

Plan Document Handbook



Medical Trust Medicare Supplement Health Plans

Comprehensive Plan
Plus Plan
Premium Plan

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 PENSION GROUP

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 cpg.org. Or you may call Client Services at (800) 480-9967, Monday through Friday 8:30AM to 8:00PM ET.

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

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HOW THIS PLAN DOCUMENT HANDBOOK CAN HELP YOU

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 Plan Document Handbook, the word "year" refers to the plan year, which is the 12-month period beginning January 1, 2021 and ending December 31, 2021. All annual benefit maximums and deductibles accumulate during the plan year.

The word "lifetime", as used in this Plan Document 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, and unless required by law, 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 Plan Document 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.

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

This Plan Document 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®, Amplifon Hearing Health Care, and the Cigna 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 Plan Document 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 Document Handbook.

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 Clergy Benefits at www.cpg.org/clergyguide.

Once Medicare becomes a member's primary coverage, the medical coverage will be coordinated with Medicare. Generally, one becomes eligible for Medicare at age 65, although a person may become eligible sooner if he or she becomes disabled.

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 plans¹.

Eligible Individuals

- A Post-65 Retired Employee
- A Retired Member of a Religious Order
- A Pre-65 Retired Employee who is enrolled in Medicare Parts A and B

¹ If a member misses the deadline for enrollment in Medicare Part B or is otherwise not enrolled, UnitedHealthcare will estimate the Medicare payments. Therefore, a member may be responsible for the difference between total billed charges and the combined benefit from the estimated amount covered by Medicare Part B and the medical plan.

- Cleric receiving benefits under The Church Pension Fund Clergy Long-Term Disability Plan who is enrolled in Medicare Parts A and B
- A Pre-65 Employee on long-term disability who is enrolled in Medicare Parts A and B

Eligible Dependents

- A Spouse or Surviving Spouse*
- A Domestic Partner or Surviving Domestic Partner
- A Dependent Disabled Child or Surviving Dependent Disabled 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

IMPORTANT NOTES

MEDICARE SECONDARY PAYER (MSP)

The Plan must comply with 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 employer group health plans to be the primary payer of health claims for individuals who are working and eligible for active group health care coverage. If an Employee who is 65 or older is eligible for coverage 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 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 the EHP or EHP SEE, if eligible.

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 health plans or Medicare HMOs for Medicare beneficiaries who are otherwise eligible for active group health coverage. Therefore, the Plan does not offer Medicare supplement health plans or Medicare HMOs to Employees and their Spouses over age 65 and the Employee and their eligible Spouse can no longer receive a subsidy under The Church Pension Fund Post-Retirement Medical Assistance Plan. Failure to comply with the MSP rules can result in penalties assessed against the employer. It is the employer's responsibility to comply with the MSP rules and by participating in the Plans, the employer agrees to indemnify and hold the Medical Trust harmless from any claims resulting from the failure to comply with the MSP rules.

SMALL EMPLOYER EXCEPTION

Medicare provides an exception from this general rule for small employers, generally, those with fewer than 20 full- and/or part-time employees in the current or preceding years. 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.

Eligible small employers must apply to the Centers for Medicare and Medicaid Services (CMS) for approval to participate in the SEE by submitting an Employee Certification Form for each participant who may be eligible to the Medical Trust. (Eligible participants generally are those age 65 or older who

are enrolled or eligible to enroll in Medicare Part A and, if applicable, Medicare Part B.) Once CMS has approved an employer and participants for the SEE, Medicare then becomes the primary payer of claims under Medicare Part A and, if applicable, Medicare Part B, for approved participants. The SEE Plan becomes the secondary payer and will coordinate benefit payments with Medicare for Medicare Part A claims and, if applicable, Medicare Part B claims.

Because Medicare will become the primary payer of claims covered under Medicare Part A, to participate in the EHP SEE, any members of the family who are eligible must be enrolled in Medicare Part A. Medicare Part A insurance helps cover the cost of inpatient care in hospitals, skilled nursing facilities, hospices, and home healthcare situations.

For all other coverage, such as doctor visits, outpatient procedures, and prescription drug coverage, the Medical Trust plan will remain the primary payer of benefits. However, if an Employee or Eligible Dependent elects to enroll in Medicare Part B coverage, Medicare will become the primary payer of Part B claims and the Medical Trust plan will coordinate benefit payments with Medicare and become the secondary payer.

When Medicare becomes the primary payer for claims under Medicare Part A or Part B, the cost to employers of providing medical coverage may be reduced. Employees' hospitalization costs, including out-of-pocket expenses such as deductibles and coinsurance, will typically be lower as well. In addition to the cost savings typically realized with Medicare as the primary payer of the claims, additional savings can be realized by using network providers. The Member will usually pay less for services from network providers than from out-of-network providers.

Individuals who are enrolled in the EHP SEE will continue to have access to the value-added benefits included in the Medical Trust plans, such as:

- Vision care through EyeMed
- Cigna Employee Assistance Program (EAP)
- Health Advocate
- Amplifon Hearing Health Care discounts
- UnitedHealthcare Global Assistance travel assistance

Participation in the EHP SEE is not mandatory. Although the employer and the individual employee may be approved to participate in the EHP SEE, the Employee has the option to elect a different plan offered by the employer.

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.

If the Post-65 Retired Employee who is working for The Episcopal Church after retirement does not qualify for coverage under the EHP or EHP SEE, then the Post-65 Retired Employee may be eligible to purchase the MSHP.

Failure to comply with the MSP rules can result in penalties assessed against the employer. It is the employer's responsibility to comply with the MSP rules and by participating in the Plans, the employer agrees to indemnify and hold the Medical Trust harmless from any claims resulting from the failure to comply with the MSP rules.

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.

ANNUAL ENROLLMENT

Annual 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 have elected until the next annual enrollment period (as long as you continue to be eligible for coverage and contributions are paid, if any are due).

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 Document 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 2021?
- 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 limits 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 worksheets located in the Appendix of this Plan Document Handbook 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.

ORIGINAL MEDICARE

Original Medicare is a federal health insurance program for people age 65 or over, under 65 with certain disabilities, and those with End-Stage Renal Disease. *Medicare & You*, published by the Centers for Medicare and Medicaid Services, provides a summary of the benefits, rights, and protections provided by Medicare. It is available for download at www.cpg.org/mtdocs.

MEDICARE PART A

Medicare Part A help cover inpatient care in hospitals. This includes critical access hospitals and inpatient rehabilitation facilities. It also help cover hospice care and home health care, as well as skilled nursing facilities. Medicare Part A does not cover custodial or long-term care.

You usually don't pay 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, and 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.

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 provided by private companies. 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.

For more information on what's covered by Medicare, download *Medicare & You* from www.cpg.org/mtdocs or visit www.medicare.gov.

WHEN TO SIGN UP FOR MEDICARE (INITIAL ENROLLMENT PERIOD)

Generally, you should enroll in Medicare Part A and Part B when you are first eligible. You become eligible to enroll during the 7-month period that:

- Begins 3 months before the month you turn 65
- Includes the month you turn 65
- Ends the 3 months after the month you turn 65

You should note that if you wait until the month you turn 65 or the 3 months after, your Part B coverage will be delayed, which may cause a gap in coverage.

In most cases, if you don't enroll in Medicare Part B when you are first eligible, you will have to pay a late enrollment penalty. You will have to pay this penalty for as long as you have Medicare Part B.

SPECIAL CIRCUMSTANCES (SPECIAL ENROLLMENT PERIOD)

If you do not enroll in Medicare Part B during your initial enrollment period, you may be able to enroll during a Special Enrollment Period (SEP) without penalty, if:

- You or your spouse is working, and
- You are covered by a group health plan through the employer because of that work.

If that is the case, then you have creditable coverage and you may delay Medicare enrollment.

You have an 8-month SEP that begins:

- The month after the employment ends
- The month after group health plan insurance based on current employment ends

Usually, you do not pay a late enrollment penalty if you enroll during a SEP.

NOTE: You may enroll in an Extension of Benefits (EOB) after employment ends. EOBs (and other COBRA coverage) are not considered coverage based on current employment, and are therefore not creditable coverage. The 8-month SEP begins when employment ends, as stated above. Do NOT wait until the end of your EOB to enroll in Medicare Part B or you will have to pay the late enrollment penalty.

THE MEDICAL TRUST'S MEDICARE SUPPLEMENT HEALTH PLANS

The Medical Trust offers three Medicare Supplement Health Plans: the Comprehensive Plan, the Plus Plan, and the Premium Plan. All three plans supplement benefits provided by Medicare Part A and Medicare Part B by helping to pay for a portion of your Medicare copayments, coinsurances, and deductibles.

After reading the information in this Plan Document Handbook, you may decide to compare our Medicare Supplement Plans with Medigap policies offered by a local insurance company, or you may join a Medicare managed care plan (HMO). This is a very important decision that only you can make, taking into account your healthcare needs and financial situation.

COMPARING THE MEDICARE SUPPLEMENTS WITH A MEDIGAP POLICY

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.

Unlike some Medigap plans, preexisting conditions do not apply for the Medical Trust Medicare Supplement 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.

MAKING AN ENROLLMENT DECISION

It's especially important that you determine what you might spend on copayments, coinsurances, deductibles, as well as your monthly contributions (premiums), in any plans you are considering. To help you estimate your costs in the Medical Trust Medicare Supplement Health Plans, worksheets are provided in the appendix in the back of this Plan Document Handbook. By listing the healthcare costs and services that you used this year on the worksheets, and also thinking about future healthcare needs, you should have a better sense of the benefits you're looking for in a Medicare Supplement Health Plan.

ADDED BENEFITS

Remember that the Medical Trust's Medicare Supplement Health Plans include other benefits at no additional cost to supplement what Medicare provides, including:

- Cost sharing of Medicare Part A and Part B deductibles and coinsurances
- An annual physical exam
- Prescription drug benefits (with no annual benefit cap)
- Vision benefits
- Hearing aid benefits
- Annual out-of-pocket limits for medical expenses
- Cigna's Employee Assistance Program
- Health Advocate services for help negotiating the healthcare landscape

If you have questions about The Medical Trust's Medicare Supplement Health Plans, please call Client Services at (800) 480-9967.

COVERED MEDICAL EXPENSES

Basically, if Medicare covers and pays for a service, then the Medicare Supplement will pay its portion. *Medicare & You*, published by the Centers for Medicare and Medicaid Services (CMS), is a wonderful resource to learn about your coverage.

If a service or item is not covered by Medicare, then it is not covered by the Medicare Supplements with certain exceptions.

Services and supplies not covered by Medicare that are covered by your Medicare Supplement are:

- Routine physicals, 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
- Hearing exams performed by your physician during a routine physical

Additionally, the Medicare Supplement Premium Plan provides for benefits beyond what Medicare covers for physical therapy, occupational therapy, speech therapy, pulmonary rehabilitation, and cardiac rehabilitation. See the Summary of Benefits and Coverage for more information and limitations.

Some of the Medicare costs that a Medical Trust Medicare Supplement can help with are illustrated in the chart on the next page.

What Medicare Asks You to Pay in 2021		Medical Trust Medicare Supplement Plans Help Pay
Hospital Stays	<ul style="list-style-type: none"> • \$1,484 deductible per benefit period • \$0 copay for the first 60 days of each benefit period • \$371 per day for days 61-90 of each benefit period • \$742 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 \$185.50 per day for days 21-100	Yes
Medicare Part B Deductible	\$203	Yes
Medicare Part B covered services	<ul style="list-style-type: none"> • 20% of the Medicare-approved amount for most covered services, including behavioral health services • Copayment for outpatient hospital services 	Yes
Medicare Part B Premium	\$148.50 (approx.) if your income is \$88,000 or less (single) or \$176,000 or less (married couple). If your income is above \$88,000/\$176,000, your Medicare Part B premium may be higher	No
Medicare Part D Premium	If your income is more than \$88,000 (single) or \$176,000 (married couple), you will pay an income-related monthly adjustment in addition to your plan premium	No

EXCLUSIONS

While these Plans cover many basic benefits, they cannot pay for everything. Among the exclusions are:

- Long-term care
- Private-duty nursing
- Cosmetic surgery
- Surgery intended to correct nearsightedness, farsightedness, presbyopia, or astigmatism
- Routine foot care
- Vaccinations (in most cases)

This is just a small representation of exclusions and limitations. For a more complete list, refer to *Medicare & You*.

YOUR COSTS FOR THE MEDICARE SUPPLEMENT HEALTH PLANS FOR 2021

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

- Comprehensive Plan \$400
- Plus Plan \$520
- Premium Plan \$605

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

- Comprehensive Plan II \$215
- Plus Plan \$250
- Premium Plan \$300

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.

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

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. You may not divide payments between pension deduction and direct billing.

If you and your spouse or domestic partner (and any other qualified dependents) enroll in different plans, then you can divide the payment between pension deduction and direct billing.

THE MEDICARE SUPPLEMENT SUBSIDY

If you are a retired clergy with 10 or more years of credited service, you may be eligible for the Church Pension Fund's Medicare Supplement Subsidy. Visit the CPG website or call Client Services for more information.

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(s) 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.

To reach Client Services, just call (800) 480-9967.

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 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 **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
PO Box 2745
New York, NY 10163
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 **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 Amount paid by Medicare (primary plan)
\$ 500
\$ 500 Considered amount (by secondary plan)
X 80% Multiplied by coinsurance percentage
\$ 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 benefit 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. This Plan is administered by Express Scripts and is called Express Scripts Medicare™ (PDP) for The Episcopal Church Medical Trust.

EXPRESS SCRIPTS MEDICARE FORMULARY

The list of drugs covered by the Plan is known as the “formulary.” It contains a list of highly utilized Medicare part D drugs selected by Express Scripts Medicare in consultation with a team of healthcare providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. The formulary also includes information on requirements or limits for some covered drugs that are part of Express Scripts Medicare’s standard formulary rules. For more information on your plan’s specific drug coverage, visit www.express-scripts.com or contact Customer service at (866) 544-6963.

CHANGES IN DRUG COVERAGE

Generally, if you are taking a drug covered by your plan in 2021, Express Scripts Medicare will not discontinue or reduce coverage of the drug during the 2021 coverage year, except when a new, less expensive generic drug becomes available or new information about the safety or effectiveness of a drug is released or the drug is removed from the market. Other types of formulary changes, such as removing a drug from the Plan’s formulary, will not affect members who are currently taking the drug. It will remain available at the same copayment or coinsurance amount for those members taking it for the remainder of the coverage year.

- **New generic drugs.** Express Scripts Medicare may immediately remove a brand-name drug on the formulary if they are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, Express Scripts Medicare may decide to keep the brand-name drug on the formulary, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, you may not be told in advance before the change is

made, but Express Scripts Medicare will later provide you with information about the specific change(s) we have made.

- If we make such a change, you or your prescriber can ask Express Scripts Medicare to make an exception and continue to cover the brand-name drug for you. The notice provided to you will also include information on the steps you may take to request an exception, and you can also find information in the section below entitled “How do I request an exception to the formulary?”
- **Other changes.** Express Scripts Medicare may make other changes that affect members currently taking a drug. For instance, Express Scripts Medicare may add a generic drug that is not new to market to replace a brand-name drug currently on the formulary or add new restrictions to the brand-name drug or move it to a different cost-sharing tier. Or changes may be made based on new clinical guidelines. If drugs are removed from the formulary, or prior authorization is added, or new limits or restrictions on a drug are introduced, or a drug is moved to a higher cost-sharing tier, if applicable, we must notify affected members of the change at least 30 days before the change becomes effective or at the time the member requests a refill of the drug, at which time the member will receive a one-month supply of the drug.

GENERIC DRUGS

Both brand-name drugs and generic drugs are covered under this plan. A generic drug is approved by the FDA as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

COVERAGE RESTRICTIONS

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** You or your doctor is required to get prior authorization for certain drugs. This means that you will need to get approval from the Plan before you fill your prescriptions. If you don't get

approval, the drugs may not be covered. These drugs are noted with “PA” next to them in the formulary.

Some drugs may be covered under Part B or under Part D, depending on your medical condition. Your doctor will need to get a prior authorization for these drugs as well, so your pharmacy can process your prescription correctly.

- **Quantity Limits:** For certain drugs, the amount of the drug that will be covered by the Plan is limited. The Plan may limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, Express Scripts Medicare may limit coverage for your prescription to no more than one pill per day. These drugs are noted with “QL” next to them in the formulary.
- **Step Therapy:** In some cases, you are required to first try certain drugs to treat your medical condition before another drug is covered for that condition. For example, if Drug A and Drug B both treat your medical condition, Drug B may not be covered unless you try Drug A first. If Drug A does not work for you, then Drug B will be covered. These drugs are noted with “ST” next to them in the formulary.

You may be able to find out if your drug has any additional requirements or limits by reviewing the formulary at www.express-scripts.com or calling Customer Service at (866) 544-6963.

You can ask to make an exception to these restrictions or limits. See the section “How do I request an exception to the formulary?” for information about how to request an exception.

IF YOUR DRUG IS NOT LISTED ON THE FORMULARY

If your drug is not included in the list of covered drugs, you should first contact Customer Service and ask if your drug is covered.

If you learn that your drug is not covered, you have two options:

- You can ask our customer Service department for a list of similar drugs that are covered. When you receive the list, show it to your doctor and ask to have one of the similar drugs prescribed.
- You can ask us to make an exception and cover your drug. See the following section for information about how to request an exception.

You should talk to your doctor to decide if you should switch to an appropriate drug that the plan covers or request an exception so that the Plan will cover the drug you are taking.

REQUESTING AN EXCEPTION TO THE FORMULARY

You can ask Express Scripts Medicare to make an exception to the coverage rules. There are several types of exceptions that you can ask Express Scripts Medicare to make.

- You can request coverage of a drug that is not currently covered by the Plan. If approved, the drug will be covered at a pre-determined cost-sharing level, and you will not be able to ask for the drug to be covered at a lower cost-sharing level.
- You can ask that a formulary drug be covered at a lower cost-sharing level. If your drug is contained in the Non-Preferred Drug tier, you can ask Express Scripts Medicare to cover it at the cost-sharing amount that applies to drugs in the Preferred Brand Drug tier instead. If approved, this would lower the amount you must pay for your drug.
- You can ask for a waiver to coverage restrictions or limits on your drug. For example, for certain drugs, Express Scripts Medicare limits the amount of the drug it will cover. If your drug has a quantity limit, you can ask for a waiver to the limit and cover a greater amount.

You should contact Express Scripts Medicare to ask for an initial coverage decision for an exception, utilization restriction exception, or to ask the Plan to cover a drug that is not currently covered. **When you are requesting an exception, you should submit a statement from your prescriber or physician supporting your request.** Generally, Express Scripts must make their decision within 72 hours of getting your prescriber's supporting

statement. You can request an expedited (fast) exception if you or your doctor believes that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, Express Scripts Medicare must give you a decision no later than 24 hours after the supporting statement from your doctor or other prescriber is received.

Generally, your request for an exception will only be approved if the alternative drugs that are covered, the lower-tiered drugs, or the additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

GETTING A TEMPORARY TRANSITION SUPPLY WHILE WAITING FOR AN EXCEPTION DECISION

As a new or continuing member in the Plan, you may be taking drugs that are not covered from one year to the next. Or, you may be taking a drug that is covered but your ability to get it is limited. For example, you may need a prior authorization from Express Scripts Medicare before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that is covered or request an exception so that Express Scripts Medicare will cover the drug you take. While you talk to your doctor to determine the right course of action for you, or while you wait for a coverage decision, Express Scripts Medicare may cover a temporary transition supply of your drug in certain cases during the first 90 days that you are enrolled in the Plan or at the start of a new coverage year.

For each of your drugs that is not on the formulary, or if your ability to get drugs is limited, Express Scripts Medicare will cover a temporary transition supply when you go to a network pharmacy. This temporary transition supply will be for a one-month supply. If your prescription is written for fewer days, Express Scripts Medicare will allow refills to provide up to a maximum of a one-month supply of medication. After your first refill of a one-month supply, Express Scripts Medicare will not pay for these drugs, even if you have been a plan member less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on the formulary, or if your ability to get your drug is limited but you are past the first 90 days of membership in the Plan, Express Scripts Medicare

will cover a minimum of a 31-day emergency transition supply of that drug while you pursue an exception.

Other times when Express Scripts Medicare will cover at least a temporary 30-day transition supply (or less, if you have a prescription written for fewer days) include:

- When you enter a long-term care facility
- When you leave a long-term care facility
- When you are discharged from a hospital
- When you leave a skilled nursing facility
- When you cancel hospice care
- When you are discharged from a psychiatric hospital with a medication regimen that is highly individualized

Express Scripts Medicare will send you a letter within 3 business days of your filling a temporary transition supply notifying you that this was a temporary supply and explaining your options.

MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM

A Medication Therapy Management (MTM) Program is a free service offered 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.

Smart90®

Your pharmacy benefit includes Smart90. With the feature, you have two ways to get up to a 90-day supply of your long-term maintenance medications (those drugs you take regularly for ongoing conditions):

- Via home delivery from the Express Scripts Pharmacy
- At any Walgreens pharmacy, plus Walgreens-affiliated pharmacies such as Duane Reade and certain Rite-Aid locations.

For more information about Smart90, Call Express Scripts customer service using the number on the back of your ID card.

VISION BENEFITS

When you are enrolled in a Medical Trust Medicare Supplement Health Plan, you will receive vision benefits through EyeMed Vision Care'sSM Insight Network. When using this network, your vision benefits include an annual eye exam with no cost share, a \$150 allowance towards frames or contact lenses with a discounted rate for a balance over \$150, a small copayment for standard lenses, enhanced benefits for progressive lenses, and much more.

EyeMed's summary of benefits can be found in the Appendix in the back of this Plan Document Handbook. You can also visit their website at www.eyemedvisioncare.com/ecmt or call (866) 723-0513 for more information or for help in finding a local provider.

HEARING AID BENEFITS

With more than 1,400 affiliate locations across the United States, Amplifon Hearing Health Care offers unparalleled access to qualified hearing specialists and discounts. You will have access to all styles of hearing instruments, including completely in the canal, in the ear, and behind the ear. You will also receive savings on all levels of technology, including the newest programmable and digital instruments.

UnitedHealthcare acts as contract administrator and will reimburse your care up to the benefit maximums. Your benefits are affected by certain limitations and conditions.

ABOUT YOUR HEARING BENEFITS

Our members enrolled in a Medical Trust Medicare Supplement Health Plan have a hearing aid benefit as follows:

- If you are enrolled in the Comprehensive Plan or the Plus Plan, you have a benefit of \$1,500 per ear every three years.
- If you are enrolled in the Premium Plan, you have a benefit of \$2,000 per ear every three years.

The hearing aid benefit includes diagnostic hearing services and tests, the costs of which will be applied to the benefit maximum of the ear requiring the hearing aid. If hearing aids are prescribed for both ears, the expenses incurred for services and tests will be applied equally to both ears.

If your hearing loss increases dramatically, or for any other reason you need to replace a hearing aid within five years, you can access your benefit as long as you have not reached your benefit maximum.

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.

Any expenses for one ear cannot be applied to the other ear. For example, if you purchase a hearing aid for your left ear, exhausting your benefit, you cannot replace the hearing aid by using the available benefit for your right ear.

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.

Through Amplifon, you will receive a savings off the manufacturer's suggested retail price of all hearing instruments, including:

- 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
- 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 to find providers in your area, call Amplifon at (866) 349-9055 or visit www.amplifonusa.com.

You do not have to use the Amplifon Network to access your benefit. However, given the significant discounts available to our members (depending on the type of device purchased), it makes sense to be sure you are getting the best deal.

ACCESSING YOUR BENEFITS

To access your benefits:

- Call (866) 349-9055 to select a provider.
- Identify yourself as a plan member of the Episcopal Church Medical Trust.
- Amplifon will mail a referral package to both you and the selected provider.

- 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 simply by mentioning that they are related to you. However, only those family members enrolled in a Medical Trust Medicare Supplement plan are eligible for the hearing aid benefit.

COVERED HEARING EXPENSES

When all of the requirements of the Plan are satisfied, the Plan will provide benefits up to benefit maximums for the following services:

- 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

HEARING AID EXPENSES NOT COVERED

The hearing aid benefit does not include coverage for the following:

- Treatment not prescribed or recommended by a healthcare provider
- Routine hearing exams or screenings (may be available under your Medicare Supplement plan)
- Investigational/experimental services or supplies
- Hearing devices for “situational hearing loss”, such as the throwaway hearing aids advertised on television
- Cochlear implants (may be available under your Medicare Supplement plan)
- Expenses for hearing aid insurance, warranties, or similar agreements

FILING A CLAIM

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 need to submit claims to the plan for reimbursement using the hearing aid claim form in the Appendix section at the back of the Plan Document Handbook. The claim form is also available at www.cpg.org/mtdocs.

An itemized copy of your bill should accompany the claim form. The Plan will need the following information:

- Retiree's name, Social Security Number, and address
- Patient's name, Social Security Number, and address (if different)
- 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

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.

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

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

The Plan will not coordinate benefits with other health plans.

TRAVEL PROTECTION

Your Medicare Supplement Health Plan includes a travel protection benefit should you have a medical emergency while traveling outside of the United States. This benefit, provided through UnitedHealthcare Global Assistance, will refer you to the nearest, most appropriate facility or provider able to meet your healthcare needs, provide necessary case management, and coordinate payment or reimburse your medically necessary care up to the benefit maximums, as outlined in this section.

UnitedHealthcare Global Assistance offers travel assistance services whenever you are more than 100 miles away from home. However, medical assistance and treatment eligible for Plan payment are restricted to covered trips outside the United States.

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.

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 the benefit maximums.

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 the Plan must satisfy certain basic conditions in order to be eligible for benefit payments.

BENEFIT MAXIMUMS

The travel benefit maximums are:

- \$25,000 per individual per cause

- \$200,000 per individual per lifetime (includes all other travel benefit maximums)

The word “lifetime” refers to the period of time you or your eligible dependents participate in a Medical Trust Medicare Supplement Plan.

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.

PRE-EXISTING CONDITIONS

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
- River running

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

MEDICALLY NECESSARY

Treatment, 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.

WHAT'S COVERED

The following services are covered:

- Medically necessary treatment received outside the United States for an acute illness or accidental injury during a covered trip. Benefits include inpatient and outpatient care.
- 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.
- Round-trip transportation for one visitor, using commercial transportation resources (rail, airfare, etc.) if you are hospitalized for seven days or longer during a covered trip.
- Medical evacuation is covered 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 that they determine 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.

- 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.
- 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.

All benefits outlined in this section 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 exclusions.

WHAT'S NOT COVERED

The Plan will not provide benefits for any of the items listed below, 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 SERVICES PROVIDED BY UNITEDHEALTHCARE GLOBAL ASSISTANCE

In addition to the covered services listed in this section, 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 vaccines 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

FILING 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 a claim to the Plan for reimbursement. The UnitedHealthcare International Claim Form is in the Appendix section at the back of the Plan Document Handbook and is also available at www.cpg.org/mtdocs.

CIGNA EMPLOYEE ASSISTANCE PROGRAM

The Cigna Employee Assistance Program (EAP) is available to all members enrolled in a Medical Trust Medicare Supplement Health Plan. This program covers a vast array of family and personal services, by providing information, educational materials, resources, referrals, and ongoing support.

EAP services are available 24 hours a day through the Cigna website or by phone. Simply register at www.mycigna.com or call (866) 395-7794. All services are free and confidential. If you are already registered (because you have Cigna Dental, for instance), you do not need to register again.

Among the services available to you are:

- In-person counseling (up to 10 sessions per issue with no copay)
- Immediate help during a crisis
- Local resources on a wide range of topics, including childcare, elder care, support groups, pet services, and so much more
- Tips and guidance on work/life balance
- A free legal and/or financial consultation

See the EAP brochure at www.cpg.org/mtdocs or visit www.mycigna.com for more information.

HEALTH ADVOCATE

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

Health Advocate can help you:

- Schedule appointments
- Find specialists
- Schedule appointments
- Help with claims or billing issues
- Arrange payment schedules
- Answer questions about test results
- Initiate communications between physicians and your insurance provider
- Help you make a coverage decision during Annual Enrollment
- And much more

For more information or to get the help you need, call Health Advocate at (866) 695-8622 or visit their website at www.healthadvocate.com.

SILVERSNEAKERS®

Members enrolled in our Medicare Supplement Health Plans have access to Tivity Health's SilverSneakers fitness program at no extra cost. You have unlimited access to workouts and fitness instruction at more than 15,000 leading fitness locations nationwide where you can participate in healthy physical activity.

There are some fitness centers and gyms that hold fitness classes exclusively for SilverSneakers members so that you won't have to worry about showing off to the 24-year-old next to you.

And if you don't like going to fitness centers, SilverSneakers also offers physical activity classes outside the gym in places like parks, community centers, and churches. These classes offer alternatives to a typical visit to the gym, with options such as hiking, swimming, and yoga.

Lastly, SilverSneakers will sometimes send invitations to members to attend health seminars and other wellness-related events. These programs place great emphasis on being a friendly community that motivates its members.

For more information, call SilverSneakers at (866) 584-7389 or visit www.silversneakers.com.

CIGNA DENTAL

The Medical Trust offers you three dental plan choices. The plans and the per month/per member contributions are:

- Preventive Dental: \$61
- Basic Dental: \$74
- Dental & Orthodontia: \$90

Each plan covers three network cleanings per year at no cost to you. You are also covered for diagnostics and restorative services, such as fillings, crowns, root canals, planing, bridges, dentures, and other services.

The dental plans are **not** included with the Medicare Supplement Health Plans and require separate enrollment.

See the Cigna Dental Plan Document Handbook, available at www.cpg.org/mtdocs for more information. You can also call Cigna Dental at (800) 244-6224 or visit www.mycigna.com.

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 insurance 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 applicable 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.

PRIVACY

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 Notice 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 associates 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; and
- Uses and disclosures that constitute a sale of PHI.

Any other use or disclosure of your PHI not identified in this section 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 Notice.

FUNDRAISING

The Plans may contact you to support their 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 jservais@cpjg.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 jservais@cpjg.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; or
- 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 jservais@cpjg.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 jservais@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 ARE A PERSON IN THE EUROPEAN UNION, THE FOLLOWING PROVISIONS WILL ALSO BE APPLICABLE TO YOU:

For the purposes of the General Data Protection Regulation 2016/679 (the "GDPR"), the Data Controller is Church Pension Group Services Corporation registered in the State of Delaware in the United States with a registered address at 19 East 34th Street, New York, NY 10016.

You can request further information from our Privacy Officer at Privacy@cpg.org.

In addition to your rights with respect to your PHI addressed above, you may have additional or overlapping rights under the GDPR. GDPR rights regarding your PHI include the following:

- You may access and export a copy of PHI;
- You may request deletion of, and update to PHI;
- You have the right to be informed about any automated decision-making of PHI including the significance and consequences of such processing for you;
- You may also object to or restrict the Plans' use of PHI. For example, you can object at any time to the Plans' use of PHI for direct marketing purposes.

- Where you believe that the Plans have not complied with its obligations under this Privacy Policy or the applicable law, you have the right to make a complaint to an EU Data Protection Authority;
- If the Plans' obtained your consent to use your PHI, you may withdraw that consent at any time.

DATA RETENTION

We only retain PHI collected for a limited time period as long as we need it to fulfill the purposes for which have initially collected it, unless otherwise required by law.

DATA TRANSFERS

We maintain servers in United States and Canada and your information may be processed on servers located in the United States and Canada. Data protection laws vary among countries, with some providing more protection than others. Regardless of where your information is processed, we apply the same protections described in this policy.

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 29, 2018.

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 measures 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.

CHILD(REN)

A Subscriber's or Subscriber's Spouse's natural child, stepchild, legal ward, foster child, 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.

CLAIM

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

COINSURANCE

Your share of the costs of a covered healthcare service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.)

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 (for example, \$15) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare 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 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

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)

DEPENDENT

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

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.

DURABLE MEDICAL EQUIPMENT (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include oxygen equipment, wheelchairs, and crutches.

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

Healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

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 (AKA ANNUAL ENROLLMENT)

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

OUT-OF-POCKET MAXIMUM

The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for healthcare costs. This limit never includes your contribution (premium), balance-billed charges or healthcare your plan doesn’t cover. Some plans don’t count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

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.

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.

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.

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.

PRIMARY PAYER

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

PROVIDER

An individual or facility that provides healthcare services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

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 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.

The Plan(s) described in this summary 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 summary 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.

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.

2021 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 68 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.

Appendixes

Use this worksheet for medical expenses 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 2019		(Column 2) x 30% = \$ _____
Other		\$ _____
Preliminary Subtotal		\$ _____ (Sum of amounts above)
<p>Medical Subtotal</p> <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 preferred brand-name prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) x \$30 = \$ _____
Enter the number of non-preferred 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 preferred brand-name prescriptions (including refills) purchased through mail order.		(Column 2) x \$70 = \$ _____
Enter the number of non-preferred 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 2019		(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 preferred brand-name prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) x \$25 = \$ _____
Enter the number of non-preferred 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 preferred brand-name prescriptions (including refills) purchased through mail order.		(Column 2) x \$60 = \$ _____
Enter the number of non-preferred 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 2019		(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 preferred brand-name prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) x \$25 = \$ _____
Enter the number of non-preferred 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 preferred brand-name prescriptions (including refills) purchased through mail order.		(Column 2) x \$60 = \$ _____
Enter the number of non-preferred 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.*



Episcopal Church Medical Trust

SUMMARY OF BENEFITS

Additional discounts

40% OFF

Complete pair of prescription eyeglasses

20% OFF

Non-prescription sunglasses

20% OFF

Remaining balance beyond plan coverage

These discounts are for in-network providers only

Take a sneak peek before enrolling

- You're on the INSIGHT Network
- For a complete list of **in-network** providers near you, use our **Enhanced** Provider Locator on www.eyemed.com or call **1-866-804-0982**.
- For Lasik providers, call 1-877-5LASER6.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	\$0 Co-pay	Up to \$30
Retinal Imaging	Up to \$39	N/A
Frames	\$0 Co-pay; \$150 allowance; 20% off balance over \$150	Up to \$47
Standard Plastic Lenses		
Single Vision	\$10 Co-pay	Up to \$32
Bifocal	\$10 Co-pay	Up to \$46
Trifocal	\$10 Co-pay	Up to \$57
Standard Progressive Lens	\$75 Co-pay	Up to \$46
Premium Progressive Lens ⁴	\$95 Co-pay - \$120 Co-pay	
Tier 1	\$95 Co-pay	Up to \$46
Tier 2	\$105 Co-pay	Up to \$46
Tier 3	\$120 Co-pay	Up to \$46
Tier 4	\$75 Co-pay, 20% off charge less \$120 Allowance	Up to \$46
Lens Options (paid by the member and added to the base price of the lens)		
UV Treatment	\$15	N/A
Tint (Solid and Gradient)	\$15	N/A
Standard Plastic Scratch Coating	\$15	N/A
Standard Polycarbonate	\$0	Up to \$28
Standard Polycarbonate - Kids under 19	\$0	Up to \$28
Standard Anti-Reflective Coating	\$45	N/A
Premium Anti-Reflective Coating ⁴	\$57 - \$68	N/A
Tier 1	\$57	N/A
Tier 2	\$68	N/A
Tier 3	80% of charge	N/A
Photochromic/Transitions	\$75	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lens Fit and Follow-Up (Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to \$40	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail	N/A
Contact Lenses		
Conventional	\$0 Co-pay; \$150 allowance; 15% off balance over \$150	Up to \$100
Disposable	\$0 Co-pay; \$150 allowance; plus balance over \$150	Up to \$100
Medically Necessary	\$0 Co-pay, Paid-in-Full	Up to \$210
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

⁴Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

What's in it for me?

Options. It's simple really. We're dedicated to helping you see clearly – and that's why we've built a network that gives you lots of choices and flexibility. You can choose from thousands of independent and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy-to-use and help you access the care you need. Welcome to EyeMed.



Benefits Snapshot	With EyeMed	Out-of-Network Reimbursement
Exam with dilation as necessary (Once every 12 months)	\$0 Co-pay	Up to \$30
Frames (Once every 12 months)	\$0 Co-pay; \$150 allowance; 20% off balance over \$150	Up to \$47
Single Vision Lenses (Once every 12 months) Or	\$10 Co-pay	Up to \$32
Contacts (Once every 12 months)	\$0 Co-pay; \$150 allowance; plus balance over \$150	Up to \$100

And now it's time for the breakdown . . .

Here's an example of what you might pay for a pair of glasses with us vs. what you'd pay without vision coverage. So, let's say you get an eye exam and choose a frame that costs \$163 with single vision lenses that have UV and scratch protection. Now let's see the difference...

**87%
SAVINGS
with us***

With EyeMed	Without Insurance**
Exam \$0 Co-pay	Exam \$106
Frame \$163 - \$150 allowance \$13 - \$2.60 (20% discount off balance) \$10.40	Frame \$163
Lens \$10 Co-pay \$15 UV treatment add-on +\$15 Scratch coating add-on \$40	Lens \$78 \$23 UV treatment add-on +\$25 Scratch coating add-on \$126
Total \$50.40	Total \$395



Download the EyeMed Members App

It's the easy way to view your ID card, see benefit details and find a provider near you.



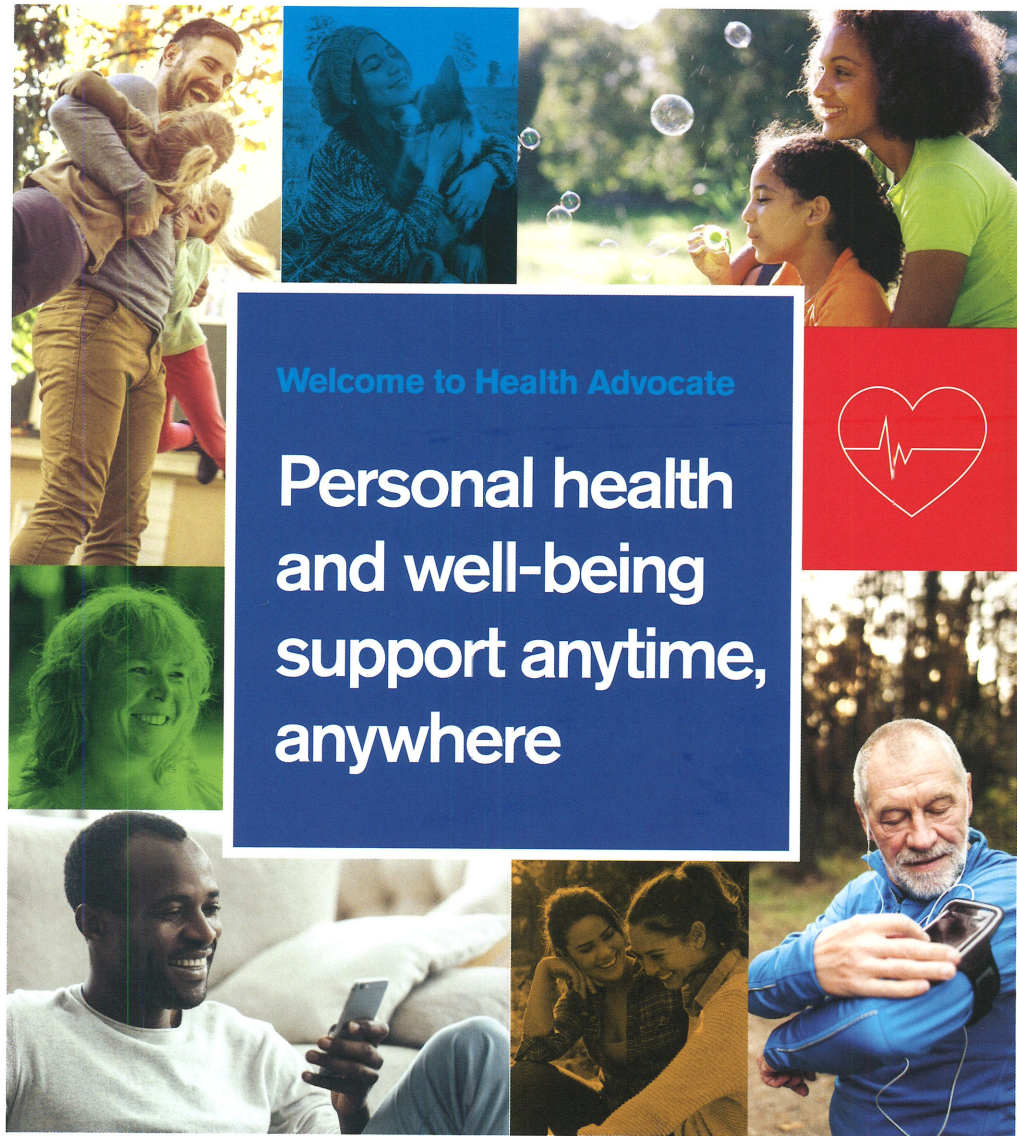
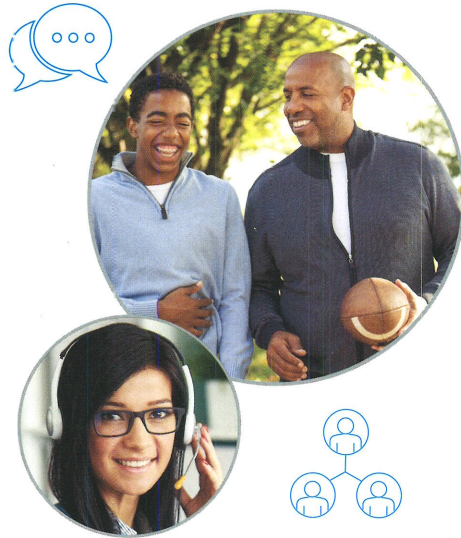
*This is a snapshot of your benefits. Actual savings will depend on provider, frame and lens selections. **Based on industry averages.

Real People, Real Stories

“They took the pressure off a serious situation.”

Don called Health Advocate after his son suffered a broken leg in a serious fall.

His Personal Health Advocate worked with the health plan and hospital to coordinate rehab services that could accommodate his son as soon as he was discharged. She also scheduled the initial follow-up appointment with the orthopedic specialist.



Welcome to Health Advocate

Personal health and well-being support anytime, anywhere



Turn to us—we can help.



866.695.8622

Email: answers@HealthAdvocate.com
Web: HealthAdvocate.com/members

Download the app today!



We're here when you need us most

Your Health Advocate benefit can be accessed 24/7. Normal business hours are Monday - Friday, from 8 am to 11 pm, Eastern Time (ET). Staff is available for assistance after hours and on weekends.

There is no cost to use our service

Your employer or plan sponsor offers your Health Advocate benefit at no cost to you.

We're not an insurance company

West's Health Advocate Solutions is not affiliated with any insurance or third party provider, and does not replace health insurance coverage, provide medical care or recommend treatment.

Your privacy is protected

Our staff carefully follows protocols and complies with all government privacy standards. Your medical and personal information is kept strictly confidential.

Our experts make healthcare easier, by supporting you and your eligible family members with a wide range of health and insurance-related issues through a single toll-free number.

HealthAdvocateSM

Welcome to Health Advocate!

This guide contains an overview of Health Advocate and the many ways we can help. Call the toll-free number anytime for **one-on-one, confidential support**.

Expert help at your side

Nothing is more important than your health and the health of your loved ones.

Our Personal Health Advocates are healthcare experts with extensive experience supporting people with important medical issues and decisions, no matter how common or complex. Typically registered nurses supported by medical directors and benefits experts, we'll work on your behalf to get you and your family the answers and peace of mind you need.

We support the whole family

Our services are available to employees, spouses, dependents, parents and parents-in-law.

Quickly reach us any time you like — by phone, email and secure messaging.



Easy access to your customized website and mobile app for articles, tips, tools and more!



How We Can Help

Have you recently been diagnosed with a medical issue?

Count on us to:

- **Answer questions** about health conditions, diagnoses and treatments, no matter how complex
- **Research and explore** the latest treatment options
- **Coordinate services** relating to all aspects of your care

Need to find a doctor? We can:

- **Use our Perfect MatchSM physician locator** to match you with the right quality doctors for your condition
- **Make an appointment** at a time that works for your schedule!

Considering a second opinion?

We'll do the work to:

- **Research and identify top experts** and Centers of Excellence nationwide
- **Arrange for the transfer of medical records**, test and lab results and X-rays
- **Set up face-to-face appointments**

Baffled by medical bills, claims denials or benefit questions?

Our experts can:

- **Explain how your benefits work**, including copays and deductibles
- **Review medical bills** to uncover possible duplicate charges or other errors
- **Do the research** and make the calls to resolve claims and billing issues





Have questions? Don't see what you're looking for? Contact us to get the assistance you need.

Call **1.866.395.7794**
Log in to **CignaBehavioral.com**
and enter your Employer ID: **episcopal**

Employee Assistance & Work/Life Support Program
24/7

Employee Assistance & Work/Life Support Program
24/7

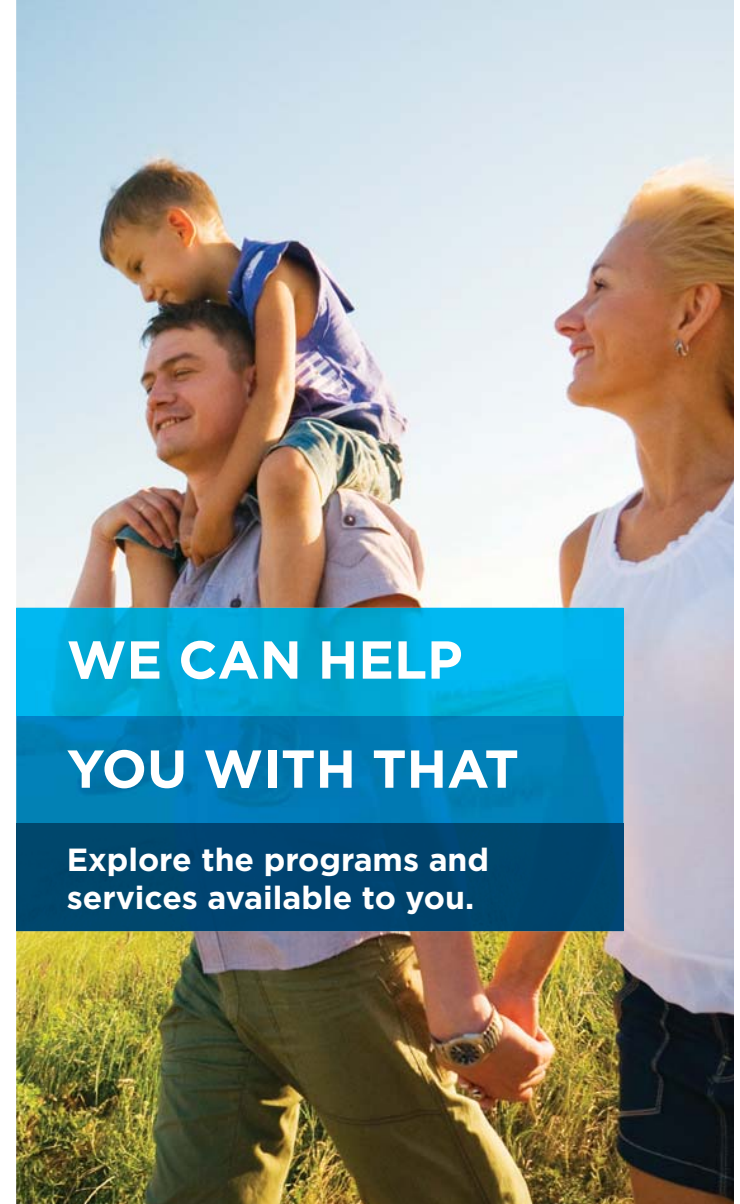


*Some Healthy Rewards programs are not available in all states, and programs may be discontinued at any time. If your health plan includes coverage for any of these services, this program is in addition to, not instead of, your plan coverage. **A discount program is NOT insurance, and you must pay the entire discounted charge.**

**Legal consultations related to employment matters are not available under this program.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Behavioral Health, Inc. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

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WE CAN HELP

YOU WITH THAT

Explore the programs and services available to you.



TAKE A DEEP BREATH. WE'RE HERE TO HELP.

The enclosed listing is just a small sampling of the support available to you at no additional cost with your Employee Assistance & Work/Life Support Program.

If you can't seem to find exactly what you're looking for, remember: we're always just a call or click away.

Call us anytime, any day.

We're here to listen to your needs, get you the information you need and guide you toward the right solution.

We can also direct you to a variety of helpful resources in your community.

Get the support you need conveniently online.

- › Read educational materials on work or life topics.
- › Access various interactive tools related to health and wellness.
- › Explore our stress toolkit, which includes assessment tools, articles and stress management techniques.
- › Take advantage of your Healthy Rewards® discount program* for savings on many health and wellness products and services.

Visit an Employee Assistance Program (EAP) provider.

1-10 sessions are available to you and your household members. Call us or go online, search the provider directory and request an authorization.

A well-balanced offering to help you live a well-balanced life.

Give us a call or go online to locate referrals for support services, such as:



Legal Consulting:** Get a free 30-minute consultation and up to 25% off select fees.



Identity Theft: Learn how to protect yourself from and respond correctly to identity theft with a free 60-minute expert consultation by phone.



Financial Services & Referral: Take advantage of a free 30-minute financial consultation by phone and 25% off on tax preparation.



Child Care: Whether you need care all day, before/after school, during the summer or just want a back-up plan for unplanned events, we'll help you find a place, program or person that's right for your family.



Senior Care: Learn about challenges and solutions related to caring for an aging loved one.



Pet Care: From vets to dog walkers, we'll help connect you with the right people and places to ensure your pets are well taken care of.

Employee Assistance & Work/Life Support Program 24/7



Get in touch. Call
1.866.395.7794 or visit
CignaBehavioral.com
and enter your
Employer ID:
episcopal



Get in touch. Call
1.866.395.7794 or visit
CignaBehavioral.com
and enter your
Employer ID:
episcopal



Your hearing health care program - for life

Brought to you by Episcopal Church Medical Trust

We offer...

 **Custom hearing solutions** - we find the solution that best fits your lifestyle and your budget from one of our 10 manufacturers.

 **Risk-free 60-day trial** - 100% money-back guarantee.

 **Continuous Care** - one year free follow-up care, two years free batteries, and a three-year warranty.

 **Hearing aid low price guarantee** - if you find the same product at a lower price, bring us the local quote and we'll not only match it, we'll beat it by 5%!

Accessing your discount is as easy as...

1

Call Amplifon at
(877) 609-0755 and
we'll find a provider
near you.

2

We'll explain the
Amplifon process and
help you schedule an
appointment.

3

We'll send information
to you and the provider,
ensuring your discount
is activated.

©2016 Amplifon Hearing Health Care, Corp.
2939MISC/ChurchPensionGr

www.amplifonusa.com

amplifon Hearing Health Care
Discount Card

- Discounted hearing testing
- Low price guarantee
- 60-day risk-free trial period
- 2 years batteries with purchase

To activate your discount,
call **(877) 609-0755** today!

amplifon Hearing Health Care

**Additional
money-saving offer!**

\$50 off one hearing aid* **-or-** **\$125** off two hearing aids*

Call **(877) 609-0755** today!

ACT NOW!

106

*Savings on top of our already discounted pricing. Please bring this offer with you to your appointment.
©2016 Amplifon Hearing Health Care, Corp.
2939MISC/ChurchPensionGroup

Hearing Benefit Reimbursement Claim Form

Guidelines for Submitting Hearing Benefit Claims to UnitedHealth Group

- This form is only for submission of charges related to Hearing Benefits. Please take this form with you when receiving services.
- MAIL the claim form and proof of payment to: **United Healthcare, Atlanta Service Center, PO Box 740827, Atlanta, GA 30374**
- Submit the bill, claim form and the receipt showing payment to: UnitedHealthcare
- Be sure to notify your employer of any address change.
- Please include your UnitedHealthcare Member ID Number or SSN and Date of Birth on any attached receipts.

A. PATIENT INFORMATION: Patient Completes This Section

Last Name:	First Name:	MI:	Date of Birth: / /
Member ID Number or SSN on UnitedHealthcare ID Card:	Policy Number: 706797	Phone: ()	
Home Address:			New Address: Yes <input type="checkbox"/> No <input type="checkbox"/>
City:	State:	Zip Code:	

B. RETIREE INFORMATION: Check here if same as Patient

Last Name:	First Name:	MI:	Date of Birth: / /
Member ID Number or SSN on UnitedHealthcare ID Card:	Policy Number: 706797	Phone: ()	
Home Address:			New Address: Yes No
City:	State:	Zip Code:	

C. PHYSICIAN OR PROVIDER: Complete This Section

<u>Right/Left Ear</u>	<u>Diagnosis</u>	<u>Date of Service</u>	INTERNAL USE ONLY <u>Place of Service</u>	<u>Procedure Code</u>	<u>Charges</u>
RIGHT			FS	HAD	
LEFT			OL	HAD	
Reimbursement Type: <input type="checkbox"/> Pay to Member <input type="checkbox"/> Pay to Provider					
Please have physician/provider fill out the information below:					Total Charge:
Physician or Provider's Tax ID Number:					Patient Amount Paid:
<small>(Internal use only: Keyer, if Tax ID is not provided please use UHC Tax ID 069000005 for member reimbursement only)</small>					
Physician or Provider's Address:					Balance Due:
Physician or Provider's Telephone Number: ()					
Physician or Provider's Signature: _____					Date: _____

D. MEMBER SIGNATURE Certification for Reimbursement

I certify that any expenses for which I am requesting reimbursement, as itemized above, were incurred by me (and/or my spouse and/or eligible dependents) for care as permitted under the Hearing Aid plan, and have not been reimbursed and I will not seek reimbursement under any other plan. To the best of my knowledge and belief, my statements are complete and true. I authorize the release of any medical or other information necessary to process this claim. ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.

Member Signature: _____ Date: _____

International Claims Transmittal



Return this form with the original medical bill or claim form via mail or fax to:

UnitedHealth Group
 International Claims
 PO Box 740817
 Atlanta, GA 30374

<input type="checkbox"/>	Check here if this is a repeat submission
--------------------------	---

Please complete all sections of this transmittal form. Claims *may* be delayed if all sections of this form are not completed. However, this does not guarantee that additional information will not be requested from you to process the claim. You will be advised in writing should additional information be required.

Please complete a new & separate claim transmittal form for:

- * Each patient * Each inpatient hospital stay * Each different healthcare provider * Each currency type

Section 1 – Member & Patient Information

Check one: I am an Expatriate or retiree living abroad. I am traveling internationally for pleasure.
 I am traveling internationally for business, however, live in the U.S.

Group Name		Group Policy #	
Member Name		Member id #	
Patient Name		Patient Relationship	
Patient Date of Birth		Member Phone #	
Is the patient covered under another Medical Health Care Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Member's Return Correspondence Address	Street Town/city Area postal code Region Country		
In which country did the treatment take place?			
What type of currency is the bill submitted in?			
What is the total amount of the claim in U.S.Dollars? (opt)			
Please check the type of service that was rendered: <input type="checkbox"/> Office visit <input type="checkbox"/> Inpatient hospital care <input type="checkbox"/> Inpatient surgery <input type="checkbox"/> Outpatient surgery <input type="checkbox"/> Emergency room visit <input type="checkbox"/> Lab or X-ray services <input type="checkbox"/> Prescription drugs covered under your UHC plan <input type="checkbox"/> Medical supplies <input type="checkbox"/> Other _____		Date of service(s): _____ A brief explanation of the purpose of your healthcare provider visit; including services rendered and/or procedures performed:	

Section 2 – Healthcare Provider Contact Information

Name of Healthcare Provider			
Name of facility or hospital			
Address	Street	Town/city	
	Area postal code	Region	
	Country		
Telephone number (including 2-digit country code)			
Fax number (if available)			

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Member signature _____ Date: _____

Continued on reverse side

Section 3 – Important Information for Submitting Your Medical Claim

- ***Faxing a Claim*** - Illegible faxes received in our mailroom will be returned to you via the fax number used to send the document to us. Therefore, when faxing correspondence to us, please make sure you use a fax machine where you can also receive correspondence.
- Submitting original documents is always helpful in expediting the processing of your claim. When possible, send the original claim, itemized bill, and medical records. This is especially helpful for inpatient hospital bills. ***Always remember to keep a copy of all documentation for your records.***
- If possible, ask the provider of service to write the bill in English and convert the currency to U.S. Dollars.
- If the provider of service is not able to present the bill or claim in English and U.S. Dollars, do not perform the translation and currency exchange yourself. United Healthcare will provide these services for you.
- Remember that all plan-filing rules apply to international claims. Submit your claims as soon as possible after treatment is rendered.
- If payment is to be issued to you, please submit a proof of payment. A cancelled check, cash receipt, charge receipt, or handwritten receipt from the medical provider is acceptable.
- If you have a U.S. address for the receipt of mail, please make sure that your employer is aware of this address so they may supply it to us for the mailing of your check and/or explanation of benefits.
- International bills can be more complicated than a regular U.S. bill due to language and currency conversion and/or the receipt of additional information required to process the claim. As a result, it may take longer to process your claim.
- Your international claim payment information is available on www.myuhc.com. Please use this as a resource when checking the status of your claim.
- If a reasonable amount of time has passed, and after checking www.myuhc.com for the status of your claim, you still have questions regarding the status or payment of your claim, please call the Member Services number on the back of your ID card.

Note for non-medical or non-UHC claims (ie: Dental, Medco Rx, etc.) – this is not the process for submitting your international bill. Please contact the Member Services number located on the applicable member id card.

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Member signature _____ Date: _____

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	(800) 708-3052
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.