

Plan Document Handbook

Medicare Supplement Health Plans

Benefits effective as of January 2017

The Episcopal Church Medical Trust
Our Health, Our Members, Our Church



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ABOUT THE MEDICAL TRUST

The Episcopal Church Medical Trust (Medical Trust)* maintains a series of benefit plans for the retirees (and their dependents) of the Protestant Episcopal Church in the United States of America (hereinafter referred to as the Church). We serve only ecclesiastical societies, dioceses, missionary districts, or other bodies subject to the authority of the Church. The benefit plans maintained by The Medical Trust are intended to qualify as “church plans” within the meaning of Section 414(e) of the Internal Revenue Code, and are exempt from the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The Medical Trust funds certain of its benefit plans through a trust fund, the Episcopal Church Clergy and Employees’ Benefit Trust (ECCEBT), that is intended to qualify as a voluntary employees’ beneficiary association (VEBA) under Section 501(c)(9) of the Internal Revenue Code. The purpose of the ECCEBT is to provide benefits to eligible employees, former employees, and/or their dependents in the event of illness or expenses for various types of medical care and treatment.

SERVING THE CHURCH

The Episcopal Church Medical Trust’s (The “Medical Trust” or “we/our”) mission is to balance compassionate benefits with financial stewardship. This is a unique mission in the world of healthcare benefits, and we believe that our experience and mission to serve the Episcopal Church offer a level of expertise that is unparalleled. If you have questions about any of our plans, please don’t hesitate to contact us. We’re looking forward to serving you.

For more information, please visit our website at **www.cpg.org**. Or you may call Client Services at (800) 480-9967, Monday through Friday 8:30AM to 8:00PM ET (excluding holidays).

**Church Pension Group Services Corporation is the sponsor of this benefits program and is doing business under the name “The Episcopal Church Medical Trust.”*

ABOUT THIS HANDBOOK

The Medical Trust has prepared this Plan Document Handbook to help you understand the various benefits under The Medical Trust's Comprehensive, Plus, and Premium Medicare Supplement Health Plans (referred to as the "Plans"). The Handbook also describes how to enroll in the Plans and how to make changes to your enrollment. Please read it carefully. Your benefits are affected by certain limitations and conditions that require you to be a wise consumer of health services and to use only those services you need. Also, benefits are not provided for certain kinds of treatments or services, even if your healthcare provider recommends them.

As used in this Handbook, the word "year" refers to the plan year, which is the 12-month period beginning January 1, 2017 and ending December 31, 2017. All annual benefit maximums and deductibles accumulate during the plan year. The word "lifetime", as used in this handbook, refers to the period of time you or your eligible dependents participate in any Medicare Supplement Health Plan sponsored by The Medical Trust.

The Medical Trust intends the Plans to be permanent, but The Medical Trust reserves the right to amend, modify, or terminate the Plans in any manner, at any time, with or without prior notice to you, which may result in the termination or modification of your coverage and/or the cost of that coverage. If the Plans are terminated, any plan assets will be used to pay for eligible expenses incurred prior to the Plans' termination, and such expenses will be paid as provided under the terms of the Plans prior to their termination.

This handbook contains only a partial, general description of the Plans. It is provided for informational purposes only and should not be viewed as a contract, an offer of coverage, or investment, tax, medical or other advice. There are additional sources of information, such as medical policy, that will be used in making benefit determinations. In the event of a conflict between this handbook and other official Plan documents, the official Plan documents will govern.

HOW THIS HANDBOOK CAN HELP YOU

This handbook describes The Medical Trust Medicare Supplement Health Plans and explains how these Plans coordinate with your original Medicare benefits.

This handbook also provides descriptions of:

- Medicare Advantage (and other similar) plans
- The Medicare Part D prescription drug program (Express Scripts Medicare™ (PDP) for The Episcopal Church Medical Trust (The Medical Trust))
- The Medical Trust Dental Plans
- The benefits provided through UnitedHealthcare Global Assistance, EyeMed Vision Care, Health Advocate, SilverSneakers®, and the Employee Assistance Program (EAP)

UNDERSTANDING MEDICARE SUPPLEMENT HEALTH PLANS

Choosing a Medicare Supplement Health Plan is a very important decision. You may wish to compare the supplement plans offered by The Medical Trust with plans offered by a local insurance company—often referred to as Medigap insurance policies.

This handbook will help you understand:

- What Medicare is
- What Medicare Supplement Health Plans are
- What Medicare Supplement Health Plans are not
- How Medicare Supplement Health Plans can help you
- What you need to do to enroll in one of The Medical Trust Medicare Supplement Health Plans

Whether you choose to enroll in one of these Plans is a decision only you can make. Depending on your healthcare needs and financial situation, you may choose to purchase a Medigap policy or join a Medicare managed care plan.

UNDERSTANDING DENTAL BENEFITS

You may also decide to enroll in one of three Dental Plans offered by The Medical Trust. All three plans offer in- and out-of-network benefits and are designed

to encourage preventive care. The Dental Plans are administered by Cigna Dental. For more information, refer to the Dental Plans handbook.

ELIGIBILITY

Definitions

This section defines common terms used throughout this document. Defined terms are identified throughout this document with capital letters.

Billed Group

A Participating Group or one of its congregations, schools or other bodies, including Employees and Pre-65 Retired Employees or Post-65 Retired Employees, that is billed by the Plan and responsible for paying monthly contributions. Also sometimes called a “List Bill.”

Coverage Tier

Coverage Tiers represent coverage classifications based on the number of Members covered. Contribution rates correspond to the Coverage Tier type (Single, Subscriber + Spouse/Domestic Partner, Subscriber + Child, Subscriber + Children, Family).

Denominational Health Plan (DHP)

A Church-wide program of healthcare benefit plans authorized by General Convention and administered by The Church Pension Fund (CPF), with benefits provided through the Medical Trust.

Dependent

A Spouse, Domestic Partner or Child of a Subscriber who meets the qualifications listed in the eligibility section.

Child(ren)

A Subscriber’s or Subscriber’s Spouse’s natural child, stepchild, legal ward, foster child¹, legally adopted child or child who has been placed with the Subscriber/Subscriber’s Spouse for adoption, and if Domestic Partner benefits are permitted by the Participating Group, a Domestic Partner's Child.

¹ A foster child is an individual who is placed with the Subscriber by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

Domestic Partner

Two adults who have chosen to share one another's lives in a mutually exclusive partnership that resembles marriage. The Plan requires completion of the Domestic Partnership Affidavit to confirm that the requirements of the Plan are met.

Spouse

A lawful husband or wife defined by the laws of the jurisdiction where the marriage occurred.

Surviving Child

A Child of a Subscriber who meets the qualifications listed in the eligibility section and is *enrolled in the Plan* at the time of the Subscriber's death. A Surviving Child shall also include a Child of a Subscriber born within 12 months of the Subscriber's death.

Surviving Domestic Partner

A Domestic Partner of a Subscriber who meets the qualifications listed in the eligibility section and is *enrolled in the Plan* at the time of the Subscriber's death.

Surviving Spouse

A Spouse of a Subscriber who meets the qualifications listed in the eligibility section and is *enrolled in the Plan* at the time of the Subscriber's death.

Disabled

A medically determinable physical or mental condition, which prevents an individual from engaging in substantial gainful activity and which can be of long-continued or indefinite duration.

Eligible Dependent

This definition can be found in the Eligibility for the Episcopal Health Plan (EHP), the Episcopal Health Plan (EHP) for Qualified Small Employer Exception Members (EHP SEE) and the Eligibility for the Medicare Supplement Health Plan (MSHP) sections of this manual.

Eligible Individual

This definition can be found in the Eligibility for the Episcopal Health Plan (EHP), the Episcopal Health Plan (EHP) for Qualified Small Employer Exception Members (EHP SEE) and the Eligibility for the Medicare Supplement Health Plan (MSHP) sections of this manual.

Employee

An individual whose income must be reported on a Form W-2 or an international equivalent by a Participating Group, including individuals on an approved leave of absence, short-term disability or long-term disability.

Exempt Employee

An Employee who is not subject to the overtime provisions of the Fair Labor Standards Act² or other applicable state law due to the nature of the work, education requirements of the position and salary range.

Even if a church and/or its clergy is not covered by the Fair Labor Standards Act ("FLSA"), the Medical Trust applies the term "Exempt Employee," as defined under the FLSA, for purposes of determining eligibility under the Episcopal Health Plan. If a cleric qualifies for the Learned Professional exemption under the FLSA, the cleric will be deemed exempt. The services traditionally performed by a cleric will generally qualify for this exemption if:

- 1) The cleric is paid on a salary basis (i.e., they are not paid hourly), and
- 2) The salary paid must be at least \$455/week.

Therefore, if a cleric is paid hourly or paid less than \$455/week, the cleric will be deemed non-exempt and must meet the minimum hour requirement (currently 1,000 hours per year) to be eligible for the Medical Trust Episcopal Health Plan.

Non-Exempt Employee

An individual who is entitled to overtime compensation under the Fair Labor Standards Act or other applicable state law.

Pre-65 Retired Employee

² http://www.dol.gov/whd/overtime_pay.htm. For purposes of these definitions, it is assumed that the Fair Labor Standards Act applies to the employer.

A former Employee of a Participating Group of the EHP:

- (a) who at the time of separation from active employment was either participating in the EHP or eligible to participate in the EHP as an Exempt Employee or a Non-Exempt Employee who was normally scheduled to work and was compensated for 1,000 or more hours per year, **and**
- (b) At the time of separation from employment with The Episcopal Church was at least 55 years of age, **and**
- (c) If a lay Employee has five (5) or more years of continuous service with The Episcopal Church **OR** if a cleric, has a vested benefit under The Church Pension Fund Clergy Pension Plan

Priest

An individual ordained to the priesthood in the Episcopal Church pursuant to the Constitution and Canons or a person who has been received as a Priest into the Episcopal Church from another Christian denomination in accordance with the Constitution and Canons.

Post-65 Retired Employee

Clergy:

A former Employee who:

- (a) Is age 65 or older **and**
- (b) Has a vested benefit under The Church Pension Fund Clergy Pension Plan.

Lay:

A former Employee who:

- (a) Is age 65 or older **and**
- (b) Who at the time of separation from active employment was either an Exempt Employee or a Non-Exempt Employee who was normally scheduled to work and was compensated for 1,000 or more hours per year for a minimum of 5 years **AND** either (1) Participated in a pension plan sponsored by The Church Pension Fund for a minimum of 5 years **OR** (2) is a former Employee of a Participating Group of the EHP.

Seasonal Employee

An Employee, who normally performs work during certain seasons or periods of the year, whose compensated employment is scheduled to last less than 5 months in a year and who is compensated for less than 1,000 hours per plan year.

Temporary Employee

An Employee who is scheduled to be employed for a limited time only or whose work is contemplated or intended for a particular project or need, usually of a short duration such as 3 months, and who is compensated for less than 1,000 hours per plan year.

Episcopal Church Clergy and Employee's Benefit Trust (ECCEBT)

The Plan funds certain of its benefit plans through this trust fund that is intended to qualify as a voluntary Employees' beneficiary association (VEBA) under Section 501(c)(9) of the Internal Revenue Code. The main purpose of the ECCEBT is to provide medical benefits to eligible Employees, former Employees and/or their dependents.

Group Administrator

The individual authorized by the Participating Group to administer its Employee benefits program.

Medical Life Participant System (MLPS)

The Medical Life Participant System (MLPS) is a web-based tool designed to make the administration of benefits easy and efficient. MLPS processes health and group life benefits enrollments in real time, and allows Group Administrators to view bills, payment history, create reports and generate mailing lists.

Medicare Secondary Payer (MSP)

The term used when Medicare pays secondary to an active plan covering a Medicare beneficiary

Medicare Secondary Payer (MSP)- Small Employer Exception (SEE)

An exception to the MSP rules that applies to an eligible small employer. If eligible for the SEE, Medicare becomes the primary payer and the Medical Trust will pay secondary.

Member

A Subscriber or enrolled Dependent.

Open Enrollment

The annual period of time during which Subscribers and other Eligible Individuals may elect and/or change Plans for the following plan year for themselves and their Eligible Dependents.

Active Open Enrollment

During an Active Open Enrollment, a Subscriber or Eligible Individual is required by the Plan to take specific actions to prevent any loss of coverage. An Active Open Enrollment generally takes place for a Participating Group upon first joining the Plan, when a Plan ceases to be available for the upcoming plan year or when there is a significant change to the existing Plans.

Passive Open Enrollment

During a Passive Open Enrollment, a Subscriber or Eligible Individual is not required by the Plan to take any action³. However, the Plan encourages Subscribers and Eligible Individuals to log on to the Open Enrollment website to verify demographic information and existing coverage and to update any data that are not accurate.

Participating Group

A diocese, congregation, agency, school, organization or other body subject to the authority of and/or associated or affiliated with the Episcopal Church, which has elected to participate in the Plan.

Plan(s)

The medical and dental plans (i.e. health plans) maintained by The Episcopal Church Medical Trust (the Medical Trust) for the benefit of Members. The Plan is intended to qualify as a “church plan” as defined by Section 414(e) of the Internal Revenue Code and is exempt from the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

³ Note, however, that some states may require a new signed authorization from the employee when the amount of the payroll deduction increases

Episcopal Health Plan (EHP)

A program of medical and dental Plans through which Eligible Individuals and Eligible Dependents of the Episcopal Church are provided health benefits. Benefits are provided through the Medical Trust.

Episcopal Health Plan (EHP) for qualified Small Employer Exception (SEE) Members

A program of medical Plans through which Eligible Individuals and Eligible Dependents of the Episcopal Church are provided health benefits. Benefits are provided through the Medical Trust. This plan is applicable only to those employers and individuals who apply and are certified by Centers for Medicare & Medicaid Services (CMS) as meeting the criteria to participate.

Medicare Supplement Health Plan (MSHP)

A program of supplemental medical and dental Plans through which Eligible Individuals and Eligible Dependents of the Episcopal Church are provided health benefits. Benefits are provided through the Medical Trust. A Medicare supplement plan provides coverage for medical expenses not covered or partially covered by the Original Medicare Plan (Part A and B).

It may also provide benefits for expenses not covered by the Original Medicare Plan such as pharmacy benefits and vision care. A Medicare supplement plan only works with the Original Medicare Plan, where Medicare pays first (primary) for a medical claim, and the Medicare supplement plan pays for the medical claim after (secondary) the Original Medicare Plan. The Original Medicare Plan and the MSHP only pay claims for services that are provided in the United States.

Seminarian

A full-time student, as defined by the seminary, enrolled at a participating seminary of the Association of Episcopal Seminaries.

Significant Life Event (SLE)

An event as described in the Plan Election and Enrollment Guidelines section, where as a result of the event, the Subscriber is eligible to make a mid-year

election change.

Subscriber

The primary Individual enrolled in the Plan who meets the qualifications listed in the eligibility section.

Eligibility for the Medicare Supplement Health Plan (MSHP)

The Medical Trust determines eligibility for the Plans. The employer or Group Administrator is responsible for determining whether the Employee is eligible for any employer contributions towards coverage, confirming that Members meet the eligibility criteria described below and for maintaining documentation related to the Members' enrollment and elections. The Medical Trust may request a copy of required documentation at any time. In addition, separate eligibility rules apply for the subsidy under The Church Pension Fund Clergy Post-Retirement Medical Assistance Plan. Additional details can be found in *A Guide to Benefits Under the Clergy Pension Plan* at www.cpg.org/clergyguide.

The terms Eligible Individual and Eligible Dependent, as defined below, are used throughout this document and identified with capital letters.

Eligible Individuals and Eligible Dependents must be enrolled in Medicare Parts A and B in order to enroll in the MSHP medical Plans, but not in the MSHP dental plans.

Eligible Individuals

- A Post-65 Retired Employee
- A Post-65 Retired Employee who is a retired postulant, novice or professed member of Episcopal Religious Orders, as defined in Title III, Canon 14.1⁴ who has been accepted or received by the Religious Order
- A Pre-65 Retired Employee who is Disabled

Eligible Dependents

- A Spouse or Surviving Spouse*
- A Domestic Partner or Surviving Domestic Partner
- A Disabled Dependent Child or Surviving Disabled Dependent Child, provided the disability began before the age of 25

**For information on the eligibility of a former spouse refer to the Termination of Individual Coverage, under Divorce*

⁴ The Constitution and Canons of the Episcopal Church, 2012

Important Notes

Pre-Existing Medical Conditions

Eligibility will not be denied due to an individual's health status.

Medicare Secondary Payer (MSP)

The Plan follows the government's Medicare Secondary Payer (MSP) law, which outlines when Medicare is not responsible for paying first for health claims. The government designed Medicare to provide health coverage for retired individuals. Medicare requires employers' group health plans to be the primary payer of health claims for individuals who are working. If an Employee who is 65 or older is covered under an employer-provided health plan, as defined by the employer's policy, then Medicare will not be the primary payer for health claims.

Each employer must determine its own policy outlining which Employees are eligible for employer-provided health benefits. The Plan cannot determine this policy. This policy should comply with the Age Discrimination in Employment Act (ADEA), which requires employers to offer to their over age 65 Employees and Spouses the same coverage that is offered to Employees and Spouses under age 65, regardless of their Medicare eligibility. In addition, this equal benefit rule applies to coverage offered to full-time and part-time Employees. Those Employees over age 65 who are qualified for employer-provided health benefits and meet the Plan's eligibility rules described in this section must be offered a group health plan.

Medicare beneficiaries are free to reject employer plan coverage and retain Medicare as their primary coverage. However, when Medicare is the primary payer, employers cannot offer such Employees (or their Spouses) secondary coverage for items and services covered by Medicare. Medicare states that an employer cannot sponsor or contribute to individual Medicare supplement plans or Medicare HMOs for Medicare beneficiaries who are actively employed. Therefore, the Plan does not offer Medicare supplement plans or Medicare HMOs to Employees and their Spouses over age 65.

Small Employer Exception

Medicare provides an exception from this general rule for small employers. A small employer may request Medicare to pay as primary for Medicare eligible

beneficiaries by seeking a “small employer exception.” This must be done through the Medical Trust as the employer’s health plan.

What Does the MSP Small Employer Exception Mean to the Employer and Member?

If approved, Medicare becomes the primary payer of Medicare Part A (hospital insurance) claims for clergy and lay Employees (and their covered spouses) who are age 65 or older and working for a church or other organization that employed fewer than 20 full and/or part time Employees for each working day in each of the 20 or more calendar weeks for the preceding and current year. The Medical Trust plan will continue to provide major medical coverage (such as physician office visits) for these eligible Employees. Therefore, eligible participants who elect to participate would not be required to enroll in Medicare Part B.

For more information, review the Medicare Secondary Payer (MSP) Manual at <http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html>

Working for the Church after Retirement

Regardless of the retired Employee’s status under The Church Pension Fund Clergy Pension Plan, if the Post-65 Retired Employee is eligible for employer-provided health benefits such as coverage under the EHP, Medicare prohibits the Plan from offering the Post-65 Retired Employee coverage under the MSHP. Depending upon the size of the Employer, the member may be eligible for the EHP SEE Plan.

If the Post-65 Retired Employee who is working for the Episcopal Church after retirement does not qualify for employer-provided health benefits and coverage under the EHP or EHP SEE then the Post-65 Retired Employee may be eligible to purchase the MSHP from the Plan. In this case, the Post-65 Retired Employee must be billed directly by the Plan for coverage in the MSHP and the employer cannot reimburse the Post-65 Retired Employee for the cost of the MSHP or provide any other incentive to the Post-65 Retired Employee.

Plan Election and Enrollment Guidelines

This section addresses the Plan's rules and requirements related to enrollment and election changes. Topics include effective dates, termination procedures, Significant Life Events, Open Enrollment and other procedures.

Subscriber Responsibilities

The Plan and its administrators rely on information provided by Subscribers when evaluating the coverage and benefits under the Plan. Subscribers must provide all required information (including their and their enrolled Dependent's social security number or individual taxpayer identification number) through a Medical Life Participant System (MLPS) submission or with an enrollment form to the Group Administrator.

All information provided must be accurate, truthful, and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation or incorrect information will be considered an intentional misrepresentation of a material fact and may result in the denial of a claim, cancellation or rescission of coverage, or any other legal remedy available to the Plan.

Plan Elections and Changes

Eligible Individuals make their Plan elections and Coverage Tier elections upon first becoming eligible to participate in the Plan.

Plan elections generally remain in place for the entire plan year, provided the required contributions for coverage are received by the Plan. A Subscriber may not change his/her elected Plan or Coverage Tier except during Open Enrollment, unless there is a Significant Life Event or a HIPAA Special Enrollment Event.

Important Note: the Plan does not allow a member to terminate dental coverage mid-year.

Significant Life Events

A Significant Life Event gives a Subscriber the opportunity to make a change to enrollment. The enrollment change must be made within 30 days of the event and must be consistent with the event. Significant Life Events include:

- Marital status change (e.g., marriage, divorce, legal separation or annulment of marriage)
- Qualification or termination of a Domestic Partnership (in Participating Groups offering Domestic Partner coverage)
- Change in the number of Dependents (e.g., an increase through marriage, birth, adoption or placement for adoption, or a decrease through death or Dependent gaining own health benefits)
- Change in Dependent status (e.g., becoming ineligible by reaching a limiting age)
- Change in employment status of a Subscriber or Dependent, that affects Plan eligibility (e.g. termination or commencement of employment, changing from full-time to part-time employment, commencement of or return from an unpaid leave of absence, changing from Employee to Pre-65 Retired Employee or Post-65 Retired Employee)
- Judgment, decree or order (e.g., Qualified Medical Child Support Order (QMCSO))
- Change in residence or work site for a Subscriber or Dependent that affects network access to the current Plan
 - For example, if a Subscriber previously resided in an area in which only the PPO was available and then moved into an area where the HMO and PPO are available, the Subscriber may elect a new Plan. Conversely, if a Subscriber moved out of the HMO service area, and was therefore no longer eligible for the HMO, the Subscriber may elect a new Plan.
- Significant change in cost or a significant curtailment of medical coverage during a plan year for a Subscriber or Dependent
- Medicare entitlement (or loss of such entitlement)
- Medicaid entitlement (or loss of such entitlement)
- HIPAA Special Enrollment Event (see below)
- Enrollment in or termination of a Medicare Part D Plan
- Change in employment or insurance status of Spouse
- Qualification of a post 65 actively working subscriber or subscriber's Spouse to participate in the EHP SEE

IMPORTANT NOTE: A healthcare provider's discontinuation of participation in a plan network is not a Significant Life Event and does not permit an election change.

The effective date of coverage for an election change due to a Significant Life Event is the first day of the month following the Significant Life Event (except in the case of birth or adoption). Election changes must be received by the Plan no later than 30 days after the Significant Life Event and are valid for the remainder of the current plan year.

HIPAA Special Enrollment Events

Certain Significant Life Events are considered to be Special Enrollment Events that would allow an Eligible Individual who is not covered by the Plan to enroll him/herself and his or her Eligible Dependents for coverage under the Plan outside of the Open Enrollment period. Special Enrollment Events include:

- Marriage
- Birth of a Child
- Adoption or placement for adoption of a Child
- Loss of coverage under another group health plan, including
 - The expiration of COBRA coverage if the other coverage was under a COBRA continuation provision, or
 - If the other coverage was not under COBRA,
 - Loss of eligibility for the other coverage or
 - Termination of employer contributions toward the Employee's other coverage
- Loss of eligibility for coverage in a Medicaid Plan under Title XIX of the Social Security Act or a state child healthcare plan under Title XXI of the Social Security Act, and
- Eligibility for assistance with coverage under the Plan through a Medicaid Plan under Title XIX of the Social Security Act or a state child healthcare plan under Title XXI of the Social Security Act

Eligible Individuals will generally have 30 days to enroll in the Plan after a Special Enrollment Event, but will have 60 days to enroll in the Plan as a result of a Special Enrollment Event that is a loss of eligibility for coverage under a Medicaid Plan or a state child healthcare plan or eligibility for assistance with coverage under the Plan through a Medicaid Plan or state child healthcare plan. In the case of birth, adoption or placement for adoption of a Child, coverage will be

effective retroactive to the date of the event. For all other Special Enrollment Events, coverage will be effective as of the first day of the month following the month in which the request for coverage is processed

Reporting Eligibility and Enrollment Changes

The Group Administrator must report all changes that affect Member benefit coverage and plan elections to the Plan when they occur, but no later than 30 days after the occurrence. Examples of what should be reported include:

- Demographic information change
- Dependent information change
- Employment status change
- Employer change (e.g. transfer to a new church or diocese)
- Change resulting from a Significant Life Event
- Change resulting from a HIPAA Special Enrollment Event
- Death of a Member
- Retirement of an Employee
- Billing information change

The Subscriber or Eligible Individual must notify the Group Administrator when a Significant Life Event or other enrollment change occurs. The Group Administrator should request supporting documentation regarding Dependent eligibility.

The Group Administrator must then notify the Plan through an MLPS submission or with an enrollment form within 30 days after the event. Failure by the Group Administrator to perform this task could jeopardize the Subscriber's or Eligible Individual's enrollment.

The following additional requirements also apply:

- Health Plan choice may be restricted if a Subscriber or an Eligible Individual has Eligible Dependents living outside the service area of a particular Plan.
- If a local managed care plan is elected, additional paper enrollment forms from the local plan option must be submitted to the Plan.
- Seminary Group Administrators must submit paper Enrollment Forms to the Plan instead of using the MLPS website. Forms should be mailed or faxed to Client Services.
- Pre-65 Retired Employees and Post-65 Retired Employees who do not receive any contribution assistance from the Participating Group may submit enrollment forms directly to the Plan.

- It should be noted that with Express Scripts Medicare — the Part D prescription drug coverage under the MSHP—that CMS has certain requirements, such as a 21 day opt out period, that need to be taken into consideration in the processing of enrollment paperwork. Therefore, to ensure timely access to prescription drug coverage, the enrollment form and all required materials must be received at least 3 months prior to your desired coverage effective date.

Other changes such as a change of address or phone number can and should be reported to the Plan when they occur.

Required Information and Documentation

All of the information requested on MLPS or the enrollment form (such as social security number and date of birth) is required in order for a plan election or other change to be processed.

The Participating Group is responsible for verifying a Member's personal data and may be required to provide the Plan with copies of the following documentation:

- Birth Certificate
- Social Security Card
- Individual Taxpayer Identification Number (ITIN) Card
- Marriage Certificate
- Divorce Decree
- Domestic Partnership Affidavit
- Statement of Dissolution of Domestic Partnership
- Child Affidavit
- Placement or Custody Order from social services, a welfare agency or court of competent jurisdiction
- Adoption Petition or Decree
- Medicare Card

Open Enrollment

Open Enrollment is the annual period during which Subscribers of the EHP, the EHP/SEE and MSHP and other Eligible Individuals may elect or change health Plans for the following plan year for themselves and their Eligible Dependents. Subscribers must complete the enrollment form or the Open Enrollment website, as appropriate. Generally, Open Enrollment occurs during the fall with changes becoming effective on January 1st of the following plan year.

At the beginning of Open Enrollment, Subscribers receive a personalized letter outlining the steps required to make plan election(s) or other changes for the upcoming plan year. The letter contains information about the Open Enrollment website, instructions, a personal login and password, and the dates the Open Enrollment website will be available.

The Group Administrator should notify the Plan of other Eligible Individuals who would like to take part in Open Enrollment prior to Open Enrollment. To administer this, the Plan will request a mailing list and other information in advance in order to include them in Open Enrollment.

The Open Enrollment website contains:

- Current demographic and coverage information
- Available medical and/or dental Plans
- Full contribution rates for each Plan and Coverage Tier⁵
- Options to add or remove Eligible Dependents
- The deadline for submitting plan elections
- Reference material and other helpful resources

Newly Eligible Individuals Enrollment

Newly Eligible Individuals have a period of 30 days immediately following the hire date or date the individual became part of the Participating Group to elect a health Plan for the remainder of the current plan year. Plan elections, once made, cannot be changed for the remainder of the current plan year, unless the Member experiences a Significant Life Event or HIPAA Special Enrollment Event.

⁵ Employer/Employee cost share information is not provided.

Specific Guidelines and Effective Dates of Coverage

Coverage is effective on the first day of the month following the date Eligible Individuals first become eligible to participate in the Plan or following the Significant Life Event, unless otherwise specified. Completed enrollment forms or MLPS submissions must be received by the Plan within 30 days of the event.

Pre-65 Retired Employees

A Pre-65 Retired Employee from a Participating Group who retires but is not Medicare-eligible, may continue coverage through the Episcopal Health Plan (EHP) with no change to the coverage effective date, provided an enrollment form or MLPS submission *confirming continuation of coverage and change to Pre-65 Retired Employee status* is received by the Plan within 30 days of the retirement date.

If the Pre-65 Retired Employee wants to make a plan election *change* as a result of retirement, then the coverage effective date of the new Plan will be the first day of the month following the retirement date. Elections must be received by the Plan no later than 30 days after the retirement date.

If the Pre-65 Retired Employee does not make an election change within 30 days of the retirement date, then he or she must wait for an applicable Significant Life Event or HIPAA Special Enrollment Event to occur, or wait until the next Open Enrollment period.

Once the Pre-65 Retired Employee becomes Medicare-eligible, he or she must actively switch enrollment to the Medicare Supplement Health Plan (MSHP). If the enrolled Spouse/Domestic Partner is not Medicare-eligible at that time, then the enrolled Spouse/Domestic Partner may remain in the EHP until becoming Medicare-eligible, at which time he or she too must actively switch enrollment to the MSHP. The enrolled Children who are not Disabled may remain in the EHP until the end of the year in which they reach age 30.

If the Pre-65 Retired Employee has a spouse who becomes age 65 and is not actively working, the Post-65 Retired Spouse of the Pre-65 Retired Employee is allowed to enroll in the MSHP provided he or she is enrolled in Medicare Parts A and B. The Pre-65 Retired Employee remains in the EHP. This reverse split is allowed because the Subscriber is a Pre-65 Retired Employee.

IMPORTANT NOTE: An Employee who terminates his/her employment with a Participating Group prior to meeting the eligibility requirements for a Pre-65 Retired Employee will be offered an Extension of Benefits.

Pre-65 Retired Employee, not covered under the Episcopal Health Plan (EHP)

Enrollment in the EHP for Pre-65 Retired Employees who are not currently enrolled in the EHP is limited to those who:

- a) Waived EHP coverage as a qualified opt out and have subsequently experienced a HIPAA Special Enrollment Event, or
- b) Are joining the EHP as part of a new Participating Group

For these limited circumstances, the Pre-65 Retired Employee may enroll in the EHP at the time of a HIPAA Special Enrollment Event or annual open enrollment, and remain in the EHP until such time as he or she becomes Medicare-eligible, at which time the Employee must actively switch enrollment to the MSHP. If the enrolled Spouse/Domestic Partner is not Medicare-eligible at that time, then the enrolled Spouse /Domestic Partner may remain in the EHP until becoming Medicare-eligible, at which time he or she too must actively switch enrollment to the MSHP.

The enrolled Children who are not Disabled may also remain in the EHP until the end of the year in which they reach age 30.

Health plan elections must be received by the Plan no later than 30 days after a HIPAA Special Enrollment Event.

Post-65 Retired Employees

The effective date of coverage for the MSHP for a Post-65 Retired Employee is the first day of the month in which he or she turns age 65, provided that he or she is enrolled in Medicare Parts A and B and meets the eligibility requirements of the Plan.

If the Post-65 Retired Employee does not enroll when initially eligible, then he or she must wait for an applicable Significant Life Event or HIPAA Special Enrollment Event to occur, or wait until the next Open Enrollment period.

Dependents

The effective date of coverage for an Eligible Dependent is the same date as the Subscriber's effective date. If the Subscriber does not enroll all Eligible Dependents within 30 days of a Significant Life Event or HIPAA Special Enrollment Event, then the Eligible Dependents may not enroll until the next Open Enrollment period or until another Significant Life Event or HIPAA Special Enrollment Event occurs.

New Children

A Subscriber's newborn Child is temporarily covered under the Plan for the first 30 days immediately following birth. However, the Subscriber must enroll the new Child for coverage within 30 days of the birth in order for coverage to continue beyond the 30-day period and to ensure claims incurred during the first 30 days are covered. The coverage effective date will be the date of birth. If applicable, monthly contribution rates will change to reflect the new Coverage Tier on the first day of the month following the date of birth. If a properly completed enrollment form or MLPS submission is not received by the Plan within the 30-day period, the Child may not be enrolled in the Plan until the next Open Enrollment period or the occurrence of a subsequent Significant Life Event or HIPAA Special Enrollment Event.

Adopted Children

Upon timely notification, coverage for the Child will be effective on the date of adoption, or, if earlier, placement for adoption. The Plan will consider a Child placed for adoption as eligible for enrollment on the date when the Subscriber becomes legally obligated to support that Child prior to that Child's adoption. If the Subscriber does not enroll the Child within 30 days of that date, then the Child may not enroll until the next Open Enrollment period or until a subsequent Significant Life Event or HIPAA Special Enrollment Event occurs. If a Child placed for adoption is not adopted, all health coverage ceases when the placement ends and will not be continued. The Plan will only cover expenses incurred

by the birth mother, including the birth itself, if the birth mother is an enrolled Member on the date of birth.

Domestic Partners

A Subscriber may enroll his/her eligible Domestic Partner for coverage under the Plan if the subscriber meets the Plan's eligibility requirements. The Plan requires a signed affidavit attesting to the Domestic Partnership. If the Subscriber does not enroll his/her eligible Domestic Partner within 30 days after submission of a valid Domestic Partner Affidavit, then the eligible Domestic Partner may not enroll until the next Open Enrollment period or until a Significant Life Event or HIPAA Special Enrollment Event occurs.

Non-Medicare-eligible Dependents

A Post-65 Retired Employee and his/her Eligible Dependents may split enrollment between the EHP and the MSHP in cases where the Post-65 Retired Employee is eligible for Medicare and the Dependents are not eligible for Medicare and are under age 65. Eligibility in the EHP will end once the Spouse/Domestic Partner becomes Medicare eligible and/or reaches age 65, at which time, he or she must actively switch enrollment to the MSHP. The Subscriber's enrolled Children who are not Disabled may continue to participate in the EHP until the end of the year in which they reach age 30.

Disabled Children

If the Dependent Child is Disabled prior to his/her 25th birthday and continues to be Disabled on the last day of the year in which the Child reaches age 30, the Child's eligibility will be extended for as long as the parent is a Subscriber, the disability continues and the Child continues to meet the Plan's eligibility requirements in all aspects other than age.

Satisfactory proof of disability must be submitted to the Plan within 30 days after the end of the month in which the Child reaches age 25. The Plan may require, at any time, a physician's statement certifying the physical or mental disability.

Children of Surviving Spouses of Limited Means

The Children's Health Insurance Program (CHIP)⁶, is a federal program through which the government assists states in providing affordable health insurance to families with Children. The program was designed with the intent to offer health coverage to uninsured Children in families with incomes that are modest but too high to qualify for Medicaid.

Surviving Spouses of limited means may find it more financially advantageous to cover their minor Children through CHIP or minor and adult dependent Children through Medicaid. For such persons, Surviving Spouses may opt to (1) cover their minor Children or adult dependent Children in a government plan, (2) decline coverage from the Plan for the dependents so covered, and (3) retain the eligibility to re-enroll these dependents should they lose coverage under the government plan on account of (i) bankruptcy or termination of the government plan, (ii) loss of eligibility under the government plan due to income changes, or (iii) other loss of eligibility for the government plan, not including reaching a limiting age. Dependents must satisfy all other eligibility criteria of the Plan in order to re-enroll. See the HIPAA Special Enrollment section for more details.

Children Subject to a Qualified Medical Child Support Order (QMCSO)

A QMCSO is a judgment, decree or order (including approval of a settlement agreement) or administrative notice that is issued pursuant to a state domestic relations law (including a community property law) or through an administrative process, which directs that a Child must be covered under a health plan. The Plan has delegated to the applicable Participating Group the responsibility to determine if a medical child support order is qualified. If the Participating Group determines that a separated or divorced Spouse or any state child support or Medicaid agency has obtained a QMCSO, and if the Participating Group offers dependent coverage, the Plan will allow the Subscriber to provide coverage for any Children named in the QMCSO.

To be qualified, a medical child support order must satisfy all of the following:

⁶ The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA or Public Law 111-3) reauthorized the Children's Health Insurance Program (CHIP). CHIPRA finances CHIP through FY 2013

- The order recognizes or creates a Child's right to receive group health benefits for which the Subscriber is eligible.
- The order specifies the Subscriber's name and last known address and the Child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the Child's mailing address.
- The order provides a description of the coverage to be provided or the manner in which the type of coverage is to be determined.
- The order states the period to which it applies.
- If the order is a National Medical Support Notice, it meets the requirements above.

The QMCSO may not require the Plan to provide any type or form of benefit or option not otherwise provided under the Plan.

Children of a Subscriber who must be covered under the Plan in accordance with a QMCSO will be covered beginning on the date the order is approved and continuing until the date or age stipulated. However, Children may not be covered beyond the eligibility age permitted under the Plan.

If a QMCSO requires that the Subscriber provide health coverage for his/her Children and the Subscriber does not enroll the Children the Participating Group will enroll the Children upon application from the Subscriber's separated or divorced Spouse, the state child support agency or Medicaid agency, provided it is required to do so by law. The Participating Group will withhold from the Subscriber's pay his/her share of the cost of such coverage.

If a QMCSO requires a separated or divorced ex-Spouse of a Subscriber to cover a Child, the Subscriber may change elections and drop coverage for the Child. However, the Subscriber may not drop coverage for the Child until the other plan's coverage begins. Subscribers may not otherwise drop coverage for a Child covered pursuant to a QMCSO unless they submit written evidence to the Participating Group that the QMCSO is no longer in effect.

Termination of Individual Coverage

Coverage ends the earliest of:

- The last day of the month in which:
 - The Subscriber no longer meets the eligibility requirements (e.g. Employee resigns or Seminarian graduates from seminary)

- The Dependent no longer meets the eligibility requirements for any reasons other than death or turning age 30 (e.g. Spouse is no longer eligible due to divorce or Subscriber ceases to be a Dependent's legal guardian)
- Monthly contributions cease
- The Participating Group's participation with the Plan terminates
- The last day of the year in which an enrolled Dependent Child reaches age 30, except if the Child is Disabled in accordance with the terms of the Plan
- The date the Plan ceases to exist

Coverage termination dates resulting from a Significant Life Event where a Subscriber loses or declines coverage will be the last day of the month in which the Significant Life Event occurred, unless otherwise specified.

Death and Surviving Dependents

Post-65 Retired Employee or Pre-65 Retired Employee

When a Post-65 Retired Employee enrolled in MSHP or a Pre-65 Retired Employee enrolled in the EHP dies, the Surviving Spouse or Surviving Domestic Partner who is also enrolled in the EHP can remain covered until he or she becomes Medicare-eligible, at which time he or she must actively enroll in the MSHP if eligible. His/her enrolled Children may remain in the EHP until the last day of the year in which they turn 30 or later if the Child is Disabled in accordance with the terms of the Plan. If the Surviving Dependents leave the EHP, they may not return to the Plan, unless they are eligible to enroll in the MSHP. Surviving Spouses and Surviving Domestic Partners enrolled in the MSHP at the time of Member's death can remain covered in the MSHP.

The coverage termination date will be the last day of the month in which the Subscriber's death occurred. The new coverage effective date for the Surviving Dependents will be the first day of the month following the Subscriber's death date.

If a Surviving Spouse remarries, any new Dependents acquired after the primary Subscriber's death are ineligible for coverage under the Plan, unless the Dependent is a Child of the Subscriber born up to 12 months after the Subscriber's

death. The same rules apply to Surviving Domestic Partners who engage in a new Domestic Partner relationship.

Dependents

If an enrolled Dependent dies, the termination date for the deceased Dependent is the end of the month in which the death occurred. The Subscriber's Coverage Tier and associated monthly contribution may change as a result, beginning on the first day of the month following the death date.

Divorce

The divorced Spouse and/or Subscriber must notify the Participating Group and the Plan of events that may cause a loss of coverage. The coverage termination date is the last day of the month in which the relationship was officially terminated.

Post-65 Retired Employees or Pre-65 Retired Employee with Dependents under age 65

The Pre-65 Spouse or Domestic Partner enrolled in the EHP who gets divorced from a Post-65 Retired Employee or Pre-65 Retired Employee can stay enrolled in the EHP. However, if the Spouse or Domestic Partner leaves the EHP, then he or she cannot enroll again with the Plan until he or she becomes eligible for the MSHP. He or she can leave the MSHP and join again at future Open Enrollment periods.

Post-65 Retired Employees or Pre-65 Retired Employees with Dependents in the MSHP

The Spouse or Domestic Partner enrolled in the MSHP who gets divorced from a Post-65 Retired Employee or Pre-65 Retired Employee can stay enrolled in the MSHP. He or she can leave the MSHP and join again at future Open Enrollment periods.

IMPORTANT NOTES

Required Monthly Contributions

The Plan does not pro-rate contribution requirements for any health Plan regardless of the termination date or the effective date. Any monthly contribution rate change will be effective the first day of the month following the change. Contributions for coverage with a retroactive effective date must be paid upon enrollment.

One Type of Coverage

The Plan prohibits two Members who are each enrolled from covering each other in the same Plan (EHP, EHP SEE or MSHP). Therefore, an individual may not participate in the Plan as a Subscriber and as a Dependent in the same Plan. If two Members both work for the Episcopal Church in Participating Groups who offer different Plans, an individual may enroll as the Subscriber in one and as a Dependent in the other (e.g. Subscriber in medical Plan, Dependent in dental Plan).

Certificate of Creditable Coverage

HIPAA requires the Plan to provide a Certificate of Creditable Coverage automatically and free of charge when a Member loses coverage under the Plan. The Plan will also provide a Certificate of Creditable Coverage, free of charge upon request by a Member or any time within 24 months after a Member's coverage ends. The Certificate of Creditable Coverage is a document that shows prior periods of coverage under the Plan. In addition to standard identification information, the Certificate will include the date on which coverage under the Plan began and ended.

ENROLLMENT

INITIAL ENROLLMENT

Initial enrollment occurs when you enroll in a Medical Trust supplement plan for the first time. Once you have received confirmation of enrollment in Medicare Part A and Part B AND you have retired, you have 30 days to enroll in a Medical Trust Medicare Supplement Health Plan.

OPEN ENROLLMENT

Open Enrollment is a period of time during which you may choose the health plan you will be enrolled in for the following calendar year. For example, if you are enrolled in the Premium Plan and you would like to switch to the Comprehensive Plan, you may do so during the open enrollment period. Once you have enrolled and the benefit year has begun, you will remain in the Plan you've elected until the next open enrollment period (as long as you continue to be eligible for coverage and contributions are paid, if any are due).

Open Enrollment for the 2017 plan year is October 13 – December 7, 2016.

SIGNIFICANT LIFE EVENTS

Your Plan enrollment election remains in place for the entire 12-month benefit year except as otherwise described in this handbook. You are allowed to change your enrollment elections during a benefit year if you have a significant life event and you notify your group/diocesan administrator or The Medical Trust within 30 days of the event.

You must complete and return all required forms. Your change in enrollment must be consistent with your significant life event. A significant life event includes:

- Marriage
- Divorce

- Legal separation
- Annulment of marriage
- Qualification or termination of a domestic partnership. Domestic partner coverage is available to those who meet the eligibility criteria of The Medical Trust
- Death of covered spouse (or domestic partner) or child
- When you, your spouse or your child becomes ineligible for Medicare
- Return to compensated work where an “active” medical plan benefit applies
- Termination or commencement of employment by your spouse, or your child, including a switch between part-time and full-time, or commencement or return from an unpaid leave of absence
- Change in dependent status for your child
- When you, your spouse, or your child becomes entitled to either Medicaid or Medicare
- Meeting or exceeding a lifetime limit on benefits
- Enrollment in a non-Medical Trust Medicare Part D Plan

WHEN COVERAGE BEGINS

Your coverage begins on the first day of the month in which you become eligible for Medicare and enroll in one of the Medicare Supplement Health Plans. Coverage for your eligible dependents begins on the later of the date your coverage begins or the date the dependents become eligible for Medicare.

WHEN COVERAGE ENDS

Your coverage ends on the earliest of:

- The end of the month in which you cease to be a retired employee
- The end of the month in which you are no longer in a class of retirees eligible for coverage
- The end of the month you stop paying any required contributions toward the cost of coverage
- The date the Plans end

Coverage for your dependents ends on the earliest of:

- The end of the month in which they are no longer eligible to participate in the Plans

- The end of the month in which required contributions cease
- The end of the month in which a clergy or lay employee's surviving spouse or domestic partner becomes eligible for non-Medical Trust employer-sponsored group coverage
- The date the Plans end

MAKING YOUR ENROLLMENT DECISION

As described elsewhere in this handbook, the levels of benefits differ among the three Medical Trust Medicare Supplement Health Plans, as well as among the three Dental Plans (described in the Dental Plans Handbook). Therefore, your out-of-pocket costs will vary based on which plan(s) you select.

Because medical costs can be high, it's especially important that you take the time to calculate how much money you think you might spend on Medicare Supplement Health Plan copayments, coinsurances, and deductibles, as well as monthly contributions.

Before enrolling, we suggest you take the following five steps:

STEP 1: REVIEW YOUR HEALTHCARE SPENDING

Who pays the monthly contribution for the plan? How much will you be responsible for starting January 2017?

On average, how much will you spend out-of-pocket on copayments, coinsurances, and deductibles each month based on your present and/or predicted healthcare needs?

Can you afford the Medicare Part A and Part B deductibles in the event an illness requires you to pay them both at the same time?

Which out-of-pocket maximums do you feel comfortable with?

How often do you expect to see doctors in the next year?

How many prescription drugs do you use? Are you using a number of maintenance medications whose costs you can predict? How does the prescription drug coverage offered by The Medical Trust plans with pharmacy compare to the coverage offered through other Medicare Part D plans?

How to Use the Worksheets

The following worksheets are intended to help you choose the Medicare Supplement Health Plan that suits your needs. There is a medical worksheet and a prescription drug worksheet for each of the three Plans. They are meant to be a tool to help you estimate your medical costs. You may find it useful to photocopy these worksheets in order to have copies for your spouse.

Remember, in reality, medical costs are often unpredictable, and your costs may be higher or lower than the costs you predict using these worksheets.

Note that the vision benefit is the same for all three Medicare Supplement Health Plans.

Column 1

Column 1 lists types of healthcare costs and services that you may have paid for last year. You can also add other healthcare costs or services that you paid for last year (or previous years) that you may want to think about when choosing a Medicare Supplement Health Plan. Write down those costs or services in the row marked "Other".

Column 2

In this column, write down the number of services you used and paid for last year. Or, place a check mark for healthcare costs you paid.

Review the amounts you list in Column 2. The rows with the larger costs are most likely the benefits you may need in a Medicare Supplement Health Plan right now. You should also think about your future healthcare needs.

After completing the worksheets, you should have a better sense of the benefits you're looking for in a Medicare Supplement Health Plan.

Use this worksheet for medical expense under the Comprehensive Plan.

Column 1	Column 2	Comprehensive Plan
Medical Services	Enter the number of times you received the services in Column 1 in the last year.	
Hospital admissions where a Medicare Part A deductible was applied		(Column 2) x \$390 = \$ _____
Number of days beyond 21 in a skilled nursing facility		\$0
Number of office visits to a physician or other provider		(Column 2) x \$20 (the maximum copay) = \$ _____
Number of outpatient surgeries or services you had (include day surgeries, chemotherapy treatment visits, etc.)		(Column 2) x \$275 (the maximum copay) = \$ _____
Estimate the amount (in dollars) Medicare said you owed for physician care when you were in the hospital in 2016		(Column 2) x 30% = \$ _____
Other		\$ _____
Preliminary Subtotal		\$ _____ (Sum of amounts above)
Medical Subtotal	<ul style="list-style-type: none"> If the Preliminary Subtotal is less than \$2,000 (the out-of-pocket maximum) enter the preliminary subtotal here. If the preliminary subtotal is greater than \$2,000, enter \$2,000 here. 	\$ _____ (Subtotal cannot be greater than \$2,000)

Use this worksheet for prescription drug expense under the Comprehensive Plan.*

Column 1	Column 2	Comprehensive Plan
Prescription Medications		
Enter the number of generic prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) x \$10 = \$ _____
Enter the number of formulary brand-name prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) x \$30 = \$ _____
Enter the number of non-formulary brand-name prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) x \$50 = \$ _____
Enter the number of generic prescriptions (including refills) purchased through mail order.		(Column 2) x \$25 = \$ _____
Enter the number of formulary brand-name prescriptions (including refills) purchased through mail order.		(Column 2) x \$70 = \$ _____
Enter the number of non-formulary brand-name prescriptions (including refills) purchased through mail order.		(Column 2) x \$120 = \$ _____
Prescription Subtotal		\$ _____ (Sum of amounts above)
TOTAL (Add the Medical Subtotal from the previous page and the prescription subtotal from this page.)		\$ _____ (Sum of both subtotals)

**Does not apply to plans without the pharmacy option.*

Use this worksheet for medical expense under the Plus Plan.

Column 1	Column 2	Plus Plan
Medical Services	Enter the number of times you received the services in Column 1 in the last year.	
Hospital admissions where a Medicare Part A deductible was applied		\$ _____ (If Column 2 is Yes, enter \$150)
Number of days beyond 21 in a skilled nursing facility		\$0
Number of office visits to a physician or other provider		(Column 2) x \$15 (the maximum copay) = \$ _____
Number of outpatient surgeries or services you had (include day surgeries, chemotherapy treatment visits, etc.)		(Column 2) x \$275 (the maximum copay) = \$ _____
Estimate the amount (in dollars) Medicare said you owed for physician care when you were in the hospital in 2016		(Column 2) x 20% = \$ _____
Other		\$ _____
Preliminary Subtotal		\$ _____ (Sum of amounts above)
Medical Subtotal <ul style="list-style-type: none"> • If the Preliminary Subtotal is less than \$1,750 (the out-of-pocket maximum) enter the preliminary subtotal here. • If the preliminary subtotal is greater than \$1,750, enter \$1,750 here. 		\$ _____ (Subtotal cannot be greater than \$1,750)

Use this worksheet for prescription drug expense under the Plus Plan.*

Column 1	Column 2	Plus Plan
Prescription Medications		
Enter the number of generic prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) x \$5 = \$ _____
Enter the number of formulary brand-name prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) x \$25 = \$ _____
Enter the number of non-formulary brand-name prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) x \$40 = \$ _____
Enter the number of generic prescriptions (including refills) purchased through mail order.		(Column 2) x \$12 = \$ _____
Enter the number of formulary brand-name prescriptions (including refills) purchased through mail order.		(Column 2) x \$60 = \$ _____
Enter the number of non-formulary brand-name prescriptions (including refills) purchased through mail order.		(Column 2) x \$100 = \$ _____
Prescription Subtotal		\$ _____ (Sum of amounts above)
TOTAL (Add the Medical Subtotal from the previous page and the prescription subtotal from this page.)		\$ _____ (Sum of both subtotals)

**Does not apply to plans without the pharmacy option.*

Use this worksheet for medical expense under the Premium Plan

Column 1	Column 2	Premium Plan
Medical Services	Enter the number of times you received the services in Column 1 in the last year.	
Hospital admissions where a Medicare Part A deductible was applied		\$0
Number of days beyond 21 in a skilled nursing facility		\$0
Number of office visits to a physician or other provider		(Column 2) x \$15 (the maximum copay) = \$ _____
Number of outpatient surgeries or services you had (include day surgeries, chemotherapy treatment visits, etc.)		(Column 2) x \$175 (the maximum copay) = \$ _____
Estimate the amount (in dollars) Medicare said you owed for physician care when you were in the hospital in 2016		(Column 2) x 20% = \$ _____
Other		\$ _____
Preliminary Subtotal		\$ _____ (Sum of amounts above)
Medical Subtotal <ul style="list-style-type: none"> • If the Preliminary Subtotal is less than \$1,500 (the out-of-pocket maximum) enter the preliminary subtotal here. • If the preliminary subtotal is greater than \$1,500, enter \$1,500 here. 		\$ _____ (Subtotal cannot be greater than \$1,500)

Use this worksheet for prescription drug expense under the Premium Plan.*

Column 1	Column 2	Premium Plan
Prescription Medications		
Enter the number of generic prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) x \$5 = \$ _____
Enter the number of formulary brand-name prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) x \$25 = \$ _____
Enter the number of non-formulary brand-name prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) x \$40 = \$ _____
Enter the number of generic prescriptions (including refills) purchased through mail order.		(Column 2) x \$12 = \$ _____
Enter the number of formulary brand-name prescriptions (including refills) purchased through mail order.		(Column 2) x \$60 = \$ _____
Enter the number of non-formulary brand-name prescriptions (including refills) purchased through mail order.		(Column 2) x \$100 = \$ _____
Prescription Subtotal		\$ _____ (Sum of amounts above)
TOTAL (Add the Medical Subtotal from the previous page and the prescription subtotal from this page.)		\$ _____ (Sum of both subtotals)

**Does not apply to plans without the pharmacy option.*

STEP 2: THINK, REVIEW, AND DECIDE

When deciding whether to purchase or enroll in a Medicare Supplement Health Plan, you should think about benefits you may need in the future and your financial situation. Consider your individual medical history, your family medical history, and your health risks when estimating future healthcare costs.

Remember that The Medical Trust's Medicare Supplement Health Plans offer several core benefits to supplement what Medicare provides, including:

- Cost sharing of Medicare Part A and Part B deductibles and coinsurances
- An annual physical exam benefit
- Prescription drug benefits (with no annual benefit cap)
- Vision benefits
- Annual out-of-pocket maximums for medical expenses
- Disease and case management for chronic and/or serious conditions

If you have questions about The Medical Trust Medicare Supplement Health Plans and what you need to know about the benefits, please call Client Services toll-free at (800) 480-9967.

STEP 3: CHOOSE YOUR MEDICARE SUPPLEMENT HEALTH PLAN

You should choose the Medicare Supplement Health Plan that is best for you. But, before you make your final choice, make sure:

- You carefully review the Medicare Supplement Health Plan benefits
- You have considered the monthly contribution
- The Plan covers the benefits you need
- You talk with someone you trust, like a family member, friend or doctor about your choice

STEP 4: CHOOSE YOUR DENTAL PLAN

Think about recent dental care needs and what needs you and your dependents may have in the future. Then review the three Dental Plans offered by The Medical Trust. Be sure to:

- Review how the plans differ in coverage
- Compare the Plans' monthly contributions
- Decide whether you want to enroll, and if so, which plan best meets your needs

STEP 5: GO ONLINE TO MAKE YOUR SELECTIONS

The retiree Open Enrollment is entirely paperless. This means you will use our online system to verify and make any changes to your coverage. The online system is easier and faster to complete than hard copy forms that must be filled in and mailed.

If you have no changes to your medical or dental coverage for 2017, then you do not need to do anything. You will remain in the same Medicare Supplement plan as you had in 2016. However, we encourage you to go online to review your personal and dependent information and to notify us of any corrections.

You must go online and make any changes no later than December 7, 2016.

As always, our Client Services call center is ready to help you with the process or answer any questions.

MEDICARE SECONDARY PAYER (MSP) — SMALL EMPLOYER EXCEPTION

Some members and/or spouses are eligible to participate in the Medicare Secondary Payer (MSP)—Small Employer Exception. Generally, Medicare is not responsible for paying first for someone who is actively working. However, Medicare allows an exception for employers with fewer than 20 employees.

If you are 65 or over, actively working, and your employer has fewer than 20 employees, you may be eligible for this program.

If you are approved and enrolled, Medicare would become the primary payer of your claims covered under Medicare Part A only. Part A is hospitalization insurance that helps cover inpatient care in hospitals, skilled nursing facilities, hospices, and home health care situations. The Medical Trust plan will act as the secondary payer of claims. The plan will coordinate benefit payments with Medicare so that any claims not paid by Medicare will be processed under the Medical Trust Plan.

If you are enrolled in Medicare Part B, the Plan will coordinate with Medicare. Otherwise, for all benefits covered by Medicare Part B, such as doctor visits, outpatient procedures, and some prescription drugs, your Anthem plan will remain the primary payer of your benefits.

Contact your employer for more information on this program and eligibility.

ORIGINAL MEDICARE

Original Medicare is a federal health insurance program for people age 65 or older, under age 65 with certain disabilities, and any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has the following parts:

- Part A (Hospital Insurance)
- Part B (Medical Insurance)
- Part C (Medicare Advantage Plans, like an HMO)
- Part D (Medicare prescription drug coverage)

MEDICARE PART A

Medicare Part A helps cover inpatient care in hospitals. This includes critical access hospitals and inpatient rehabilitation facilities. It also helps cover hospice care and home health care, and skilled nursing facilities (but not custodial or long-term care). You must meet certain conditions to get these benefits.

You usually don't pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes while working.

MEDICARE PART B

Medicare Part B helps cover medically necessary services like doctors' services, outpatient care, and other medical services. Part B also covers some preventive services. These include a one-time "Welcome to Medicare" physical exam, bone mass measurements, flu and pneumococcal shots, cardiovascular screenings, cancer screenings, diabetes screenings, an annual wellness exam, and more.

MEDICARE PART C

Also known as Medicare Advantage, these are plans provided by private insurance companies.

In addition to providing the same coverage as Parts A and B, a Medicare Part C plan also provides some of the extra coverage of a Medigap insurance policy.

Costs can vary widely depending on your state and the private insurer you choose, as well as whether you choose an HMO or PPO for coverage.

If you are enrolled in a Medical Trust Medicare Supplement Health Plan, you may not enroll in a Medicare Advantage Plan.

MEDICARE PART D

Medicare Part D is a program to subsidize the cost of certain prescription drugs for Medicare beneficiaries.

This coverage may help lower prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. You choose the drug plan and pay a monthly premium. Like other insurance, if you decide not to enroll in a drug plan when you are first eligible, you may pay a penalty if you choose to join later, **but only if you do not have employer coverage that meets Medicare's creditable coverage definition.**

If you are enrolled in a Medical Trust Medicare Supplement Health Plan with prescription drug coverage, your benefits are considered creditable coverage, which means it is equal to (if not better than) the coverage available under other Medicare Part D plans.

SERVICES COVERED BY MEDICARE

Different services and supplies are covered under Medicare Part A and Part B when medically necessary.

Medicare Part A helps pay for:

- Inpatient hospital care
- Skilled nursing facility care
- Hospice care
- Some home health care
- Pints of blood you receive at a hospital or skilled nursing facility during a covered stay

Medicare Part B helps pay for:

- Doctors' services
- Annual wellness exams

- Outpatient hospital care
- Some other medical services that Medicare Part A does not cover (such as some of the services of physical and occupational therapists, and some home health care)
- Pints of blood you receive as an outpatient or as part of a Medicare Part B covered service

Original Medicare also helps cover:

- Ambulance services
- Chiropractic services (limited)
- Clinical research studies
- Diabetic self-management training
- Diabetic supplies
- Durable medical equipment
- Emergency room services
- Eyeglasses (after cataract surgery)
- Foot exams and treatment
- Hearing and balance exams
- Kidney dialysis services
- Medical nutrition therapy services
- Mental healthcare
- Practitioner services
- Prosthetic and orthotic items (with certain limitations)
- Second surgical opinion
- Smoking cessation counseling
- Surgical dressings
- Tests
- Transplant services
- Travel outside the United States (only when in US but nearest treatment facility is outside the country, or when crossing international borders in order to get from US territory to another)
- Urgently needed care

SERVICES NOT COVERED BY ORIGINAL MEDICARE

Original Medicare does not cover everything. Items and services that aren't covered include, but are not limited to:

- Acupuncture
- Cosmetic surgery
- Custodial care at home or in a nursing facility

- Deductibles, coinsurance, copayments
- Dental care and dentures (with a few exceptions)
- Eye refractions
- Healthcare while outside the US (except in certain circumstances)
- Hearing aids and hearing aid fitting exams
- Hearing tests without doctor's orders
- Long-term care (such as custodial care in a nursing home)
- Orthopedic shoes (with only a few exceptions)
- Routine foot care (with only a few exceptions)
- Routine eye care and most eyeglasses
- Screening tests and screening laboratory tests (except certain preventive screenings)
- Shots (vaccinations) except certain preventive procedures
- Some diabetic supplies (syringes or insulin, except when used in an insulin pump)

TO FIND A DOCTOR

Many doctors accept Medicare assignment. If you need help finding a provider that accepts Medicare assignment to help keep your overall healthcare costs down, visit www.medicare.gov/physician/home.asp, or contact Medicare directly at (800) MEDICARE (1 (800) 633-4227), 24 hours a day, 7 days a week for assistance. TTY users should call 1 (877) 486-2048.

FOR MORE INFORMATION

This handbook does not include everything that is covered or excluded by Medicare. For more detailed information or to request a copy of the publication *Medicare and You*, please contact Medicare at (800) MEDICARE (1 (800) 633-4227), 24 hours a day, 7 days a week for assistance. TTY users should call 1 (877) 486-2048.

THE MEDICAL TRUST MEDICARE SUPPLEMENT HEALTH PLANS

BENEFITS OF A MEDICARE SUPPLEMENT HEALTH PLAN

Medicare Supplement Health Plans provide you with additional healthcare coverage by helping you pay many of your out-of-pocket expenses after Medicare pays its portion. They supplement Medicare by paying a portion of Medicare copayments, coinsurances, and deductibles, and by paying for some services not covered under Medicare, such as hearing aids.

Medicare Supplement Health Plans are similar to Medigap policies in that they fill the gaps in Medicare coverage.

The Supplement Plans offered through The Medical Trust use Medicare-approved medical treatment as a guideline for covered services.

If you are covered by Medicare, a Medicare Supplement Health Plan may help you lower your out-of-pocket costs and increase your level of healthcare coverage.

What you pay out-of-pocket under Medicare will depend on:

- Whether your doctor or supplier accepts assignment
- How often you need healthcare
- What type of healthcare you need
- Whether you enroll in a Medicare Supplement Health Plan
- Which Medicare Supplement Health Plan you enroll in
- Whether you have other healthcare coverage

The chart on the following page contains examples of some of the out-of-pocket expenses you could incur under Medicare.

What Medicare Asks You to Pay in 2017		Medical Trust Supplement Plans Help Pay
Hospital Stays	<ul style="list-style-type: none"> • \$1,316 deductible per benefit period • \$0 copay for the first 60 days of each benefit period • \$329 per day for days 61-90 of each benefit period • \$658 per lifetime reserve day after day 90 of each benefit period (up to a maximum of 60 days over your lifetime) 	Yes
Skilled Nursing Facility Days	Up to \$164.50 per day for days 21-100	Yes
Blood	Cost of the first three pints	Yes
Medicare Part B Deductible	\$183	Yes
Medicare Part B Covered Services	<ul style="list-style-type: none"> • 20% of the Medicare-approved amount for most covered services, including mental health services • Copayment for outpatient hospital services 	Yes
Medicare Part B Premium	\$109.00 (approx) if you were enrolled in Medicare Part B prior to January 1, 2017, or \$134.00 if you enroll in Medicare Part B for the first time in 2017, and your income is \$85,000 or less (single) or \$170,000 or less (married couple). If your income is above \$85,000/\$170,000, your Medicare Part B premium may be higher	No
Medicare Part D Premium	If your income is more than \$85,000 (single) or \$170,000 (married couple), you will pay an income-related monthly adjustment in addition to your plan premium.	No

THREE MEDICAL TRUST MEDICARE SUPPLEMENT HEALTH PLANS

The Medical Trust is offering three Medicare Supplement Health Plans for the 2017 benefit year:

- Comprehensive Plan
- Plus Plan
- Premium Plan

These plans are also available without prescription drug benefits only for those who enroll in a non-Medical Trust Medicare Part D plan.

All three Plans supplement benefits provided by Medicare Part A and Part B by helping to pay for a portion of your Medicare copayments, coinsurances, and deductibles. They also provide prescription drug benefits with no annual benefit maximum, an annual routine physical, vision benefits, an employee assistance program, the Health Advocate program, the SilverSneakers program, and disease and case management for chronic and/or serious conditions.

These Medicare Supplement Health Plans are not:

- Active health coverage you might receive when you are employed
- A Medicare Advantage plan (like a Medicare managed care or Private Fee-for-Service plan)
- Medicare Part A or Medicare Part B
- Medicaid

All three Plans include some member cost-sharing. This means you will be responsible for some out-of-pocket expenses, such as copayments, coinsurances, and deductibles.

For example, if you choose supplemental coverage under the Comprehensive Plan, you will pay a copayment of up to \$20 for a visit to the doctor.

Unlike Medicare, these Plans have an individual annual out-of-pocket maximum. For the Comprehensive Plan, this means you will never pay more than \$2,000 in a given benefit year for hospital stays, doctor's office visits, and other covered medical expenses.

BENEFIT EXCLUSIONS

While these Plans provide many basic benefits, they cannot pay for everything. Examples of what these Plans don't cover are:

- Long-term custodial care
- Dental care
- Private-duty nursing

IMPORTANT NOTE ABOUT MEDICARE ADVANTAGE PLANS

You may not need a Medicare Supplement Health Plan if you are in a Medicare Advantage plan, such as a Medicare managed care plan (like an HMO); a Medicare Private Fee-for-Service plan, or TRICARE for Life. Call Client Services at (800) 480-9967 if you have any questions.

COVERED MEDICAL EXPENSES

When all of the eligibility and enrollment provisions of the Plans are satisfied, the Medicare Supplement Health Plans will provide benefits as outlined on the Summaries of Benefits and Coverage only for expenses eligible for coverage under Medicare, but which exceed the benefits provided by Medicare.

In addition, the services and supplies listed below will be covered:

- Routine physicals not covered by Medicare, limited as outlined on the Summaries of Benefits and Coverage
- Routine and preventive X-rays, laboratory services, and tests which are associated with your routine physical and are not covered by Medicare
- Blood not covered by Medicare, limited as outlined on the Summaries of Benefits and Coverage

The Plans will not provide benefits for any items that are not eligible under Original Medicare, except as specified in this handbook or as required by applicable law. Prescription drugs and vision benefits not eligible for coverage under Medicare may be available through your prescription drug and vision programs.

PREVENTIVE CARE AND ROUTINE PHYSICALS

Preventive care is an important and valuable part of your healthcare. Regular physical checkups and appropriate screenings can help you and your doctor detect illness early. When you treat an illness or condition early, you help minimize the risk of a serious health problem and reduce the risk of incurring greater costs.

That's why Medicare and The Medical Trust Medicare Supplement Health Plans provide benefits for many preventive care services at no cost to you. There are steps you can take to lower your risk of disease and illness. Medicare provides coverage for many preventive services to help you stay healthy, including:

- Tests for breast cancer, cervical cancer, vaginal cancer, and colorectal cancer
- Bone mass measurements
- Diabetes monitoring and diabetes self-management
- Flu, pneumonia, and hepatitis B Shots

- Prostate cancer screening tests
- Smoking cessation

In addition, The Medical Trust Medicare Supplement Health Plans will provide benefits for:

- Routine physicals, including all related X-rays and laboratory services performed in conjunction with the physical
- Hearing exams performed by your physician during a routine physical

The Medicare Supplement Health Plans will cover 100% of the physician office visit charge for routine physicals up to an annual maximum of \$200. In addition, the Plans may provide benefits for charges for other diagnostic and laboratory services not covered by Medicare that were ordered by your physician during your routine physical. The Medical Trust, either itself or through a vendor, may review diagnostic and laboratory services provided or ordered during your routine physical and not approved by Medicare for medical necessity.

If you feel a diagnostic X-ray or lab should have been paid as part of the routine benefit instead of the diagnostic X-rays and laboratory services benefit, please contact UnitedHealthcare at (800) 708-3052.

EXCLUSIONS AND LIMITATIONS

In most cases, The Medical Trust Medicare Supplement Health Plans will not provide benefits for any healthcare costs not covered by Original Medicare. This list is intended to give you a general description of services and supplies not covered by Medicare or the Plans

- Acupuncture
- Copayments, coinsurances, and deductibles when you receive healthcare services
- Dental care and dentures (in most cases). However, dental services are covered by The Medical Trust's Dental Plans. See the Dental Plans Document Handbook for more information
- Cosmetic surgery
- Custodial care (help with bathing, dressing, using the bathroom, or eating) at home or in a nursing home
- Orthopedic shoes
- Routine foot care (with only a few exceptions)
- Screening tests (in most cases)
- Shots (vaccinations) (in most cases)
- Diagnosis or treatment of the jawbones, including Orthognathic surgery (procedure to correct underbite or overbite), jaw alignment and treatment for the temporomandibular joint, except as treatment of obstructive sleep apnea
- Treatment of benign gynecomastia (abnormal breast enlargement in males)
- Orthotic appliances and devices, except when prescribed by a physician for a medical purpose, and custom manufactured or custom fitted to an individual covered person
- Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism, including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy
- Foods of any kind, including enteral feedings and other nutritional and electrolyte formulas, infant formula, and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU)

In addition, dollar thresholds and plan maximums included in the Summaries of Benefits and Coverage also apply.

ADMINISTRATIVE INFORMATION

PRE-EXISTING CONDITIONS

Unlike other Plans, preexisting conditions do not apply for these plans. This means that The Medical Trust will not require you to submit a doctor's note or any statements from previous health plans explaining your health status and there will be no exclusions for preexisting conditions.

YOUR COSTS FOR THE MEDICARE SUPPLEMENT HEALTH PLANS for 2017

The costs per person per month for Plans *with prescription drug benefits* are as follows:

- Comprehensive Plan \$340
- Plus Plan \$465
- Premium Plan \$540

The costs per person per month for Plans without prescription drug benefits are as follows:

- Comprehensive Plan II \$195
- Plus Plan II \$230
- Premium Plan II \$280

The portion of the cost you will have to pay may be affected by a number of factors, including:

- The Plan you choose
- Years of credited service in the Church Pension Fund (clergy)
- The amount of assistance provided by the Church Pension Fund (clergy)
- Years of employment with your former employer or the diocese from which you retired (clergy and lay)
- The amount your former employer or diocese may choose to contribute

You will need to contact your diocese or former employer to determine what portion, if any, might be paid on your behalf.

When you enroll in one of the Medicare Supplement Health Plans, The Medical Trust will charge you, your former employer, or the Church Pension Fund a monthly contribution. Your coverage will continue, as long as the contribution is

paid. This contribution is different and separate from the Medicare Part B premium (and, if you have enrolled in a separate Medicare Part D prescription drug plan, your monthly Medicare Part D premium).

COMPARING THE COST OF A MEDICARE SUPPLEMENT HEALTH PLAN WITH A MEDIGAP POLICY

Remember, the cost of a standard Medigap policy from an insurance company may be affected by a number of other factors, including, but not limited to:

- Where you live
- Your age
- The insurance company
- Your gender
- Whether you smoke
- Whether you are married
- Medical underwriting

The cost of The Medical Trust's Medicare Supplement Health Plans does not vary based on any of these factors.

YOUR COSTS FOR THE DENTAL PLANS

The per person per month cost for the three Dental Plans is as follows:

- Dental & Orthodontia \$85
- Basic Dental \$69
- Preventive Dental \$45

Your cost for Dental Plan coverage may vary based on individual circumstances. For example, your former employer may pay for this coverage. In addition, if you do not elect to participate in a Medicare Supplement Health Plan from The Medical Trust (e.g., you have TRICARE for Life from the federal government) and you qualify for assistance from the Church Pension Fund, you may apply the assistance subsidy toward a Dental Plan.

BILLING

You have several options for how to pay for your coverage under the Plans.

If your former employer or the diocese from which you retired subsidizes any portion of your contribution, the bill for your contribution may be sent directly to

the former employer or diocese. In some cases, you may be billed and your diocese/former employer may reimburse you.

You may choose to be billed directly or, if you receive a pension benefit from the Church Pension Fund, you may pay for your Plan through a monthly pension check deduction.

If you and your spouse or domestic partner (and any other qualified dependents) enroll in the same Plan, then you have the same choices mentioned above. In this case, the total cost for you and your family would be directly billed to you, the former employer or diocese, or deducted from your pension benefit. Please note that you cannot divide the payment between direct billing and pension check deduction. You must choose one or the other.

If you and your spouse (and any other qualified dependents) enroll in different Medicare Supplement Health Plans, then you can divide the payment between direct billing and pension check deduction. For example, if you choose the Comprehensive Plan, and your spouse chooses the Plus Plan, then you can choose to have the cost of your Plan deducted from your pension benefit and the cost of your spouse's plan billed to you directly.

The same applies for dental. For example, if you and your spouse both enroll in the Basic Dental Plan, the total cost would be directly billed to you or deducted from your pension benefit. Again, you cannot divide the payment between direct billing and pension check deduction. You must choose one or the other.

ID CARDS FOR 2017

UnitedHealthcare – For 2017, you will receive a new ID card only if you are enrolling in a Medical Trust Medicare Supplement Health Plan for the first time. If you switch from one plan to another, you will not receive a new ID card.

Express Scripts – You will receive a new ID card from Express Scripts only if you are enrolling for the first time..

EyeMed – You will only receive a new ID card if you are enrolling for the first time.

Amplifon Hearing Health Care – No ID card is provided or needed to access benefits.

Cigna Dental – You will only receive a new ID card if you are enrolling for the first time or if you switch from one plan to another.

Health Advocate – No ID card is required. A brochure describing your benefits is available at www.cpg.org/mtdocs.

Employee Assistance Program – A brochure containing contact information is available at www.cpg.org/mtdocs.

SilverSneakers – You will receive an ID card with your information kit.

MEMBER SERVICES

The Medical Trust Client Services team is ready to help you with questions you have about your health plans.

Client Services can:

- Verify your eligibility
- Enroll you in the Plan of your choice
- Assist you in making an informed decision regarding your Plan choice
- Explain the benefits and costs of each Plan
- Assist you with claims resolution
- Help you understand your bill
- Arrange your pension check deductions

Please refer to the back of this guide to find out how to contact us.

CLAIMS AND APPEALS

MEDICARE CLAIMS

Under the Medicare electronic claims-filing requirements, in most cases, doctors, suppliers, and providers must send all Medicare claims electronically. If Medicare denies any claim because it was not sent electronically, you cannot be billed for the claim. If you are billed, you should contact your provider immediately to make sure the claim was filed electronically, and then contact your Medicare carrier if the claim still is not filed electronically.

Please note that there is a time limit for filing a Medicare claim. The time limit may be as short as 15 months or as long as 27 months, depending on when you received the service or supply. If a claim is not filed within this time limit, Medicare will not pay its share. UnitedHealthcare can provide you with more information.

HOSPITAL CLAIMS

At the time of hospital admission, present your Medicare card and your UnitedHealthcare Medicare Supplement ID card at the hospital's admission office. The hospital should submit its claim electronically to Medicare as soon as an expense is incurred.

PHYSICIAN AND OTHER MEDICAL EXPENSES

In most situations, your doctor will file claims directly with Medicare. UnitedHealthcare will receive the claims electronically from the claims-processing organizations that pay your Medicare claims. For more details about filing Medicare claims, please see "Medicare Billing" at www.medicare.gov, or call (800) 633-4227.

MEDICARE SUPPLEMENT HEALTH PLAN CLAIMS

All medical claims must be received by the Medicare Supplement Health Plan within 180 days from the date of your Medicare Summary Notice, or 180 days from the date the expenses were incurred for eligible services not covered by Medicare.

If additional information is needed to process your claim, you or your healthcare provider will be notified. If you receive a letter regarding your claim, prompt completion and return of the letter with any requested attachments will expedite processing of the claim. The claim will be denied for lack of necessary information if the information requested in the letter is not supplied within 45 days. If you submit the requested information after the 45-day period, this will be treated as a new submission of the claim.

Please send completed claims to:

UnitedHealthcare Insurance Company
P.O. Box 30555
Salt Lake City, UT 84130-0555

The Plans will provide you with notice of the claim determination within a reasonable period of time, but no later than 30 days after receipt of the claim. If the Plans request additional information, this time period will be delayed until the requested information is received by the Plans. The Plans may also request a 15-day extension if matters beyond their control require the extension and notice is provided to you within the 30-day period.

If you have any questions regarding your claim, please call UnitedHealthcare. You may also check the status of your claim or download any necessary forms via the internet by logging on www.myuhc.com.

HOW TO APPEAL A DENIAL OF MEDICAL BENEFITS

To request a clarification of a benefit determination, you or your authorized representative may call UnitedHealthcare at (800) 708-3052. However, if you believe a claim denial was improper, the following process is available.

CLAIM APPEAL PROCESS

Within 180 days of receipt of the notice of the claim denial, you may request, in writing, that the Plan(s) conduct a review of the processed claim. All requests for a review of claim denial should include a copy of the initial denial letter and any other relevant information (e.g., written comments, documents, articles, or records). The party reviewing the appeal will:

- Review all comments, documents, records, and other information submitted by you

- Consult with an appropriate healthcare professional if the claim was denied because it was not considered medically necessary, or the service was considered experimental/investigational. You may request the name of the healthcare professional who was consulted.
- Request additional information necessary to review the appeal. You should provide the information as soon as possible.
- Use discretionary authority in making an appeal determination. However, such discretionary authority will be consistent with determinations for similarly situated Plan participants.
- Provide notice of the appeal determination in writing

Send all written information to the contract administrator:

UnitedHealthcare Insurance Company
P.O. Box 30555
Salt Lake City, UT 84130-0555

Requests for appeals that do not comply with these procedures will not be considered, except in extraordinary circumstances.

You will be notified if the appeal request has not been considered, and you will be allowed to present evidence of why the appeal should be considered.

You will be notified of the final decision within a reasonable time period, but not later than 60 days.

If you are not satisfied with the claims administrator's appeal decision, you may request to have your appeal reviewed by the Plan. The Plan offers this voluntary review for covered individuals following the required appeal process with the claims administrator. If you wish to pursue a voluntary review, please send a written request within 60 days of the date the claims administrator notified you of its appeal decision.

Your written request should include:

- Specific request for a voluntary review
- Enrollee's name, address, and ID number
- Service for which coverage was denied
- Any new, relevant information that was not provided during the internal appeal
- Signed, written authorization for healthcare providers to release relevant medical information to the Plan

Please submit this information to:

The Episcopal Church Medical Trust
19 East 34th Street
New York, NY 10016
Attn: Clinical Management

The Plan Administrator has the exclusive right to interpret and administer the Plan. All decisions by the Plan are conclusive, final and binding.

TIME PERIOD FOR FILING LEGAL ACTIONS

No action at law or in equity shall be brought to recover under these Plans until the appeal procedures of these Plans have been exhausted with respect to the claim, nor (unless applicable state law permits a longer period) will any action be brought unless it is within two years from the expiration of the time within which proof of loss is required to be furnished under these Plans.

COORDINATION OF BENEFITS

GENERAL PROVISION

When you and/or your dependents are covered under Medicare and/or another group health plan, the plan assuming primary payor status will establish benefits first, without regard to benefits provided under any other group health plan. Refer to your Medicare carrier or www.medicare.gov for details regarding when Medicare may pay secondary to the Medicare Supplement Health Plans or any other health plans. To determine when The Medical Trust Medicare Supplement Health Plans are secondary to your other healthcare coverage, see “Order of Payment When Coordinating Payment With Other Group Health Plans” in this chapter.

When a Medical Trust Plan is the secondary payor, it will reimburse, subject to all Plan provisions and at the eligible coinsurance percentage under the Plan, the balance of remaining expenses not paid by Medicare.

COORDINATION OF BENEFITS EXAMPLE

For example, if a covered service falls under All Other Covered Medicare Part B Expenses as shown on the Summary of Benefits for the Medical Trust’s Comprehensive Plan, then the Plan will coordinate benefits as follows:

\$1,000	Submitted eligible amount
- 500	<u>Amount paid by Medicare (primary plan)</u>
\$ 500	
\$ 500	Considered amount (by secondary plan)
X 80%	<u>Multiplied by coinsurance percentage</u>
\$ 400	Benefit paid by Comprehensive Plan (secondary plan)

Based on this example, for an initial eligible charge of \$1,000, your out-of-pocket cost after both plans have paid would be \$100 (\$500 - \$400). The Comprehensive Plan’s payment may be reduced if you have other group health coverage.

GOVERNMENT PROGRAMS AND OTHER GROUP HEALTH PLANS

The term group health plan, as it relates to coordination of benefits, includes the government programs Medicare, Medicaid, and TRICARE for Life. The regulations governing these programs take precedence over the determination of benefits under the Medicare Supplement Health Plans. For example, in determining the benefits payable under the Plans, the Plans will not take into account the fact that you or any eligible dependent(s) are eligible for or receive benefits under a Medicaid plan.

The term “group health plan” also includes all group insurance and group subscriber contracts, such as union welfare plans, and benefits provided under any group or individual automobile no-fault or fault-type policy or contract. Individual policies or contracts are not included.

AUTOMOBILE INSURANCE

The Medicare Supplement Health Plans provide benefits relating to medical expenses incurred as a result of an automobile accident on a secondary basis only. Benefits payable under the Plans will be coordinated with and secondary to benefits provided or required by any no-fault automobile insurance statute, whether or not a no-fault policy is in effect, and/or any other automobile insurance.

Any benefits provided by the Plans will be subject to the Plans’ reimbursement and/or subrogation provisions.

ORDER OF PAYMENT WHEN COORDINATING WITH OTHER GROUP HEALTH PLANS

When all plans covering you and/or your dependents contain a coordination of benefits provision, the first of the following rules that describes which plan will pay benefits before another plan is the rule to follow:

1. The plan covering an individual other than as a dependent (for example, as an active employee or retiree) will be primary to a plan covering the same individual as a dependent.
2. The plan that covers an individual as an employee who is neither laid-off nor retired (or as that employee’s dependent) is primary. However, the order of ben-

efit determination for an individual covered as both a retiree and as a dependent of that individual's spouse will be determined under section No. 1 above.

3. The plan covering the individual as an employee or retiree (or as that individual's dependent) will be primary to the plan providing continuation coverage under federal (COBRA) or state law.

4. The plan that has covered the individual for the longer period of time will be considered primary.

5. If none of the above rules determine the primary plan, the allowable expenses will be shared equally between the plans.

RIGHT TO MAKE PAYMENTS TO OTHER ORGANIZATIONS

Whenever payments that should have been made by the Medicare Supplement Health Plans have been made by any other plan(s), these Plans have the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision.

Amounts paid will be considered benefits paid under the Medicare Supplement Health Plans and, to the extent of such payments, the other plan will be fully released from any liability regarding the person for whom payment was made.

PHARMACY

The Episcopal Church Medical Trust offers its prescription drug plan under the Medicare Part D Program. The plan will be administered by Express Scripts and is called **Express Scripts Medicare™ (PDP)** for The Episcopal Church Medical Trust (Medical Trust).

You will receive additional information about your prescription drug coverage from Express Scripts Medicare. Be sure to review any mail you receive so that you may fully understand your benefits under this plan.

This chapter gives you a basic overview of your benefit after combining standard Medicare Part D with additional coverage being provided by The Episcopal Church Medical Trust.

Yearly Deductible Stage

Because this plan does not have a deductible, this stage does not apply to you.

Initial Coverage Stage

During the Initial Coverage stage, you will pay a specific copayment for prescription drugs as outlined in the Prescription Drug Benefits Summary, which can be found on page 123. The chart in that section provides information about your cost-sharing amounts during the Initial Coverage stage of this benefit. This plan provides coverage across all stages of your benefit.

COVERAGE GAP STAGE

After your total yearly drug costs reach \$3,700, you will continue to pay the same cost-sharing amount as in the Initial Coverage stage until your yearly out-of-pocket drug costs reach \$4,950. In other words, you will not experience a change in copayments while in the “donut hole” in this plan.

CATASTROPHIC COVERAGE STAGE

After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by our

Medicare prescription drug plan) reach \$4,950, you will pay the greater of 5% coinsurance or:

- A \$3.30 copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage.
- A \$8.25 copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage.

LONG-TERM CARE (LTC) PHARMACY

Long-term care pharmacies must dispense brand-name drugs in amounts less than a 14-day supply at a time. They may also dispense less than a one-month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

OUT-OF-NETWORK COVERAGE

You must use Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay additional costs for drugs received at an out-of-network pharmacy. Please contact Express Scripts Medicare Customer Service for more details.

IMPORTANT PLAN INFORMATION

- The service area for this plan is all 50 states, the District of Columbia, and Puerto Rico. You must live in one of these areas to participate in this plan. We may reduce our service area and no longer offer services in the area in which you reside.
- Your plan uses a formulary—a list of covered drugs. Express Scripts may periodically add or remove drugs, make changes to coverage limitations on certain drugs, or change how much you pay for a drug. **If any formulary change limits your ability to fill a prescription, you will be notified before the change is made.**

- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
- Your healthcare provider must get prior authorization from Express Scripts Medicare for certain drugs.
- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.
- If you request an exception for a drug and Express Scripts Medicare approves the exception, you will pay the Non-Preferred Brand Drug cost-share for that drug.
- You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party, even if your Medicare Part D plan premium is \$0.

DOES MY PLAN COVER MEDICARE PART B OR NON-PART D DRUGS?

In addition to providing coverage of Medicare Part D drugs, this plan provides coverage for Medicare Part B medications, as well as for some other non-Part D medications that are not normally covered by a Medicare prescription drug plan. The amounts paid for these medications will not count toward your total drug costs or total out-of-pocket expenses. Please call Express Scripts Medicare Customer Service for additional information about specific drug coverage and your cost-sharing amount.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer to help you manage your medications. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate, but it is recommended that you take full advantage of this covered service if you are selected. Contact Express Scripts Medicare for more details.

VISION BENEFITS

When you are enrolled in a Medical Trust Medicare Supplement Health Plan, you will receive vision benefits through EyeMed Vision CareSM.

Vision Care Services	Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary	\$0 copay	Up to \$30
Standard Contact Lens Fit and Follow-Up*	Up to \$55	n/a
Premium Contact Lens Fit and Follow-Up**	90% of retail price	n/a
Frames (any available frame at provider location)	Member receives \$130 allowance and pays 80% of balance over \$130	Up to \$47
Standard Plastic Lenses (Single Vision)	\$10 copay	Up to \$32
Standard Plastic Lenses (Bifocal)	\$10 copay	Up to \$46
Standard Plastic Lenses (Trifocal)	\$10 copay	Up to \$57
Lens Tint (Solid and Gradient)***	\$15 copay	n/a
UV Coating***	\$15 copay	n/a
Standard Scratch Resistance***	\$15 copay	n/a
Standard Polycarbonate***	\$0 copay	n/a
Standard Anti-Reflective***	\$45	n/a
Standard Progressive (add-on to bifocal)***	\$75	n/a
Other Add-Ons and Services	80% of retail price	n/a

Contact Lenses (conventional)****	Member receives \$130 allowance and pays 85% of balance over \$130	Up to \$100
Contact Lenses (disposables)****	Member receives \$130 allowance and pays 100% of balance over \$130	Up to \$100
Medically Necessary	\$0 copay	Up to \$210
<p>* Standard contact lens fitting; spherical clear contact lenses in conventional wear and planned replacement (examples include but not limited to disposable, frequent replacement, etc.).</p> <p>**Premium contact lens fitting; all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.).</p> <p>***Paid by the member and added to the base price of the lens.</p> <p>****Allowance covers materials only.</p>		

You also receive 15% off the retail price OR 5% off the promotional price for LASIK and PRK Vision Correction Procedures at participating providers. There is no out-of-network benefit for vision correction procedures.

VISION SERVICES NOT COVERED

- Orthoptic or vision training
- Subnormal vision aids and any associated supplemental testing
- Aniseikonic lenses
- Medical and/or surgical treatment of the eyes
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the plan
- Services provided as a result of Workers' Compensation law
- Plano non-prescription lenses and non-prescription sunglasses (except for the 20% EyeMed discount)
- Two pairs of glasses in lieu of bifocals (does not apply to Primary Plan members)
- Services or materials provided by any other group benefit providing for vision care

HEARING AID BENEFIT

The Medical Trust offers hearing aid benefits with your Medicare Supplement Health Plans. This additional coverage is intended to cover hearing aid services and supplies not generally covered by Medicare. You may access your hearing aids benefits through the Amplicon Hearing Health Care network.

UnitedHealthcare will act as contract administrator, reimbursing your care up to the benefit maximums.

Your benefits are affected by certain limitations and conditions.

ABOUT YOUR HEARING AID BENEFITS

The Hearing Benefit Maximum under the Plan is \$1,000 individual per ear every five years for those enrolled in the Comprehensive or Plus Medicare Supplement Health Plans, and \$2,000 individual per ear every five years for those enrolled in the Premium Medicare Supplement Health Plan. Total Plan payments for each covered person are limited to these maximum benefit amounts.

Any expenses incurred above the maximum for one ear cannot be applied toward the other ear, even if services are considered medically necessary. For example, if you purchase a hearing aid for your right, exhausting your right ear maximum, you cannot replaced the hearing aid by using the available left ear maximum.

The summary on the next page summarizes coinsurance amounts paid by you and the Plan, benefit maximums, and provides additional information and explanation.

Benefit Description	You Pay	Hearing Aid Benefit Pays	Additional Limitations and Explanations
Diagnostic Hearing Services	0%	100%	Subject to the hearing benefit maximum. Benefits include diagnostic hearing tests or exams. Expenses will be applied toward the maximum of the ear requiring the hearing aid. If hearing aids are prescribed for both ears, expenses will be divided equally between the maximums for the right and left ears. Expenses for routine hearing exams should be submitted to your Medicare Supplement Health Plan.
Hearing Aids/Supplies:			Subject to the hearing benefit maximum. Benefits include hearing aids, batteries, supplies, and maintenance.
Right Ear	0%	100%	
Left Ear	0%	100%	

ABOUT THE Amplifon NETWORK

The Amplifon Hearing Health Care network is made up exclusively of audiologists and board-certified hearing instrument specialists. The Amplifon network includes only quality hearing professionals licensed in the state in which they practice.

You may receive a savings off the manufacturer’s suggested retail price of all Amplifon brand hearing instruments. Your benefits include:

- Savings on all styles of hearing instruments, including completely in the canal, in the ear, and behind the ear

- Savings on all levels of technology, including the newest programmable and digital instruments
- Access to more than 1,400 Amplifon affiliate locations across the United States
- Discounts on repairs for hearing aids purchased through Amplifon
- A 60-day trial period with a money-back guarantee
- Comprehensive follow-up services at no charge for one year
- Free demonstrations of the latest available technologies
- Testing performed by licensed hearing care professionals

For more information about the Amplifon network, or for a listing of Amplifon providers in your area, call Amplifon, or visit www.amplifonusa.com.

To access your benefits, follow these four steps:

- 1) Call (866) 349-9055 to select a provider.
- 2) Identify yourself as a plan member of the Episcopal Church Medical Trust.
- 3) Amplifon will mail a referral package to both you and the selected provider.
- 4) After you receive your referral package, call the selected provider and set up an appointment.

Members of your extended family are also eligible for Amplifon discounts. They simply need to mention that they are related to you in order to access the Amplifon discounts.

However, only those family members enrolled in a Medicare Supplement Health Plan sponsored by The Medical Trust are eligible for the hearing benefit as outlined in the previous chart.

COVERED HEARING EXPENSES

When all of the provisions of this Plan are satisfied, the Plan will provide benefits as outlined in the Summary of Hearing Benefits only for the services listed below.

- Hearing examinations or related diagnostic tests associated with the hearing aid prescription
- Hearing aids, related supplies, and maintenance
- Mailing and/or shipping and handling expenses related to delivery of hearing aids or related supplies
- Sales tax related to delivery of hearing aids or related supplies

Note: Routine screenings for hearing loss may be considered under the Medicare Supplement Health Plan. You should submit claims for routine services to your Medicare Supplement Health Plan.

HEARING EXPENSES NOT COVERED

The Plan will not provide benefits for any of the items listed in this section, regardless of the recommendation of a healthcare provider.

This list is intended to give you a general description of services and supplies not covered by the Plan.

- Treatment not prescribed or recommended by a healthcare provider
- Services or supplies for which there is no legal obligation to pay
- Investigational/experimental equipment, services, or supplies
- Routine hearing exams or screenings (Routine screenings for hearing loss may be available under your Medicare Supplement Health Plan.)
- Cochlear implants (Benefits may be available for services covered by Medicare under your Medicare Supplement Health Plan.)
- Services furnished by or for the United States Government or any other government, unless payment is legally required
- Any condition, disability, or expense sustained as a result of duty as a member of the armed forces of any state or country; engaging in a war or act of war, whether declared or undeclared; participation in a civil revolution or riot; or an intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime
- Any condition or disability sustained as a result of being engaged in any activity primarily for wage, profit, or gain, and that could entitle the covered person to a benefit under a workers' compensation act or similar legislation
- Expenses for preparing or copying medical reports, itemized bills, or claim forms
- Expenses for broken appointments or telephone calls
- Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government
- Travel expenses of a physician or a covered person
- Treatment or services rendered outside the United States of America or its territories
- Expenses for hearing aid insurance, warranties, or similar agreements
- Repairs on hearing aids not purchased through an Amplifon provider

HOW TO FILE A CLAIM FOR REIMBURSEMENT

Providers may submit the claim directly to UnitedHealthcare on your behalf. This would allow payment for the claim to be made to the provider. However, if your provider requires you to pay for services at the time you receive care, you will then need to submit claims to the plan for reimbursement using a claim form that can be obtained from UnitedHealthcare or your healthcare provider. An itemized copy of your bill should accompany the claim form. You will need to provide the Plan with the following information:

- Retiree's name, Social Security number, and address
- Patient's name, Social Security number, and address if different from the retiree's
- Provider's name, address, and tax identification number
- Date(s) of service
- Diagnosis
- Procedure codes (describes the treatment or services rendered)
- Signed release of information statement
- Amount charged for each service, including proof of payment

Claims should be submitted for each individual. Do not attach or staple claims together. If additional information is needed to process your claim, you will be notified.

If you receive a letter regarding your claim, prompt completion and return of the letter with any requested attachments will expedite processing of the claim.

The claim will be denied for lack of necessary information if the information requested in the letter is not supplied within 45 days. If you submit the requested information after the 45-day period, this will be treated as a new submission of the claim.

Please send completed claim forms to:

UnitedHealthcare
Atlanta Service Center
PO Box 740827
Atlanta, GA 30374

The Plan will provide you with notice of the claim determination within a reasonable period of time, but no later than 30 days after receipt of the claim. This time

period will be delayed, if the Plan requests additional information, until the requested information is received by the Plan. The Plan may also request a 15-day extension if matters beyond its control require the extension and notice is provided to you within the 30-day period.

All claims must be received by the Plan within 180 days from the date the expenses were incurred.

If you believe a claim denial was improper, please contact UnitedHealthcare at the address listed above.

This Plan will not coordinate benefits with other health plans.

FREQUENTLY ASKED QUESTIONS

If I lose my hearing aid for my right ear, may I purchase another using the benefit maximum for my left ear since I only need one hearing aid?

No. The maximums are per ear. You may not use more than \$1,000 per ear (or \$2,000 per ear for those enrolled in the Premium Plan).

Why should I use the Amplifon Network if I already have a hearing aid vendor in my area?

You do not have to use the Amplifon Network. However, the Amplifon Network does provide significant discounts to members (depending on the type of hearing device being purchased). It makes sense to check to be sure you are getting the best deal.

Can I apply my benefit to the purchase of the throwaway hearing aids they sell on TV?

Since the “Songbird” hearing device is suggested for “situational hearing loss,” it would not be reimbursable under this benefit.

If I only purchase one hearing aid this year, but decide I need the second one a year or two from now, can I still use the benefit at that time for my other ear?

Yes, as long as you have not reached your benefit maximum.

If my hearing aid costs less than the benefit maximum and I later decide to get a better quality aid, can I apply what is left of the benefit to my next purchase?

Yes, as long as you have not reached your benefit maximum for that ear.

What if my hearing decreases dramatically and I need a new hearing aid before the end of the five-year period?

If you have a portion of the benefit remaining for that particular ear, you will be able to access that amount. If, however, there is no remaining benefit, no further reimbursement will be provided.

If I have a previously owned hearing aid that is no longer helpful and I need a new one, can I upgrade it using the benefit?

Yes, as long as you have not reached your benefit maximum.

TRAVEL PROTECTION BENEFITS

The Medical Trust offers the Travel Protection Benefit with your Medicare Supplement Health Plan coverage, subject to certain restrictions, when you become ill or are injured during a covered trip in a foreign country. This travel coverage is intended to cover medically necessary treatment for an accidental injury or acute illness while you are traveling outside of the United States. The travel benefit pays expenses that Medicare generally does not cover, except in limited circumstances.

Your benefits are affected by certain limitations and conditions that require you to be a wise consumer of health services and to use only those services you need. Also, benefits are not provided for certain kinds of treatments or services, even if your healthcare provider recommends them.

The cost of the Travel Protection Benefit is included in your Medicare Supplement Health Plan contribution. From time to time, The Medical Trust may adjust the amount of contributions required for coverage. In addition, the coinsurance may also change periodically. You will be notified of any changes in the cost of Plan coverage.

The Medical Trust has contracted with UnitedHealthcare Global Assistance to provide you with this ancillary travel benefit. Please see the Summary of Travel Benefits for coverage details. UnitedHealthcare Global Assistance will refer you to the nearest, most appropriate facility or provider able to meet your healthcare needs, or provide you with a list of available providers. UnitedHealthcare will provide necessary case management and coordinate or reimburse your medically necessary care up to the benefit maximums, as outlined on the Summary of Travel Benefits.

Please note that you may be asked to pay for your care at the time of service and then file a claim for reimbursement.

All benefits provided under this Plan must satisfy certain basic conditions in order to be eligible for benefit payments.

COVERED TRIP

A covered trip is one that originates from your permanent residence, goes between at least two points, has a travel distance greater than 100 miles, and

lasts no more than 365 days. UnitedHealthcare Global Assistance offers travel assistance services within the United States whenever you travel the minimum distance from your home address. However, medical assistance and treatment eligible for Plan payment are restricted to covered trips outside the United States.

PRE-EXISTING CONDITION

A pre-existing condition is any illness or injury for which you received treatment from a healthcare provider within 60 days prior to a covered trip. If you or your dependents have a pre-existing condition, expenses related to that condition will not be considered under this benefit.

HAZARDOUS PURSUIT

Hazardous pursuit is an activity that involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the class of leisure time activities commonly considered to involve unusual or excessive risks. Such activities include, but are not limited to, sky diving, parachuting, hang gliding, glider flying, and similar forms of air travel, flight in any kind of aircraft except as a passenger on a regularly scheduled commercial airline flight, use of all-terrain vehicles (ATVs), rock climbing, use of explosives, automobile or speedboat racing, travel to countries with advisory warnings, and river running.

Medical assistance and treatment related to a hazardous pursuit are not eligible for coverage under the Plan.

MEDICALLY NECESSARY

Treatments, procedures, services, or supplies that the plan administrator (or its delegate) determines, in the exercise of its discretion:

- Are expected to be of clear clinical benefit to the patient
- Are appropriate for the care and treatment of the injury or illness in question
- Conform to standards of good medical practice as supported by applicable medical and scientific literature

A treatment, procedure, service, or supply must meet all of the criteria listed above to be considered medically necessary and to be eligible for coverage under the Plan. In addition, the fact that a healthcare provider has prescribed,

ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above.

When all of the provisions of this benefit are satisfied, the Plan will provide benefits as outlined in the Summary of Travel Benefits below.

Per Cause Maximum	\$25,000 per individual
Lifetime* Maximum	\$200,000 per individual <i>(includes all other travel benefit maximums)</i>
Benefit Description	Additional Limitations and Explanations**
Medical Services in a Foreign Country	Medically necessary treatment received outside the United States for an acute illness or accidental injury during a covered trip. Benefits include inpatient or outpatient care.
Dental Services in a Foreign Country	Dental services received outside the United States after an accidental injury to teeth during a covered trip. This includes replacement of teeth and related x-rays. Hospital confinement expenses for dental services will be considered only if hospitalization is necessary to safeguard your health.
Visitor Travel Assistance	If you are hospitalized for seven days or longer during a covered trip, the Plan will pay for round-trip transportation for one, using commercial transportation resources (rail, airfare, etc.).
Medical Evacuation	If you sustain an injury or suffer a sudden and unexpected illness and adequate medical treatment is not available in the current location, UnitedHealthcare Global Assistance will arrange for a medically supervised evacuation to the nearest medical facility UnitedHealthcare Global Assistance determines to be capable of providing appropriate medical treatment. Your medical condition and situation must be considered medically necessary by your treating healthcare provider and UnitedHealthcare Global Assistance. The Plan will pay up to the travel benefit per cause maximum.

Transportation After Stabilization	Following emergency medical evacuation and stabilization, UnitedHealthcare Global Assistance will coordinate transportation to your point of origin. UnitedHealthcare Global Assistance will coordinate transportation to your home country if they determine that hospitalization or rehabilitation should occur there. The Plan will pay airfare costs up to the per cause maximum.
Facilitation of Hospital Payment	Upon securing payment or a guarantee to reimburse, UnitedHealthcare Global Assistance will wire funds or guarantee required emergency hospital admittance deposits. You or the plan is ultimately responsible for the cost of medical care and treatment, including hospital expenses. The Plan will pay up to the travel benefit per cause maximum.

**The word "lifetime" refers to the period of time you or your eligible dependents participate in this Plan.*

*** All benefits outlined on the Summary of Travel Benefits will (a) be paid by the Plan at 100%, (b) are subject to the per cause and lifetime benefit maximums, (c) are limited to medically necessary treatment for an accidental injury or acute illness while traveling outside the United States, including services not covered by Medicare, and (d) will be denied for expenses for treatment required due to a non-covered trip, hazardous pursuit, pre-existing condition, or Plan exclusion.*

Upon securing payment or a guarantee to reimburse, UnitedHealthcare Global Assistance will wire funds or guarantee required emergency hospital admittance deposits. You or the Plan is ultimately responsible for the cost of medical care and treatment, including hospital expenses. The Plan will pay up to the travel benefit per cause maximum.

PLAN EXCLUSIONS

The Plan will not provide benefits for any of the items listed in this section, regardless of any recommendation by a healthcare provider. This list is intended to give you a description of expenses for services and supplies not covered by the Plan.

- Treatment not prescribed or recommended by a healthcare provider
- Services, supplies, or treatment that are not medically necessary
- Services or supplies for which there is no legal obligation to pay

- Experimental/investigational equipment, services, or supplies
- Treatment or services received as the result of an accidental injury while the covered individual is engaged in a hazardous pursuit
- Routine care, including physical exams, x-rays and laboratory services, vaccinations, inoculations, or immunizations (Services performed in the United States may be eligible for coverage under your Medicare Supplement Health Plan.)
- Expenses related to services, supplies, or treatment for any medical condition for which medical treatment was received within 60 days prior to a covered trip
- Expenses related to a non-covered trip

ADDITIONAL ASSISTANCE PROVIDED BY UNITEDHEALTHCARE GLOBAL ASSISTANCE

In addition to the covered services outlined in the Summary of Travel Benefits, UnitedHealthcare Global Assistance will provide travel assistance when you travel more than 100 miles from home, either in the United States or abroad. While UnitedHealthcare Global Assistance is available to help coordinate these services, UnitedHealthcare Global Assistance and The Medical Trust are not responsible for the cost of these services. Examples of assistance services available through UnitedHealthcare Global Assistance at your cost are:

- Worldwide medical and dental referrals
- Dissemination of coverage information to medical providers
- Emergency vaccine and blood transfers
- Replacement of prescription medications and corrective lenses
- Emergency transfer of funds
- Assistance with the replacement of lost or stolen travel documents
- Emergency translation services
- Emergency message transmittals
- Coordination of emergency pet housing and/or pet return

HOW TO FILE A CLAIM FOR REIMBURSEMENT

Your healthcare provider may require you to pay for services at the time you receive care. You will then need to submit claims to the plan for reimbursement using a HCFA or UB-92 claim form. The appropriate claim forms may be obtained by contacting UnitedHealthcare. An itemized copy of your bill should accompany the claim form. You will need to provide the plan with the following information:

- Retiree's name, Social Security number, and address
- Patient's name, Social Security number, and address if different from the retiree's
- Provider's name, address, and degree
- Date(s) of service
- Diagnosis
- Description of the treatment or services rendered
- Amount charged for each service, including proof of payment
- Proof that the trip met the minimum requirements of a covered trip, such as travel receipts or other documentation verifying the length of stay, distance from your permanent residence, and any evidence the trip originated from that residence
- Signed release of information statement

Claims should be submitted for each individual and should not be attached or stapled together. If additional information is needed to process your claim, you or your healthcare provider will be notified. If you receive a letter regarding your claim, prompt completion and return of the letter with any requested attachments will expedite processing of the claim. The claim will be denied for lack of necessary information if the information requested in the letter is not supplied within 45 days. If you submit the requested information after the 45-day period, this will be treated as a new submission of the claim.

Completed claim forms should be sent to:

Episcopal Church Medical Trust
Travel Protection Coordinator
P.O. Box 2745
New York, NY 10163

All claims must be received by the plan within 180 days of the date the expense was incurred.

If you believe a claim denial was improper, please contact the Travel Protection Benefit Coordinator at the address listed above.

Travel Protection benefits will not be coordinated with health plan or other benefits.

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP), which is managed by Cigna, is available to all members enrolled in any Medicare Supplement Health Plan through the Episcopal Church Medical Trust and covers a vast array of family and personal services. The program assists members with information, educational materials, resources, referrals, and ongoing support.

EAP services are available 24 hours a day through the Cigna website or by phone. All services are free and confidential. EAP staff members are trained to provide a multitude of services including:

- Help finding counseling services
- Support for managing stress
- Information on grief and loss
- Assistance in researching nursing homes

To access the Cigna EAP services, visit the EAP website at www.cignabehavioral.com or call (866) 395-7794.

SILVER Sneakers®

Healthways Silver Sneakers® Program

Enrollees in all Medicare Supplement health plans can access the popular Healthways Silver Sneakers fitness program at no extra cost. Members will enjoy workouts and fitness instruction at more than 12,000 leading fitness locations nationwide and can also attend classes at parks and recreational centers. Silver Sneakers also includes Steps, a self-directed option which provides at-home and travel-based fitness, and its website contains features that promote overall well-being.

HEALTH ADVOCATE

Health Advocate is a program that helps members navigate and facilitate medical and administrative issues in the healthcare system.

Eligible retirees and their spouses (or domestic partners) and dependent children are covered by this service. Additionally, the parents and parents-in-law of the retiree are also eligible to use Health Advocate if the need should arise.

HEALTH ADVOCATE BENEFITS

Health Advocate's services are provided by Personal Health Advocate, typically registered nurses, backed up by a team of medical directors and administrative experts who will:

- Identify healthcare providers and institutions anywhere in the country
- Arrange and schedule appointments
- Sort out claims questions, billing and payment arrangements and related administrative issues
- Schedule specialized treatment and tests
- Answer questions about test results, treatment recommendations and medications recommended by your physician
- Assist in the transfer of medical records, x-rays, and lab results
- Arrange for home care equipment following discharge from a hospital
- Foster communication and benefits coordination between physicians and insurance companies and coverage providers

To access Health Advocate's services, call (866) 695-8622 (toll-free) and you or a covered family member will be connected to your own Personal Health Advocate.

OTHER IMPORTANT PLAN PROVISIONS

ASSIGNMENT OF BENEFITS

All benefits payable by the Plans are automatically assigned to the provider of services or supplies, unless evidence of previous payment is submitted with the claim. Payments made in accordance with an assignment are made in good faith and release the Plans' obligation to the extent of the payment. Payments will also be made in accordance with any assignment of rights required by a state Medicaid plan.

REIMBURSEMENT TO THE PLANS

Whenever any other party (including, but not limited to, your own insurer under an automobile or other policy, any compensation fund, uninsured motorist coverage, underinsured motorist coverage, medical payments coverage, personal umbrella coverage, workers compensation coverage, no-fault automobile insurance coverage, or first-party insurance coverage) is legally responsible or agrees to compensate you or your dependent, by settlement, verdict, or otherwise, for an illness or injury, you have an obligation to reimburse the Plans from any recovery by you, your dependent, or your representative. If another party is legally responsible or agrees to provide any compensation, you or your dependent (or legal representatives, estate, heirs, or trusts established on behalf of either you or your dependent) must promptly reimburse the Plans for any benefits paid relating to that illness or injury, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized and regardless of whether you or your dependent has been made whole).

If the Plans have not yet paid benefits relating to that illness or injury, the Plans may reduce or deny future benefits on the basis of the compensation received or constructively received by you, your dependent, or your representative.

In order to secure the rights of the Plans under this section, you or your dependent hereby:

- Grant to the Plans a first-priority, equitable lien against the proceeds of any full or partial settlement, verdict, or other amounts received by you, your dependent, or your representative, no matter how those proceeds are captioned or characterized

- Assign to the Plans any benefits you or your dependent may have under any automobile policy or other coverage, to the extent of the Plans' claim for reimbursement
- Agree that you, your dependent, or your representative will hold any compensation in constructive trust for the benefit of the Plans and all their participants who have contributed to the funding of the Plans. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat the Plans' rights. The Plan has a first priority to any recovery from a third party to the extent that benefits have been paid or are payable under the Plan. This means that the Plan's claim to reimbursement must be paid before any other claim against amounts received from the third party.
- Agree that the Plan has the right to initiate a lawsuit or other proceeding or to intervene in a proceeding to exercise or pursue its reimbursement rights.

You or your dependent must cooperate with the Plans and their agents, and must sign and deliver such documents in a timely manner as the Plans or their agents reasonably request to protect the Plans' right of reimbursement. You or your dependent must also provide any relevant information and take such actions as the Plans or their agents reasonably request to assist the plans in making a full recovery of the reasonable value of the benefits provided. You or your dependent must not take any action that prejudices the Plans' right of reimbursement. If you receive payment as part of a settlement or judgment from any third party as a result of a sickness or injury, and the Plans allege that some or all of the funds are due and owed to them, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as trustee over those funds to the extent of the benefits the Plans have paid. The Plans may reduce or deny future benefits on the basis that you or your dependents have refused to sign and deliver such documents as the Plans or their agents reasonably request to protect the Plans' right of reimbursement.

The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation, unless separately agreed to, in writing, by The Medical Trust, in the exercise of its sole discretion. If the Plans incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plans have the right to

recover those fees and costs from you. You may not accept any settlement that does not fully reimburse the Plans without their prior written approval.

The Plan may exercise its reimbursement rights if you or any of your dependents becomes or may become entitled to acquire a direct or indirect interest in or otherwise receive amounts paid by a party on account of any event or circumstance that causes or contributes to you or your dependent's illness, injury or condition. These rights apply to all settlements, judgments, actions and amounts regardless of any and all of the following:

- Whether a party admits liability
- How any amounts that are or may become payable to you or your dependent are characterized. Accordingly, these rights apply to amounts that are designated as payment for medical or dental expenses, or designated for any other purpose, including but not limited to compensation for pain or suffering, non-economic damages, or general damages only. These rights also apply to amounts that are not given any particular designation at all.
- The source or form of payment
- The legal expenses that are or may be incurred in obtaining such payments

By accepting benefits under the Plan (whether paid to you, your dependent, or to a provider on you or your dependent's behalf), you agree that, if you receive payment from any party as the result of an illness, injury or condition, you will serve as a constructive trustee over the funds that constitute the payment. Failure to hold the amounts in trust will be deemed a breach of your duty to the Plan.

You also accept that the Plan has an equitable lien against any amounts recovered from any party as the result of an illness, injury or condition to the extent that benefits have been paid or are payable on account of that illness, injury or condition under the Plan. The lien may be enforced against any party who possesses funds or proceeds from the recovery.

SUBROGATION

Whenever any other party (including, but not limited to, your own insurer under an automobile or other policy, any compensation fund, uninsured motorist coverage, underinsured motorist coverage, medical payments coverage, personal umbrella coverage, workers compensation coverage, no-fault automobile insur-

ance coverage, or first-party insurance coverage) is legally responsible or agrees to compensate you or your dependent for your or your dependent's illness or injury, and the Plans have paid benefits related to that illness or injury, the Plans have the right to restore plan assets to the Plans for the benefit of all participants. The actions of another party caused the Plans to incur expenses they would not normally have incurred; therefore, the Plans are entitled to pursue any cause of action or pursue any remedy available to you or your dependents (regardless of how that action may be characterized and regardless of whether you or your dependent has been made whole).

The Plans are subrogated to all of the rights of you or your dependent against any party liable for your or your dependent's illness or injury, to the extent of the value of the benefits provided to you or your dependent under the Plans. The Plans may assert this right in independently of you or your dependent.

You and/or your dependent are obligated to cooperate with the Plans and their agents in order to protect the Plans' subrogation rights. Cooperation means providing the Plans or their agents in a timely manner with any relevant information requested by them, signing and delivering such documents as the Plans or their agents reasonably request to secure the Plans' subrogation claim, and obtaining the consent of the Plans or their agents before releasing any party from liability for payment of medical expenses.

If you or your dependent enters into litigation or settlement negotiations regarding the obligations of other parties, you or your dependent must not prejudice, in any way, the subrogation rights of the Plans under this section. Please see "Reimbursement to the Plans" section above regarding your or your dependent's obligations regarding any compensation received or constructively received.

The costs of legal representation of the Plans in matters related to subrogation will be borne solely by the Plans. The costs of legal representation of you or your dependent must be borne solely by you or your dependent.

The Plan may exercise its subrogation rights if you or any of your dependents becomes or may become entitled to acquire a direct or indirect interest in or otherwise receive amounts paid by a party on account of any event or circumstance that causes or contributes to you or your dependent's illness, injury or condition. These rights apply to all settlements, judgments, actions and amounts regardless of any and all of the following:

- Whether a party admits liability
- How any amounts that are or may become payable to you or your dependent are characterized. Accordingly, these rights apply to amounts that are designated as payment for medical or dental expenses, or designated for any other purpose, including but not limited to compensation for pain or suffering, non-economic damages, or general damages only. These rights also apply to amounts that are not given any particular designation at all.
- The source or form of payment
- The legal expenses that are or may be incurred in obtaining such payments

By accepting benefits under the Plan (whether paid to you, your dependent, or to a provider on you or your dependent's behalf), you agree that, if you receive payment from any party as the result of an illness, injury or condition, you will serve as a constructive trustee over the funds that constitute the payment. Failure to hold the amounts in trust will be deemed a breach of your duty to the Plan.

You also accept that the Plan has an equitable lien against any amounts recovered from any party as the result of an illness, injury or condition to the extent that benefits have been paid or are payable on account of that illness, injury or condition under the Plan. The lien may be enforced against any party who possesses funds or proceeds from the recovery.

RECOVERY OF EXCESS PAYMENTS

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of these Plans, the Plans have the right to recover these excess payments from any individual (including yourself and your dependent(s)), insurance company, or other organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise all available legal rights, including its right to withhold payment on future benefits, until the overpayment is recovered.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

Consistent with any applicable privacy requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended and other appli-

cable law, the Plans may, without the consent of or notice to any person, release to or obtain from any organization or person information needed to implement Plan provisions, including medical information. When you request benefits, you must either furnish or authorize the release of all the information required to implement Plan provisions. Your failure to fully cooperate will result in a denial of the requested benefits, and the Plans will have no further liability for such benefits.

ALTERNATE PAYEE PROVISION

Under normal conditions, benefits are payable to the provider of services or supplies, unless evidence of previous payment is submitted with the claim form. If conditions exist under which a valid release or assignment cannot be obtained, the Plans may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment. The Plans must make payments to your separated/divorced spouse if required by a qualified domestic relations order (QDRO), state child support agencies, or Medicaid agencies if required by a qualified medical child support order (QMCSO) or state Medicaid law. The Plans may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the Plans. Any payment made by the Plans in accordance with this provision will fully release the plans of their liability to you.

RELIANCE ON DOCUMENTS AND INFORMATION

Information required by The Medical Trust may be provided in any form or document that The Medical Trust considers acceptable and reliable. The Medical Trust relies on the information provided by you and others when evaluating coverage and benefits under the Plans. All such information, therefore, must be accurate, truthful, and complete. The Medical Trust is entitled to conclusively rely upon, and will be protected for any action taken in good faith in relying upon, any information provided to The Medical Trust. In addition, any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result in the denial of the claim, cancellation or rescission of coverage, or any other legal remedy available to the Plans.

No WAIVER

The failure of The Medical Trust to enforce strictly any term or provision of these Plans will not be construed as a waiver of such term or provision. The Medical Trust reserves the right to enforce strictly any term or provision of these Plans at any time.

PHYSICIAN/PATIENT RELATIONSHIP

These Plans are not intended to disturb the physician/patient relationship. Physicians and other healthcare providers are not agents or delegates of the employer, The Medical Trust, the ECCEBT, or the third-party contract administrator. Nothing contained in the Plans will require you or your dependent to commence or continue medical treatment by a particular provider. Further, nothing in the Plans will limit or otherwise restrict a physician's judgment with respect to the physician's ultimate responsibility for patient care in the provision of medical services to you or your dependent.

RIGHT TO AMEND OR TERMINATE THE PLANS

The Medical Trust reserves the right to amend, modify, or terminate the Plans and/or any benefits offered under the Plans in any manner, for any reason, at any time, with or without prior notice.

ADDITIONAL INFORMATION ON COVERED AND EXCLUDED BENEFITS

If you would like to receive additional information regarding a specific drug, medical test, device, or procedure that is either a covered or excluded benefit under these plans, you may contact UnitedHealthcare.

Chapter 13

Privacy

Joint Notice of Privacy Practices

This chapter describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction

Church Pension Group Services Corporation, doing business as The Episcopal Church Medical Trust (Medical Trust), is the plan sponsor of certain group health plans (each a Plan and together the Plans) that are subject to the Health Insurance Portability and Accountability Act of 1996 and the regulations enacted thereunder (HIPAA). HIPAA places certain restrictions on the use and disclosure of Protected Health Information (PHI) and requires the Medical Trust to provide this Joint Notice of Privacy Practices (the Notice) to you. PHI is your individually identifiable health information that is created, received, transmitted or maintained by the Plans or its business associates, regardless of the form of the information. It does not include employment records held by your employer in its role as an employer. This chapter describes how your PHI may be used and disclosed by the Plans and by employees of the Medical Trust that are responsible for internal administration of the Plans. It also describes your rights regarding the use and disclosure of such PHI and how you can gain access to it.

What This Notice Applies To

This Notice applies only to health benefits offered under the Plans. The health benefits offered under the Plans include, but may not be limited to, medical benefits, prescription drug benefits, dental benefits, the health care flexible spending account, and any health care or medical services offered under the employee assistance program benefit. This Notice does not apply to benefits offered under the Plans that are not health benefits. Some of the Plans provide benefits through the purchase of insurance. If you are enrolled in an insured Plan, you will also receive a separate notice from that Plan, which applies to your rights under that Plan.

Duties and Obligations of the Plans

The privacy of your PHI is protected by HIPAA. The Plans are required by law to:

- Maintain the privacy of your PHI
- Provide you with a notice of the Plans' legal duties and privacy practices with respect to your PHI
- Abide by the terms of the Notice currently in effect

When the Plans May Use and Disclose Your PHI

The following categories describe the ways the Plans are required to use and disclose your PHI without obtaining your written authorization:

Disclosures to You. The Plans will disclose your PHI to you or your personal representative within the legally specified period following a request.

Government Audit. The Plans will make your PHI available to the U.S. Department of Health and Human Services when it requests information relating to the privacy of PHI.

As Required By Law. The Plans will disclose your PHI when required to do so by federal, state or local law.

For example, the Plans may disclose your PHI when required by national security laws or public health disclosure laws.

The following categories describe the ways that the Plans *may* use and disclose your PHI without obtaining your written authorization:

- Treatment. The Plans may disclose your PHI to your providers for treatment, including the provision of care or the management of that care. For example, the Plans might disclose PHI to assist in diagnosing a medical condition or for pre-certification activities.
- Payment. The Plans may use and disclose your PHI to pay benefits. For example, the Plans might use or disclose PHI when processing payments, sending explanations of benefits (EOBs) to you, reviewing the Medical Necessity of services rendered, conducting claims appeals and coordinating the payment of benefits between multiple medical plans.
- Health Care Operations. The Plans may use and disclose your PHI for Plan operational purposes. For example, the Plans may use or disclose PHI for quality assessment and claim audits.
- Public Health Risks. The Plans may disclose your PHI for certain required public health activities (such as reporting disease outbreaks) or to prevent serious harm to you or other potential victims where abuse, neglect or domestic violence is involved.
- National Security and Intelligence Activities. The Plans may disclose your PHI for specialized government functions (such as national security and intelligence activities).
- Health Oversight Activities. The Plans may disclose your PHI to health oversight agencies for activities authorized by law (such as audits, inspections, investigations and licensure).
- Lawsuits and Disputes. The Plans may disclose your PHI in the course of any judicial or administrative proceeding in response to a court's or administrative tribunal's order, subpoena, discovery request or other lawful process.
- Law Enforcement. The Plans may disclose your PHI for a law enforcement purpose to a law enforcement official, if certain legal conditions are met (such as providing limited information to locate a missing person).
- Research. The Plans may disclose your PHI for research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability).
- To Avert a Serious Threat to Health or Safety. The Plans may disclose your PHI to avert a serious threat to the health or safety of you or any other person.
- Workers' Compensation. The Plans may disclose your PHI to the extent necessary to comply with laws and regulations related to workers' compensation or similar programs.
- Coroners, Medical Examiners and Funeral Directors. The Plans may disclose your PHI to coroners, medical examiners or funeral directors for purposes of identifying a decedent, determining a cause of death or carrying out their respective duties with respect to a decedent.
- Organ and Tissue Donation. If you are an organ donor, the Plans may release your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- Military and Veterans. If you are a member of the armed forces, the Plans may release your PHI as required by military command authorities.
- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plans may release your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- Business Associates. The Plans may contract with other businesses for certain plan administrative services. The Plans may release your PHI to one or more of their business associ-

ates for plan administration if the business associate agrees in writing to protect the privacy of your information.

- Plan Sponsor. ECMT, as sponsor of the Plans, will have access to your PHI for plan administration purposes. Unless you authorize the Plans otherwise in writing (or your individual identifying data is deleted from the information), your PHI will be available only to the individuals who need this information to conduct these plan administration activities, but this release of your PHI will be limited to the minimum disclosure required, unless otherwise permitted or required by law.

The following categories describe the ways that the Plans *may* use and disclose your PHI upon obtaining your written authorization:

- Most uses and disclosures of psychotherapy notes
- Uses and disclosures of PHI for marketing purposes
- Uses and disclosures that constitute a sale of PHI

Any other use or disclosure of your PHI not identified in this chapter will be made only with your written authorization.

Authorizing Release of Your PHI

To authorize release of your PHI, you must complete a medical information authorization form. An authorization form is available at www.cpg.org or by calling (800) 480-9967. You have the right to limit the type of information that you authorize the Plans to disclose and the persons to whom it should be disclosed.

You may revoke your written authorization at any time. The revocation will be followed to the extent action on the authorization has not yet been taken.

Interaction with State Privacy Laws

If the state in which you reside provides more stringent privacy protections than HIPAA, the more stringent state law will still apply to protect your rights. If you have a question about your rights under any particular federal or state law, please contact the Church Pension Group Privacy Officer. Contact information is included at the end of this chapter.

Fundraising

The Plans may contact you to support its fundraising activities. You have the right to opt out of receiving such communications.

Underwriting

The Plans are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

Your Rights With Respect to Your PHI

You have the following rights regarding PHI the Plans maintain about you:

Right to Request Restrictions. You have the right to request that the Plans restrict their uses and disclosures of your PHI. You will be required to provide specific information as to the disclosures that you wish to restrict and the reasons for your request. The Plans are not required to agree to a requested restriction, but may in certain circumstances. To request a restriction, please write to the

Church Pension Group Privacy Officer and provide specific information as to the disclosures that you wish to restrict and the reasons for your request.

Right to Request Confidential Communications. You have the right to request that the Plans' confidential communications of your PHI be sent to another location or by alternative means. For example, you may ask that all EOBs be sent to your office rather than your home address. The Plans are not required to accommodate your request unless your request is reasonable and you state that the ordinary communication process could endanger you. To request confidential communications, please submit a written request to the Church Pension Group Privacy Officer.

Right to Inspect and Copy. You have the right to inspect and obtain a copy of the PHI held by the Plans. However, access to psychotherapy notes, information compiled in reasonable anticipation of or for use in legal proceedings, and under certain other, relatively unusual circumstances, may be denied. Your request should be made in writing to the Church Pension Group Privacy Officer. A reasonable fee may be imposed for copying and mailing the requested information. You may contact the Medical Trust Plan Administration at astill@cpg.org for a full explanation of ECMT's fee structure.

Right to Amend. You have the right to request that the Plans amend your PHI or record if you believe the information is incorrect or incomplete. To request an amendment, you must submit a written request to the Medical Trust Plan Administration at astill@cpg.org. Your request must list the specific PHI you want amended and explain why it is incorrect or incomplete and be signed by you or your authorized representative. All amendment requests will be considered carefully. However, your request may be denied if the PHI or record that is subject to the request:

- Is not part of the medical information kept by or for the Plans
- Was not created by or on behalf of the Plans or its third party administrators, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the information that you are permitted to inspect and copy
- Is accurate and complete

Right to an Accounting of Disclosures. You have the right to receive information about when your PHI has been disclosed to others. Certain exceptions apply to this rule. For example, a Plan does not need to account for disclosures made to you or with your written authorization, or for disclosures that occurred more than six years before your request. To request an accounting of disclosures, you must submit your request in writing to the Medical Trust-Plan Administration at astill@cpg.org and indicate in what form you want the accounting (e.g., paper or electronic). Your request must state a time period of no longer than six years and may not include dates before your coverage became effective. The Medical Trust Plan Administrator will then notify you of any additional information required for the accounting request. A Plan will provide you with the date on which a disclosure was made, the name of the person or entity to whom PHI was disclosed, a description of the PHI that was disclosed, the reason for the disclosure and certain other information. If you request this accounting more than once in a 12-month period, you may be charged a reasonable, cost-based fee for responding to these additional requests. You may contact Medical Trust Plan Administration at astill@cpg.org for a full explanation of the Medical Trust's fee structure.

Breach Notification. You have the right to receive a notification from the Plans if there is a breach of your unsecured PHI.

Right to a Paper Copy of This Notice. You are entitled to get a paper copy of this Notice at any time, even if you have agreed to receive it electronically. To obtain a paper copy of this Notice, please contact the Church Pension Group Privacy Officer.

If You Believe Your Privacy Rights Have Been Violated

If you believe your privacy rights have been violated by any Plan, you may file a complaint with the Church Pension Group Privacy Officer and with the Secretary of the U.S. Department of Health and Human Services.

All complaints must be filed in writing. You will not be retaliated against for filing a complaint.

To contact the Church Pension Group Privacy Officer:

Privacy Officer
The Church Pension Group
19 East 34th Street
New York, NY 10016
(212) 592-8365
privacy@cpg.org

To contact the Secretary of the U.S. Department of Health and Human Services:

U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
(202) 619-0257 | (877) 696-6775 (toll-free)
www.hhs.gov/contactus.html

Effective Date

This Notice is effective as of August 24, 2015.

Changes

Each Plan sponsored by the Medical Trust reserves the right to change the terms of this Notice and information practices and to make the new provisions effective for all PHI it maintains, including any PHI it currently maintains as well as PHI it receives or holds in the future, as permitted by applicable law. Any material amendment to the terms of this Notice and these information practices will be provided to you via mail or electronically with your prior written consent.

GLOSSARY

APPROVED AMOUNT

The fee a health plan sets as reasonable and customary for a covered medical service. This is the amount the provider or supplier is paid for services or supplies. It may be less than the actual amount charged.

ASSIGNMENT OF BENEFITS

A direct payment from an insurer to a provider of a healthcare service. When providers accept assignment, they are agreeing to accept the health plan's approved amount as the total charge for that services. The patient cannot be billed for any expense over and above the Medicare coinsurance when the provider accepts assignment of benefits.

BENEFICIARY

An individual who is eligible for, or receiving benefits under, a pension plan.

BENEFIT PERIOD

The way a health plan measure your use of hospital and skilled nursing facility services. Under Medicare, a benefit period starts the day you enter one of these facilities. The benefit period ends when you haven't received care at one of these facilities for 60 consecutive days. If you return to one of these facilities after 60 days, a new benefit period begins, and you are subject to new deductible charges. Benefit periods are unlimited under Medicare.

BENEFIT YEAR

The 12-month period during which all annual benefit maximums and deductibles accumulate. The benefit year for the Plans described in this handbook is January 1 through December 31.

BRAND-NAME DRUG

A drug advertised and sold under its protected trademark.

CASE MANAGEMENT

A process whereby covered individuals with specific healthcare needs are identified, and a plan that efficiently utilizes healthcare resources is formulated and implemented to achieve the optimum patient outcome in the most cost-effective manner.

CLAIM

A request for payment under the terms of a benefit plan.

COINSURANCE

The portion (usually a specified percentage) of covered healthcare costs for which the covered person has financial responsibility after meeting any deductible requirements.

CONGENITAL ANOMALY

Physical developmental defect that is present at birth and is identified within twelve months of birth.

COORDINATION OF BENEFITS

A method of regulating payments to eliminate duplicate coverage when a beneficiary is covered by multiple plans. The provision prevents double payment by making one coverage the primary payer and ensuring that not more than 100% of the cost is covered. Standard rules determine which of two or more plans pays its benefits first (primary payer) and which becomes the supplementary payer (secondary payer) on a claim.

COSMETIC PROCEDURES

Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the claims administrator; reshaping a nose with a prominent bump is a good example of a cosmetic procedure because appearance would be improved, but there would be no improvement in a function, such as breathing.

COPAYMENT

A fixed amount of money an individual pays for a healthcare service, such as a physician office visit, prescription drug, or outpatient hospital service.

COVERED HEALTH SERVICES

Those health services, including services, supplies or pharmaceutical products, which the Plan Administrator determines to be:

- Provided for the purpose of preventing, diagnosing or treating sickness, injury, mental illness, substance abuse, or their symptoms
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below
 - Not provided for the convenience of the covered person, physician, facility or any other person
 - Described as covered in the official plan documents
 - Provided to a covered person who meets the Plan's eligibility requirements, as described in the official plan documents
 - Not identified as an excluded benefit

In applying the above definition, “scientific evidence” and “prevailing medical standards” have the following meanings:

- “Scientific evidence” means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community
- “Prevailing medical standards and clinical guidelines” means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other healthcare professionals on UnitedHealthcare Online.

CREDITABLE COVERAGE

Coverage provided through a group health plan and other specified coverage that meets or exceeds the actuarial value of standard Part D coverage. Entities that offer drug coverage are required to notify eligible individuals of whether their coverage qualifies as creditable.

CUSTODIAL CARE

Services that do not require special skills or training, such as:

- Providing assistance in activities of daily living (including, but not limited to, feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating)
- Do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively

DEDUCTIBLE

The amount an individual pays out-of-pocket before a health plan will begin to pay for approved healthcare services.

DURABLE MEDICAL EQUIPMENT

Equipment that can stand repeated use and is primarily used to serve a medical purpose at home or in the community. Examples include hospital beds, wheelchairs, and oxygen equipment.

ELIGIBILITY DATE

The defined date a covered person becomes eligible for benefits under an existing contract or plan.

ELIGIBLE EXPENSES

Charges for covered health services that are provided while the Plan is in effect. For network providers, eligible expenses are based on contracted rates with that provider. If you receive covered health services from an out-of-network provider in an emergency, eligible expenses are the amounts billed by the provider, unless the claims administrator negotiates lower rates.

For certain covered health services, you are required to pay a portion of eligible expenses in the form of a copay and/or coinsurance.

EXPERIMENTAL AND INVESTIGATIONAL SERVICES

Medical, surgical, diagnostic, psychiatric, substance abuse or other healthcare services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time UnitedHealthcare and the Employer make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use
- Subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight.

Exceptions:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and the Employer may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, UnitedHealthcare and the Employer must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

FORMULARY

A list of prescription medications that are covered by the prescription drug plan. In the case of the coverage provided through Express Scripts Medicare, it tells which commonly used Part D prescription drugs are covered by the plan. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has

approved the Express Scripts Medicare Drug List. The Drug List also tells you if there are any rules that restrict coverage for covered drugs. The plan does not cover all prescription drugs. In some cases, the law does not allow any Medicare plan to cover certain types of drugs. See your Evidence of Coverage for more information about the plan's formulary.

GENERIC DRUG

A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a generic drug works the same as a brand-name drug and usually costs less.

HOME DELIVERY

A pharmacy that fills prescriptions through the mail, often in greater quantities and at lesser cost than retail pharmacies. Many **home delivery** pharmacies are affiliated with health plans.

HOME HEALTH CARE

Skilled services provided to individuals in their homes, including physical therapy, occupational therapy, speech therapy, nursing care, and home health aide assistance with activities of daily living.

LIMITING CHARGE

The highest amount of money that can be charged for a covered service by doctors and other providers who don't accept assignment. Medicare's limit is 15% over the approved amount. It does not apply to supplies or equipment.

MEDICALLY NECESSARY

Services or supplies that are proper, needed, and used for diagnosis or treatment of a medical condition and meet the standards of good medical practice.

MEDICARE

A health insurance program for people age 65 or older, some people under age 65 with disabilities, and individuals with End-Stage Renal Disease (ESRD).

MEDICARE AS SECONDARY PAYER

Medicare is the secondary payer for actively employed individuals covered under an employer group health plan.

MEDICARE CARRIER

A private company that has a contract with Medicare to process Part B claims. Also known simply as a Carrier.

MEDICARE PART A

Coverage for hospital care, skilled nursing facility care, hospice care, home health care, and in some cases, blood.

MEDICARE PART B

Coverage for medical expenses, including physician services, lab tests, and medical supplies.

MEDICARE PART D (MEDICARE PRESCRIPTION DRUG PLAN (PDP))

A stand-alone drug plan, offered by insurance and other private companies to add prescription drug coverage to Original Medicare Plans, some Medicare Cost plans, some Medicare Private Fee-for-Service plans and Medicare Medical Savings Account plans that don't have prescription drug coverage. Some Medicare Advantage plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

MEDICARE SUPPLEMENT

A health benefits program sponsored by employers to pay some of the costs that Medicare does not pay.

MEDIGAP POLICY

A standard health insurance policy sold by private insurance companies to fill the "gaps" in Medicare coverage.

NON-FORMULARY BRAND-NAME DRUG

A medication not on a health plan's formulary.

OPEN ENROLLMENT

The period of time during which you can change from one health plan to another, without having experienced a significant life event.

ORIGINAL MEDICARE

The federal health insurance program, created in 1965, under which the government pays providers directly for each service a person receives (on a fee-for-service basis).

About 89% of the Medicare population is enrolled in Original Medicare, as opposed to a private Medicare plan (HMO, PPO).

OUT-OF-POCKET MAXIMUM

The most you will have to pay in any given benefit year for certain types of benefits.

PENSION CHECK DEDUCTION

A direct deduction from a pension check authorized by the payee for the payment of certain benefits.

PLAN SERVICE AREA

A geographic area in which a Part D drug plan provides access to covered Part D drugs. The Centers for Medicare and Medicaid Services has established 26 Medicare Advantage regions and 34 prescription drug plan regions. The prescription drug plan offered by The Medical Trust's plan service area includes all 50 states, the District of Columbia and Puerto Rico.

PREMIUM

The periodic payment made to Medicare, an insurance company, or a healthcare plan for coverage. The payment is generally made monthly. If authorized, payments to The Medical Trust may be automatically deducted from benefit checks.

PDP SPONSOR

An entity that offers a prescription drug plan option under Medicare Part D.

PREVENTIVE SERVICES

Care to keep an individual healthy or to prevent illness, such as yearly physicals, mammograms, cancer screenings, and flu shots.

PRIMARY PAYER

The health plan that will make the first payment or reimbursement for any claims.

PROVIDER

An individual or facility offering healthcare services.

RECONSTRUCTIVE PROCEDURES

A procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a reconstructive procedure is either to treat a medical condition or to improve or restore physiologic function. Covered reconstructive procedures include surgery or other procedures which are associated with an injury, sickness, or congenital anomaly where the primary purpose of the procedure is not to change or improve physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a reconstructive procedure.

RETAIL PHARMACY

A store that sells medications in small quantities directly to the consumer.

UNPROVEN SERVICES

Health services—including medications—that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received).
- Well-conducted cohort studies are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific healthcare services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com

Please note:

- If you have a life threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and the employer may, at their discretion, consider an otherwise Experimental or Investigational Service to be a covered health service for that sickness or condition. Prior to such consideration, UnitedHealthcare and the employer must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

Summary of BENEFITS and Coverage

COMPREHENSIVE MEDICARE SUPPLEMENT HEALTH PLAN

Annual Medicare Supplement Out-of-Pocket Maximum	\$2,000 Individual
Annual Medicare Supplement Part A Benefit Maximum	\$50,000 Individual
Lifetime Medicare Supplement Part A Benefit Maximum	\$200,000 Individual

Benefit Description	You Pay*	Comprehensive Plan Pays**	Additional Limitations and Explanations
Medicare Part A Deductible	\$390 per benefit period	100% of remaining eligible expenses	You must pay the first \$390 per benefit period. Expenses in excess of Medicare-approved days will be your responsibility. Subject to the annual and lifetime Medicare Part A benefit maximums.
Skilled Nursing Facility (Days 21-100)	0%	100%	Expenses in excess of Medicare-approved days will be your responsibility. Subject to the annual and lifetime Medicare Part A benefit maximums.
Outpatient Hospital Services (Facility)	Up to \$275 per visit	100% of remaining eligible expenses	You must pay the first \$275 per visit, which applies to the facility only. Benefits include medical or surgical care for which Medicare Part B helps pay, but which does not include an overnight hospital stay, including blood transfusions; certain drugs; mental healthcare; medical supplies such as splints and casts; emergency room or outpatient clinic, including same-day surgery; and radiation services. Physician services will be considered

Benefit Description	You Pay*	Comprehensive Plan Pays**	Additional Limitations and Explanations
			as All Other Covered Medicare Part B Expenses or as outlined on this schedule. Hospital-billed x-rays and laboratory tests will be considered as Diagnostic X-Rays and Laboratory Services.
Physician Office Visits	Up to \$20 per visit	100% of remaining eligible expenses	You must pay the first \$20 per visit of any Medicare coinsurance for the office visit only. Any covered services performed during the visit will be considered as All Other Covered Medicare Part B Expenses.
Outpatient Mental Health and Substance Abuse Treatment	Up to \$20 per visit	100% of remaining eligible expenses	You must pay the first \$20 per visit. Benefits include doctor and professional fees for mental health and substance abuse treatment. Facility charges will be considered as Outpatient Hospital Services.
Blood Not Covered by Medicare	0%	100%	Limited to the first three pints per cause.
Routine Physicals Not Covered by Medicare	0%	100%	\$200 individual annual maximum for physician office visit charges. Any routine or diagnostic tests, x-rays, or laboratory services performed in conjunction with the visit will be considered under Preventive Services.
Preventive Services Including Services Not Covered by Medicare**	0%	100%	Benefits include routine or diagnostic x-rays, labs, or tests associated with your routine physical (e.g., bone mass measurements, colo-

Benefit Description	You Pay*	Comprehensive Plan Pays**	Additional Limitations and Explanations
			<p>rectal cancer screenings, diabetes services and supplies, and mammogram screenings); vaccinations, inoculations, and immunizations covered by Medicare (e.g., hepatitis B). Flu and pneumonia shots are covered 100% by Medicare when your provider accepts Medicare assignment. If your provider does not accept assignment, Medicare will only pay a portion of the cost and the remainder will be considered under this benefit.</p>
<p>Diagnostic X-Rays and Laboratory Services</p>	<p>0%</p>	<p>100%</p>	<p>Benefits include covered Part B services received in a physician's office, an independent facility, or an outpatient hospital. If service occurred on the same day and as part of an Outpatient Hospital Service, then your coinsurance may be waived.</p> <p>Please call United-Healthcare if you receive an EOB for a diagnostic x-ray or lab service that falls into this category.</p>
<p>Durable Medical Equipment</p>	<p>0%</p>	<p>100%</p>	<p>Examples of durable medical equipment include wheelchairs, hospital beds, oxygen, and walkers.</p>
<p>Chiropractic Services</p>	<p>30%</p>	<p>70%</p>	<p>See your Medicare carrier for information about covered services.</p>

Benefit Description	You Pay*	Comprehensive Plan Pays**	Additional Limitations and Explanations
All Other Covered Medicare Part B Expenses	30%	70%	Limited to expenses eligible for covered under Medicare, but which exceed the benefits provided by Medicare, excluding any amounts over the Medicare-allowable amount.

** Coinsurance for Medicare-approved charges is calculated based on the Medicare coinsurance as indicated on your Medicare Summary Notice, not the actual billed charges. See “Coinsurance” in this handbook for additional information.*

*** Some medical conditions require office visits for labs and tests routinely throughout the year (e.g. a follow-up visit to review a maintenance medication). These visits are not considered part of a routine physical.*

Note: The word “lifetime” refers to the period of time you or your eligible dependents participate in the Plan or any other Medicare Supplement Health Plan sponsored by the Medical Trust. All benefits are limited to expenses approved by Medicare, except as indicated in “Covered Medical Expenses” in the Handbook or as outlined on this schedule.

PLUS MEDICARE SUPPLEMENT HEALTH PLAN

Annual Medicare Supplement Out-of-Pocket Maximum	\$1,750 Individual
Annual Medicare Supplement Part A Benefit Maximum	\$50,000 Individual
Lifetime Medicare Supplement Part A Benefit Maximum	\$200,000 Individual

Benefit Description	You Pay*	Plus Plan Pays**	Additional Limitations and Explanations
Medicare Part A Deductible	Up to \$150 per benefit period	100% of remaining eligible expenses	You must pay the first \$150 per benefit period. Expenses in excess of Medicare-approved days will be your responsibility. Subject to the annual and lifetime Medicare Part A benefit maximums.
Skilled Nursing Facility (Days 21-100)	0%	100%	Expenses in excess of Medicare-approved days will be your responsibility. Subject to the annual and lifetime Medicare Part A benefit maximums.
Outpatient Hospital Services (Facility)	Up to \$275 per visit	100% of Remaining eligible expenses	<p>You must pay the first \$275 per visit, which applies to the facility only. Benefits include medical or surgical care for which Medicare Part B helps pay, but which does not include an overnight hospital stay, including blood transfusions; certain drugs; mental healthcare; medical supplies such as splints and casts; emergency room or outpatient clinic, including same-day surgery; and radiation services. Physician services will be considered as All Other Covered Medicare Part B Expenses or as outlined on this schedule.</p> <p>Hospital-billed x-rays and laboratory tests will be considered as Diagnostic X-Rays and Laboratory Services.</p>

Benefit Description	You Pay*	Plus Plan Pays**	Additional Limitations and Explanations
Physician Office Visits	Up to \$15 per visit	100% of Remaining eligible expenses	You must pay the first \$15 per visit of any Medicare coinsurance for the office visit only. Any covered services performed during the visit will be considered as All Other Covered Medicare Part B Expenses.
Outpatient Mental Health and Substance Abuse Treatment	Up to \$15 per visit	100% of remaining eligible expenses	You must pay the first \$15 per visit. Benefits include doctor and professional fees for mental health and substance abuse treatment. Facility charges will be considered as Outpatient Hospital Services.
Blood Not Covered by Medicare	0%	100%	Limited to the first three pints per cause.
Routine Physicals Not Covered by Medicare	0%	100%	\$200 individual annual maximum for physician office visit charges. Any routine or diagnostic tests, x-rays, or laboratory services performed in conjunction with the visit will be considered under Preventive Services.
Preventive Services Including Services Not Covered by Medicare**	0%	100%	Benefits include routine or diagnostic x-rays, labs, or tests associated with your routine physical (e.g., bone mass measurements, colorectal cancer screenings, diabetes services and supplies, and mammogram screenings); vaccinations, inoculations, and immunizations covered by Medicare (e.g., hepatitis B). Flu and pneumonia shots are covered 100% by Medicare when your provider accepts Medicare assignment. If your provider does not accept assignment, Medicare will only pay a portion of the cost and the

Benefit Description	You Pay*	Plus Plan Pays**	Additional Limitations and Explanations
			remainder will be considered under this benefit.
Diagnostic X-Rays and Laboratory Services	0%	100%	Benefits include covered Part B services received in a physician's office, an independent facility, or an outpatient hospital. If service occurred on the same day and as part of an Outpatient Hospital Service, then your coinsurance may be waived. Please call UnitedHealthcare if you receive an EOB for a diagnostic x-ray or lab service that falls into this category.
Durable Medical Equipment	0%	100%	Examples of durable medical equipment include wheelchairs, hospital beds, oxygen, and walkers.
Chiropractic Services	20%	80%	See your Medicare carrier for information about covered services.
All Other Covered Medicare Part B Expenses	20%	80%	Limited to expenses eligible for covered under Medicare, but which exceed the benefits provided by Medicare, excluding any amounts over the Medicare-allowable amount.

* Coinsurance for Medicare-approved charges is calculated based on the Medicare coinsurance as indicated on your Medicare Summary Notice, not the actual billed charges. See "Coinsurance" in this handbook for additional information.

** Some medical conditions require office visits for labs and tests routinely throughout the year (e.g. a follow-up visit to review a maintenance medication). These visits are not considered part of a routine physical.

Note: The word "lifetime" refers to the period of time you or your eligible dependents participate in the Plan or any other Medicare Supplement Health Plan sponsored by the Medical Trust. All benefits are limited to expenses approved by Medicare, except as indicated in "Covered Medical Expenses" in the Handbook or as outlined on this schedule.

Premium Medicare Supplement Health Plan

Annual Medicare Supplement Out-of-Pocket Maximum	\$1,500 Individual
Annual Medicare Supplement Part A Benefit Maximum	\$50,000 Individual
Lifetime Medicare Supplement Part A Benefit Maximum	\$200,000 Individual

Benefit Description	You Pay*	Premium Plan Pays**	Additional Limitations and Explanations
Medicare Part A Deductible	0%	100% of eligible expenses	Expenses in excess of Medicare-approved days will be your responsibility. Subject to the annual and lifetime Medicare Part A benefit maximums.
Skilled Nursing Facility (Days 21-100)	0%	100%	Expenses in excess of Medicare-approved days will be your responsibility. Subject to the annual and lifetime Medicare Part A benefit maximums.
Outpatient Hospital Services (Facility)	Up to \$175 per visit	100% of remaining eligible expenses	<p>You must pay the first \$175 per visit, which applies to the facility only. Benefits include medical or surgical care for which Medicare Part B helps pay, but which does not include an overnight hospital stay, including blood transfusions; certain drugs; mental healthcare; medical supplies such as splints and casts; emergency room or outpatient clinic, including same-day surgery; and radiation services. Physician services will be considered as All Other Covered Medicare Part B Expenses or as outlined on this schedule.</p> <p>Hospital-billed x-rays and laboratory tests will be considered as Diagnostic X-Rays and Laboratory Services.</p>

Benefit Description	You Pay*	Premium Plan Pays**	Additional Limitations and Explanations
Physician Office Visits	Up to \$15 per visit	100% of remaining eligible expenses	You must pay the first \$15 per visit of any Medicare coinsurance for the office visit only. Any covered services performed during the visit will be considered as All Other Covered Medicare Part B Expenses.
Outpatient Mental Health and Substance Abuse Treatment	Up to \$15 per visit	100% of remaining eligible expenses	You must pay the first \$15 per visit. Benefits include doctor and professional fees for mental health and substance abuse treatment. Facility charges will be considered as Outpatient Hospital Services.
Blood Not Covered by Medicare	0%	100%	Limited to the first three pints per cause.
Routine Physicals Not Covered by Medicare	0%	100%	\$200 individual annual maximum for physician office visit charges. Any routine or diagnostic tests, x-rays, or laboratory services performed in conjunction with the visit will be considered under Preventive Services.
Preventive Services Including Services Not Covered by Medicare**	0%	100%	Benefits include routine or diagnostic x-rays, labs, or tests associated with your routine physical (e.g., bone mass measurements, colorectal cancer screenings, diabetes services and supplies, and mammogram screenings); vaccinations, inoculations, and immunizations covered by Medicare (e.g., hepatitis B).

Benefit Description	You Pay*	Premium Plan Pays**	Additional Limitations and Explanations
			Flu and pneumonia shots are covered 100% by Medicare when your provider accepts Medicare assignment. If your provider does not accept assignment, Medicare will only pay a portion of the cost and the remainder will be considered under this benefit.
Diagnostic X-Rays and Laboratory Services	0%	100%	Benefits include covered Part B services received in a physician's office, an independent facility, or an outpatient hospital. If service occurred on the same day and as part of an Outpatient Hospital Service, then your coinsurance may be waived. Please call UnitedHealthcare if you receive an EOB for a diagnostic x-ray or lab service that falls into this category.
Durable Medical Equipment	0%	100%	Examples of durable medical equipment include wheelchairs, hospital beds, oxygen, and walkers.
Chiropractic Services	0%	100%	See your Medicare carrier for information about covered services.
Outpatient Therapy Services	0%	100%	<p>Benefit includes:</p> <ul style="list-style-type: none"> • Physical therapy • Occupational Therapy • Speech therapy • Post-cochlear implant aural therapy • Pulmonary rehabilitation • Cardiac rehabilitation <p>All rehabilitation services must be provided by a licensed therapy provider under the direc-</p>

Benefit Description	You Pay*	Premium Plan Pays**	Additional Limitations and Explanations
			<p>tion of a physician.</p> <p>The Plan will pay benefits for speech therapy only when the speech impediment or dysfunction results from injury, sickness, stroke, cancer, autism spectrum disorder or a congenital anomaly, or is needed following the placement of a cochlear implant.</p>
All Other Covered Medicare Part B Expenses	20%	80%	Limited to expenses eligible for covered under Medicare, but which exceed the benefits provided by Medicare, excluding any amounts over the Medicare-allowable amount.

* Coinsurance for Medicare-approved charges is calculated based on the Medicare coinsurance as indicated on your Medicare Summary Notice, not the actual billed charges. See “Coinsurance” in this handbook for additional information.

** Some medical conditions require office visits for labs and tests routinely throughout the year (e.g. a follow-up visit to review a maintenance medication). These visits are not considered part of a routine physical.

Note: The word “lifetime” refers to the period of time you or your eligible dependents participate in the Plan or any other Medicare Supplement Health Plan sponsored by the Medical Trust. All benefits are limited to expenses approved by Medicare, except as indicated in “Covered Medical Expenses” in the Handbook or as outlined on this schedule.

2017 Prescription Drug Benefits

Please Note: The information in this section does not apply to plans without the pharmacy option (Comprehensive II, Plus II, Contribution II.)

Comprehensive Plan

Feature	Retail Up to a 31-day Supply	Retail Up to a 90-day Supply	Home Delivery Up to a 90-day Supply
Generic Drug Copayment	You pay \$10	You pay \$30	You pay \$25
Preferred Brand Drugs	You pay \$30	You pay \$90	You pay \$70
Non-Preferred Brand Drugs	You pay \$50	You pay \$150	You pay \$120

Plus and Premium Plans

Feature	Retail Up to a 31-day Supply	Retail Up to a 90-day Supply	Home Delivery Up to a 90-day Supply
Generic Drug Copayment	You pay \$5	You pay \$15	You pay \$12
Preferred Brand Drugs	You pay \$25	You pay \$75	You pay \$60
Non-Preferred Brand Drugs	You pay \$40	You pay \$120	You pay \$100

Please refer to page 67 for information about your costs in the coverage gap stage and the catastrophic coverage stage.

If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.

You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through Express Scripts' home delivery service. There is no charge for standard shipping.

Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. Please contact Express Scripts Medicare Customer Service at (866) 544-6963 for more information. Members using TTY should call (800) 716-3231.

How to Contact Us

To enroll or ask questions about the Medical Trust Medicare Supplement Health Plans, contact your diocesan administrator or Client Services at (800) 480-9967, Monday through Friday, from 8:30 a.m. to 8:00 p.m. eastern time.

Resource	Phone Number and Website
The Medical Trust Client Services Center	(800) 480-9967 8:30AM – 8:00PM ET Monday-Friday www.cpg.org/healthcare/retirees email: mtcustserv@cp.org
Medicare	(800) 633-4227 24 hours a day, 7 days a week www.medicare.gov
UnitedHealthcare	(800) 708-3052 www.myuhc.com
UnitedHealthcare NurseLine	(866) 229-2919
Express Scripts Medicare	(866) 544-6963 www.express-scripts.com
EyeMed Vision Care	(866) 723-0513 www.eyemedvisioncare.com
Cigna Behavioral Health (Employee Assistance Program)	(866) 395-7794 www.cignabehavioral.com
Health Advocate	1-866-695-8622 www.HealthAdvocate.com
UnitedHealthcare Global Assistance	(800) 527-0218 (from U.S., Canada, Puerto Rico, Virgin Islands, and Bermuda)* 410-453-6330 (all other locations) (call collect) https://members.uhcglobal.com 24 hours a day, 7 days a week
Amplifon Hearing Health Care	(866) 349-9055 www.amplifonusa.com M-F 8:00 a.m. to 5:00 p.m. CT

The Plan(s) described in this handbook are sponsored and administered by the Church Pension Group Services Corporation ("CPGSC"), also known as the Episcopal Church Medical Trust (the "Medical Trust"). The Plans that are self-funded are funded by the Episcopal Church Clergy and Employees' Benefit Trust ("ECCEBT"), a voluntary employees' beneficiary association within the meaning of section 501(c)(9) of the Internal Revenue Code.

This handbook contains only a partial description of the Plans intended for informational purposes only. It should not be viewed as a contract, an offer of coverage, or investment, tax, medical, or other advice.

The Church Pension Fund and its affiliates, including but not limited to the Medical Trust, CPGSC and ECCEBT (collectively, "CPG"), retain the right to amend, terminate, or modify the terms of the Plans, as well as any post-retirement health subsidy, at any time, for any reason and unless required by law, without notice.

The Plans are church plans within the meaning of section 3(33) of the Employee Retirement Income Security Act and section 414(e) of the Internal Revenue Code. Not all Plans are available in all areas of the United States, and not all Plans are available on both a self-funded and fully insured basis. The Plans do not cover all healthcare expenses, and Members should read the official Plan document carefully to determine which benefits are covered, as well as any applicable exclusions, limitations, and procedures.

CPG does not provide any healthcare services and therefore cannot guarantee any results or outcomes. Healthcare providers and vendors are independent contractors in private practice and are neither employees nor agents of CPG. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.