Adventist Church in Canada.

"Defined Benefit Plans" means the Seventh-day Adventist Retirement Plan of the North American Division and/or the Seventh-day Adventist Hospital Retirement Plan.

"Defined Contribution Plan" means the Adventist Retirement Plan.

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

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

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

"Eligible Retiree" means a retiree of a NAD participating employer organization hired before July 1, 2020, who satisfies the requirements for eligibility described in the Eligibility section of this document.

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

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

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

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

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

"Plan Year" means the calendar year.

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

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

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

- Employees hired before January 1, 2000 with Defined Benefit Plan service shall continue to accrue service credit toward SHARP healthcare assistance.
- Employees hired between January 1, 2000 and June 30, 2020 with only Defined Contribution Plan service shall cease accruing service credit toward SHARP healthcare assistance beginning on July 1, 2020.
- Employees hired on or after July 1, 2020 are not eligible to participate in SHARP.

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

"Usual, Reasonable, & Customary Charge" ("U&C") means:

a) Medical: For eligible claims submitted for services covered under this Plan where Medicare is not primary or did not pay, the allowable charge will be based on the normal and necessary charges submitted or made for similar services or supplies provided by other providers with like experience in the same geographic area. The term "geographic area" as it applies to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a statistically representative cross-section of the level of charges. The U&C is determined using the 80th percentile of all charges for the same service or supply in the geographic area based on survey data collected and maintained.

b) Dental: For eligible claims submitted for dental services, the allowable charge will be based on the normal and necessary charges submitted or made for similar services or supplies provided by other providers with like experience in the same geographic area. The term "geographic area" means a county or such greater area as is necessary to obtain a statistically representative cross-section of the level of charges. The U&C is determined using the 80th percentile of all charges for the same service or supply in the geographic area based on survey data collected and maintained.

"SHARP" means the Supplemental Healthcare Adventist Retirement Plan and the plan benefit options described in this document

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

"Spouse" means a participant's spouse, as determined under the policies of the participating employer or parent organization of the participant.

Appendix A: Preventive Care Services

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

Covered Preventive Services for All Adults

www.healthcare.gov/preventive-care-adults/

Covered Preventive Services for Women

https://www.healthcare.gov/preventive-care-women/

Covered Preventive Services for Children

https://www.healthcare.gov/preventive-care-children/

Preventive Care Services – Prescription

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

The following list of preventive medications shall be used as a guide and should not be considered a comprehensive listing of medications available or covered without cost-sharing.

Coverage of any of the listed medications (including all over-the-counter medications) requires a prescription from a licensed health care provider and must be filled at a participating network pharmacy. Additional plan requirements may apply (i.e., pre-authorization, home delivery).

Drug or Drug Category

1. **Aspirin** – to prevent cardiovascular events; Aspirin 81 MG and 325 MG
    a. Men ages 45 to 79 years
    b. Women ages 55 to 79 years

2. **Bowel Prep Agents**; Bisacodyl, Magnesium Citrate, Milk of Magnesia, PEG 3350-Electrolyte
    a. Men and women ages >49 and <76 years of age
    b. Fill Limit: 2 prescriptions per 365 days

3. **Female Contraception Methods** – all FDA-approved methods of contraception for women; hormonal, barrier, emergency, and implanted devices including over-the-counter contraceptive methods, oral contraceptives, and contraceptive devices
    a. Women up to age 50 years

4. **Folic Acid**; Folic acid tablet 0.4 MG and 0.8 MG; prenatal vitamins with folic acid; multivitamins with folic acid
    a. Women through age 50 years

5. **Iron Supplements**; Iron (various strengths) drops, liquid, suspension, granules; chewable 0.25 MG and 0.5 MG; drops 0.25 MG and 0.5 MG; suspension
    a. Children ages 6 to 12 months who are at risk for iron deficiency anemia

6. **Oral Fluoride**; Fluoride chewable tablet 0.25 MG and 0.5 MG; Fluoride drops 0.125 MG, 0.25 MG and 0.5 MG
    a. Children older than 6 months of age through age 5

7. **Smoking Cessation**; Bupropion SR 150 MG; Chantix; Nicotine gum, lozenge, and patch (OTC products only)
    a. Men and women ages > 18 who use tobacco products

8. **Vitamin D**; Vitamin D 1,000 units or less per dose u nit; calcium with vitamin D
    a. Men and women ages >65 who are at risk of falls

9. **Breast Cancer Primary Prevention**; Tamoxifen, raloxifene, and Soltamox (Tamoxifen liquid). When prescribed for use in primary prevention of invasive breast cancer in women at high risk.

Appendix B

Important Medicare Rules You Need to Understand Relating to SHARP-Ex (age 65) and the Alight Retiree Health Solutions Enrollment: There are specific Medicare-mandated enrollment windows called "**Special Enrollment Periods**" or "**SEP**." You are limited in when and how often you can join, change, or leave a Medicare plan depending on the type of plan or certain qualifying events.

Due to some "qualifying event," usually a retiree becoming eligible for new coverage, or losing their current coverage, retirees may enroll in a new plan outside of Initial Enrollment Period or Annual Election Period. (IEP/AEP). The details depend on the specific qualifying event.

Enrolling in a Medicare Advantage Plan or Medicare Prescription Drug Plan (Part D, or PDP): Your chance to enroll begins prior to your retirement date and lasts for two (2) full months after your qualifying coverage ends.

Enrolling in a Medicare Supplement (also called a Medigap) Plan through Alight Retiree Health Solutions: You may enroll up to 63 days after the date your qualifying coverage ends with Guaranteed Issue in select plans through Alight Retiree Health Solutions. Guaranteed Issue means you cannot be denied coverage, or have a premium increase based on past or present health issues. If you had creditable coverage, the carrier also cannot exclude any preexisting conditions, with limited exceptions. Please contact Alight Retiree Health Solutions at 1-844-360-4714.

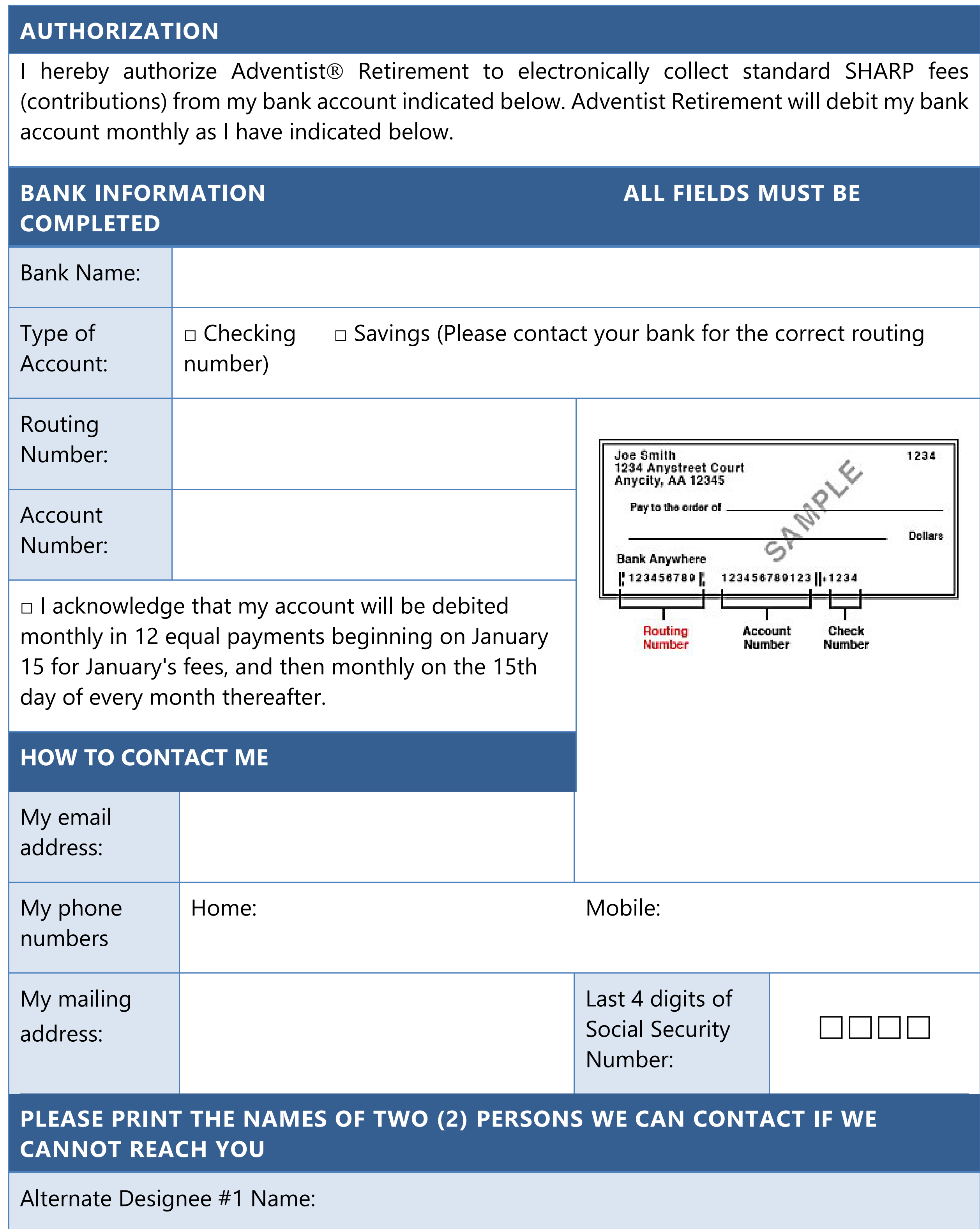
It is important to select your new plans and enroll within the appropriate time frame, to avoid a lapse in your insurance coverage.

If you are moving: You must notify Social Security of the move date to create an SEP. If you are enrolled in a Medigap plan, the plan will follow you to the new state of residence. You may pay a higher or lower premium based upon the insurance carrier offerings in that state. If you are enrolled in a Medicare Advantage plan and move out of state or to a new region within a state, you are entitled to an SEP to enroll into another Med-Advantage or Medigap plan of your choice. Again, you may pay a higher or lower premium based upon the insurance carrier offerings in that state.

Medicare Part D Late Enrollment Penalty (LEP): If you do not join a Medicare Prescription Drug Plan (PDP) when you are first eligible OR if you have a period of 63 or more days in a row without "creditable drug coverage," Medicare will assess a penalty for every month you were not covered under a drug plan. This LEP is permanent and is an amount added to your Medicare Part D monthly premium. The penalty depends on how long you went without Part D or other creditable prescription drug coverage.

Medicare Part B Late Enrollment Penalty (LEP): In most cases, if you don't sign up for Part B when you're first eligible, you'll have to pay a late enrollment penalty. You'll have to pay this penalty for as long as you have Part B. Your monthly premium for Part B may go up 10% for each full 12-month period that you were eligible for Part B but didn't sign up for it. Also, you may have to wait until the General Enrollment Period (from January 1 to March 31) to enroll in Part B. Coverage will start July 1 of that year.

Authorization Agreement For Recurring Direct Payments (ACH Debits)



AUTHORIZATION

I hereby authorize Adventist® Retirement to electronically collect standard SHARP fees (contributions) from my bank account indicated below. Adventist Retirement will debit my bank account monthly as I have indicated below.

BANK INFORMATION ALL FIELDS MUST BE COMPLETED

Bank Name:	
Type of Account:	☐ Checking ☐ Savings (Please contact your bank for the correct routing number)
Routing Number:	
Account Number:	

Joe Smith
1234 Anystreet Court
Anycity, AA 12345
1234
Pay to the order of
Dollars
Bank Anywhere
123456789 123456789123 1234
SAMPLE
Routing Number
Account Number
Check Number

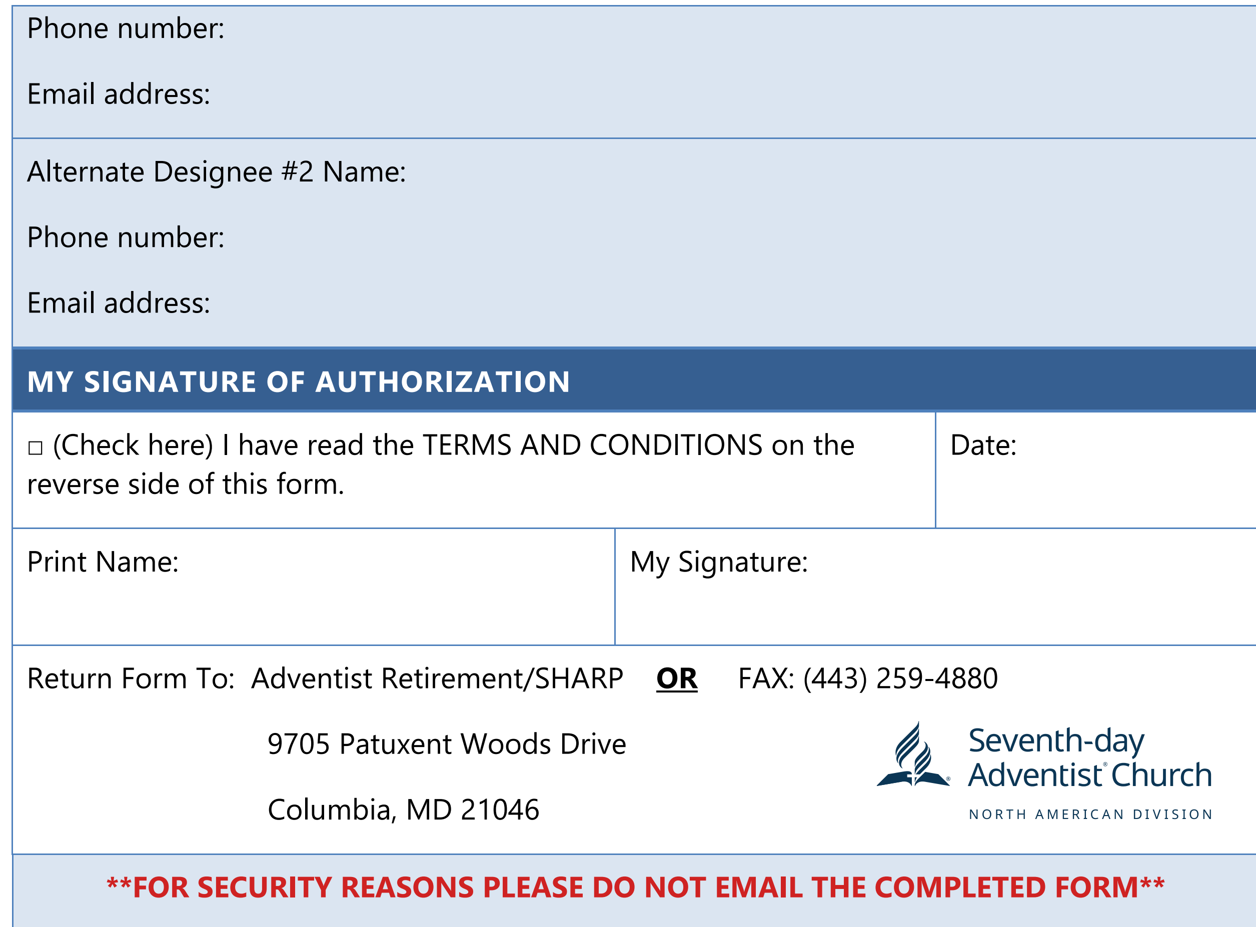
☐ I acknowledge that my account will be debited monthly in 12 equal payments beginning on January 15 for January's fees, and then monthly on the 15th day of every month thereafter.

HOW TO CONTACT ME

My email address:			
My phone numbers	Home:	Mobile:	
My mailing address:		Last 4 digits of Social Security Number:	☐☐☐☐

PLEASE PRINT THE NAMES OF TWO (2) PERSONS WE CAN CONTACT IF WE CANNOT REACH YOU

Alternate Designee #1 Name:



Phone number: Email address:		
Alternate Designee #2 Name: Phone number: Email address:		
MY SIGNATURE OF AUTHORIZATION		
□ (Check here) I have read the TERMS AND CONDITIONS on the reverse side of this form.		Date:
Print Name:	My Signature:	
Return Form To: Adventist Retirement/SHARP **OR** FAX: (443) 259-4880 9705 Patuxent Woods Drive Columbia, MD 21046 Seventh-day Adventist Church NORTH AMERICAN DIVISION		
****FOR SECURITY REASONS PLEASE DO NOT EMAIL THE COMPLETED FORM****		

Authorization Agreement For Recurring Direct Payments (ACH Debits)

TERMS AND CONDITIONS

________ Initial — Voluntary termination is only permitted per conditions outlined in the Plan document. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Adventist Retirement in writing of any changes in my account, or termination of this authorization at least 15 days prior to the next billing date.

________ Initial — SHARP fees are required to be paid in the month of receiving coverage. Persons paying monthly will have their account debited on the 15th day of the month (i.e., the fee for January 2025 coverage will be paid on January 15, 2025.)

________ Initial — If the regularly scheduled payments fall on a weekend or holiday, I understand that the payments will be executed on the next business day.

________ Initial — For ACH debits to my bank account, I understand that as these are electronic transactions, these funds may be withdrawn from my account as early as the regularly scheduled payment date (i.e., the 15th day of every month).

________ Initial — In the case of an ACH transaction being rejected by my bank for Non-Sufficient Funds (NSF) or any other reason, I understand that Adventist Retirement may attempt to process the charge again within fifteen (15) days. I agree to an additional fifteen-dollar ($15.00) charge for each transaction rejected by my bank. This additional charge will also be initiated by Adventist Retirement as an ACH transaction separate from the authorized recurring payment. I understand that Adventist Retirement is not responsible for any fees charged to me by my bank for rejected ACH transactions, whether for NSF or for some other reason.

________ Initial — If my bank rejects the first and second attempts to process a payment, I understand that my coverage will be terminated, and the termination is a lifetime termination with no opportunity for reinstatement or future coverage.

________ Initial — I acknowledge that the origination of ACH transactions to my bank account must comply with the provisions of U.S. law. I certify that I am an authorized user of this bank account and will not dispute these scheduled transactions with my bank so long as the transactions correspond to the terms indicated on this authorization form.

AdventistRetirement
9705 Patuxent Woods Drive, Columbia, MD 21046
PHONE: (443) 391-7300 FAX: (443) 259-4880

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Instructions for Completing the SHARP Forms

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

1. The SHARP form completion depends upon meeting the eligibility requirement for the SHARP or the Pre-Medicare/Non-Medicare Options. Refer to the Eligibility section of this document to determine which coverage is the correct one for your needs. **All Medicare-eligible** individuals over age 65 may only choose from the SHARP-Ex Option.
2. For each individual seeking healthcare benefits please complete the Name, Date of Birth (DOB) and Social Security Number (SSN) on the form. Use the Pre-Medicare/Non-Medicare SHARP form for those less than age 65, not Medicare eligible and dependent children. Use the SHARP – Disability status form for those less than age 65 with Medicare Part A and Part B. Enter the dollar amount for the options selected.
3. Pre-Medicare: Remember inpatient & outpatient medical benefits are separate from DVH & Rx benefits. If the Pre-Medicare retiree wishes to also have dental, vision, hearing and prescription benefits he/she *must enroll separately* using the Pre-Medicare/Non-Medicare form. Refer to the Pre-Medicare/Non-Medicare document Schedule of Benefits.
4. Non-Medicare: This coverage includes medical inpatient and outpatient expenses, dental, vision, hearing and prescription drugs as described within the policy. Refer to the Pre-Medicare/Non-Medicare document Schedule of Benefits.
5. Total ALL monthly selections.
6. If the retiree meets the eligibility requirements refer to the Earned Credit Table in the Earned Credit section. Enter the Earned Credit for the retiree, spouse and dependent child. Remember, only spouses who are eligible on the date the retiree has retired are eligible for the Earned Credit. Special enrollees are not eligible for Earned Credit.
7. Add the total cost of all Options selected. Subtract the Earned Credit if eligible. The "Total" will be the monthly cost for the retiree's elected benefits.
8. For each individual who selects SHARP Options, Step 6 should be completed.
9. **Read all conditions carefully and sign the form**. Return the form within **30** days of retirement to the SHARP Office for processing. If there is no signature, the application and enrollment will NOT be processed.
10. For assistance with the enrollment process please contact the SHARP Office at: 443-391-7338 Monday–Thursday / 8 a.m. – 5 p.m. Eastern Standard Time.

2025 SHARP ENROLLMENT FORM
Disability with Medicare Only

Retiree Name: **SSN:**

	Retiree Name	Spouse Name
	DOB:	**DOB:**
	SSN:	**SSN:**
SHARP Disability with Medicare		
Base – $60/month/person		
DVH – $107/month/person		
Rx – $159/month/person		
Gross Standard SHARP Cost	$ –	$ –
Minus Standard SHARP Earned Credit	–	–
Standard SHARP Cost:	$ –	$ –
Total:		–

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

- SHARP provides BASE Medical, Dental/Vision/Hearing (DVH) and Prescription Drug (Rx) options. The BASE Medical does not include DVH and Rx, which must be selected independently.
- SHARP BASE Medical and Rx options will cease at age 65 when I will be given an opportunity to join a Medicare exchange option through Alight Retiree Health Solutions.
- My non-eligible spouse may participate in SHARP, but will receive no financial assistance towards options selected.
- SHARP's BASE Medical, Rx and DVH options include calendar year deductibles and/or maximums, neither of which will be prorated during enrollment year.
- If I do not enroll in SHARP DVH now, I will have an open enrollment upon my 65th birthday. SHARP does not provide annual or three-year anniversary open enrollments.
- Upon age 65+ enrollees must enroll directly in Medicare A and B. Medicare rules regarding delayed enrollment in Medicare B (outpatient) or Medicare D (prescription drug coverage) may result in a Medicare premium penalty. It is my responsibility to enroll with Medicare on a timely basis.
- All service credit and other information will be reviewed by the Retirement Office before finalization. A SHARP employee will contact me to step through my selections. If my address/phone changes before processing, I will contact Adventist Retirement.

Retiree Signature ______________________ **Date** ____________

Effective Date of Options Selected: ______________________

Application must be signed and returned within 30 days of retirement effective date.

Adventist Retirement
9705 Patuxent Woods Dr
Columbia, MD 21046

Phone: 443-391-7338
Fax: 443-259-4880
SHARP@nadadventist.org

Notes

Contact Information

SHARP Office – Adventist Retirement

Email (preferred method of contact):	SHARP@nadadventist.org
Phone:	1-443-391-7338
Web site:	www.adventistretirement.org
Fax:	1-443-259-4880
Address:	Adventist Retirement Attn: SHARP 9705 Patuxent Woods Dr Columbia, MD 21046

Reasons to contact the SHARP Office:
Enrollment questions, Appeals, Request replacement SHARP ID card

WebTPA/Adventist Risk Management, Inc. (ARM)

Customer Service, Claims	1-800-447-5002
Benefits & Prior-Authorization	www.webtpa.com
Claims Address:	WebTPA/Adventist Risk Management, Inc. PO Box 1928 Grapevine, TX 76099-1928
Claims Website:	https://secure.healthx.com/webtpamember.aspx

Reasons to contact WebTPA/ARM:
All claim payment issues, verification of benefits

Express Scripts

Phone and Prior-Authorization:	1-800-841-5396
Web site:	www.express-scripts.com

Reasons to contact Express Scripts:
Prior-Authorization required for certain medications, or obtain the Prescription Drug Reimbursement Form

Other

Medicare:	www.medicare.gov 1-800-633-4227
SHARP Privacy Officer	1-443-391-7301