Guide to the Medicare Supplement Plan
For retired members
Table of Contents

A Message from the Board of Pensions 4
Overview 6
About the Medicare Supplement Plan 6
When you need assistance 6
Eligibility and Enrollment 8
Who is eligible to enroll 8
Eligibility to postpone enrollment 8
20-year participation exception 9
Enrolling for coverage 9
Waiving coverage 9
Subscription rates 9
How to pay your subscription 10
Your ID cards 10
What’s Covered 12
How it works 12
Expenses covered by Medicare Supplement 13
Limitations 14
Special provisions 14
What’s not covered 15
Expenses not covered by Medicare Supplement 15
Hospital and Medical Benefits 17
Your share of the cost 17
Medicare-participating providers 17
Preventive care 17
Routine vision exams 18
Other medical care and treatment 18
How claims are paid 19
Summary of coverage 19
Prescription Drug Benefits 21
Formulary listing of covered drugs 22
Brand name or generic? 22
How to get prescriptions filled 23
To start a new maintenance medication 24
Special programs designed to limit costs 24
Specialty medications 24
Drugs not covered 24

The Medicare Supplement Plan in Action 25
Assumptions 25
Ending Coverage, Re-Enrolling, and Special Circumstances 27
Ending your coverage 27
Special circumstances 28
Appendix A Medicare Supplement Plan contacts 29
Appendix B Medicare and related contacts 30
Appendix C Explanation of benefits statement 31
Appendix D Administrative and compliance provisions 32
Appendix E Appeal procedures 34

This guide is not a full description of benefits and limitations of the Medicare Supplement Plan. If there is any difference between the information presented in this guide and the provisions of the Benefits Plan of the Presbyterian Church (U.S.A.), the plan terms will govern.

Visit pensions.org or call the Board of Pensions at 800-773-7752 (800-PRESPLAN) for a copy of the official plan document. The Medicare Supplement Plan is administered by Highmark Blue Cross Blue Shield and OptumRx.
A Message from the Board of Pensions

Dear Retired Member,

Welcome to the Medicare Supplement Plan, a medical benefits program for retired members, offered through the Benefits Plan of the Presbyterian Church (U.S.A.) and reflecting our commitment to provide benefits through the stages of your life.

Available to eligible members on a self-paid basis, this coverage complements Original Medicare (Parts A and B). It also provides Part D and supplemental prescription drug coverage.

We are pleased to provide you with this guide, which describes the ways that the Medicare Supplement Plan builds on your Medicare coverage. Here you’ll find information on eligibility for benefits, covered services, out-of-pocket costs, and more.

In addition to this guide, a variety of retiree benefit tools and resources are available on our website, pensions.org. If you are seeking detailed information on specific plan provisions, please refer to Article XIV of the Benefits Plan of the Presbyterian Church (U.S.A.), the official document of the Benefits Plan.

Medicare's preventive coverage includes annual well visits, or physicals, and a growing list of preventive screenings and related services. Your Medicare Supplement also includes an annual preventive benefit of up to $125, which you may use, in full or in part, for a routine vision exam and/or the cost of any routine tests associated with your well visit that are not fully covered by Medicare. You do not need to pay a deductible or copay. We encourage you to schedule a physical every year, as during these exams your doctor can identify potential health risks and suggest ways to take better care of yourself — information that can improve your health and increase your longevity.

Please read this guide and refer to it often; it can help you make the best use of your benefits. If you have questions about your coverage after referencing this booklet, please visit pensions.org for further information, call us at 800-773-7752 (800-PRESPLAN), or contact one of the service providers listed in appendices of this guide. Although we do our best to simplify them, benefit provisions can be confusing; we want you to understand them and be a wise consumer of healthcare services.

We wish you the very best of health!

Sincerely,

Patricia M. Haines
Executive Vice President, Chief Benefits Officer
When you retire, your coverage under the Medical Plan of the Presbyterian Church (U.S.A.) ends. To provide retired members with access to healthcare coverage similar to that which they had during their years of service to the Church, the Board of Pensions established the Medicare Supplement Plan. This program gives you the opportunity to supplement your Medicare coverage — and to contact the Board of Pensions when you need additional information or assistance. You pay a monthly subscription for coverage under the Medicare Supplement Plan.

About the Medicare Supplement Plan
As its name implies, the Medicare Supplement Plan (“Medicare Supplement”) supplements, or adds to, the coverage provided under Original Medicare. In addition to meeting certain eligibility requirements (see Who is eligible to enroll), you must be enrolled in Medicare Part A and Part B to enroll in the Medicare Supplement Plan. Medicare pays its portion of covered services first and Medicare Supplement provides secondary coverage. Medicare Supplement also provides Medicare Part D and supplemental prescription drug coverage.

The Medicare Supplement Plan covers a wide range of medical services and supplies as well as outpatient prescription drugs. This guide summarizes these benefits, how to access them, and the cost to you. It also explains the rules surrounding eligibility and enrollment, how to preserve your ability to enroll at a later date, and more.

Note: As you prepare to retire, it’s important to be informed about your options for healthcare coverage. Read the Board of Pensions publication Choosing Healthcare Coverage at Retirement, available on pensions.org or by calling the Board, to learn about the coverage options that may be available to you. You may also reference the Medicare & You handbook, mailed to you by Medicare.

When you need assistance
The Board of Pensions is here to help you understand — and make the best use of — your benefits.

Member Services
Call Member Services at 800-773-7752 (800-PRESPLAN) to speak with the Board’s specially trained service representatives, who can

- answer questions about plan benefits in general or how the plan covers specific services (including when you are evaluating whether to enroll in Medicare Supplement);
- discuss an explanation of benefits statement if you’ve contacted the service provider and need additional assistance;
- help you with reporting a major life change, such as a change of address, marriage, or death of a spouse; and
- send you hard copies of benefits booklets.

Remember to notify the Board within 60 days of major changes in your life, such as moving to a new home, getting married or divorced, or the death of a spouse.
Benefits Connect

Benefits Connect, the Board’s secure benefits website, provides you with online access to plan-related information as well as useful tools. Through Benefits Connect, you can

- view your benefits information;
- view and update your payment information;
- view and update your personal information; and
- view and update your dependent information.

You also can link directly to certain service providers, such as Highmark, to view your medical claims.

If you have not already done so, register for Benefits Connect today. Go to pensions.org; click Log On next to the Benefits Connect logo and select I am a new user on the Benefits Connect home page.

Pre- and post-retirement seminars

The Board of Pensions offers seminars, at no cost to you, on retirement topics, including Social Security, Medicare, and Medicare Supplement. You may attend the seminar whose date and or location works best for you.

The pre-retirement planning seminar “Growing into Tomorrow … Today” is open to all clergy and lay members of the Benefits Plan, as well as their spouses or guests. Retirees, spouses, and surviving spouses are encouraged to attend the Board’s post-retirement seminars. You can register online at pensions.org for these events or contact the Board’s Meeting Planning Team (education@pensions.org) for more information.

When you need help now …

You should contact the appropriate service providers directly when you have specific benefit or claim questions. The phone numbers and web addresses of the Board of Pensions, Medicare Supplement service providers, and Medicare itself are listed in the Appendices of this guide.
This section explains who may enroll in the Medicare Supplement Plan and how to enroll.

Who is eligible to enroll
You may enroll in Medicare Supplement if you

- are Medicare-eligible (generally age 65 or older);
- are participating in the Medical Plan of the PC(USA) as an active member when you retire;
- meet the Rule of 70 (see below); and
- are enrolled in Original Medicare (Medicare Part A and Part B)

The Rule of 70

- You must be age 55 or older when you terminate eligible service to the Presbyterian Church (U.S.A.).
- You must have at least five years of Medical Plan participation.
- The sum of your age and years of Medical Plan participation at termination must equal 70 or more.

Family members who may enroll
These family members also may enroll for Medicare Supplement coverage, regardless of whether you choose to enroll when you are eligible:

- your spouse or eligible child who has maintained continuous medical coverage and is enrolled in Original Medicare
- your surviving spouse or former spouse who has maintained continuous coverage and is enrolled in Original Medicare

Eligibility to postpone enrollment
You or your spouse (including a surviving or former spouse) may be able to postpone enrollment — or waive coverage — in Medicare Supplement if you

- meet the Rule of 70; and
- are covered by other qualified health plan coverage, such as the medical continuation coverage offered at termination of service to eligible former members or healthcare coverage through your spouse’s employer.

Exercising this waiver allows you to sign up for the Medicare Supplement Plan at a later date, if you are otherwise eligible. For more information, see Waiving coverage, later in this section.

1 The medical continuation coverage provides healthcare coverage on a member-paid basis and for a limited period of time. It is offered at termination of service to eligible former Benefits Plan members, and to their spouses, former spouses, surviving spouses, and other eligible family members under the age of 65.
Examples
Under this rule, if you terminated eligible service to the Presbyterian Church (U.S.A.) at age 58, have at least five years of eligible service, and are now age 65, you would qualify to sign up for Medicare Supplement. If, however, you terminated eligible service at age 52, have at least five years of eligible service, and are now age 65, you would not be eligible to enroll.

So even though, generally, you must be age 65 to start Medicare and Medicare Supplement, you also must have terminated eligible service at age 55 or older (in addition to the other Rule of 70 criteria).

Enrolling for coverage
Once you have enrolled in Medicare Part A and Part B and otherwise qualify, you can sign up for the Medicare Supplement Plan. To enroll, complete only Parts A, B, and C of the Medicare Supplement Subscription, Waiver, or Withdrawal form and return it, together with a copy of your Medicare ID card, to the Board of Pensions, either by mail or fax. (The form contains the Board’s mailing address and fax number.) You must complete this form at least 30 days in advance of your last day of coverage as an active member of the Medical Plan.

Note: Payment of your first month’s subscription charge activates coverage. The Board cannot verify eligibility for coverage or reimburse you for expenses incurred for any period of time for which the Board has not yet received payment.

Waiving coverage
If you are eligible to postpone enrollment in the Medicare Supplement Plan, you may preserve your right to enroll in the plan at a later date if you complete and submit a waiver form to the Board of Pensions within 30 days of your last day of coverage as an active member of the Medical Plan.

To waive coverage, complete the Medicare Supplement Subscription, Waiver, or Withdrawal form mailed to you upon your retirement. Remember, you must send the Board your completed form by mail or fax so that it arrives within the required 30 days. (The form contains the Board’s mailing address and fax number.) Note that signatures by both you and your spouse, if any, are required on this form.

If you are under age 65
If you retire before age 65 and you are eligible for medical continuation coverage, you waive participation using the Medical Continuation Subscription or Waiver form. Provided you continue to have other qualified health plan coverage, this waiver remains in force once you turn 65, so you won’t need to submit another waiver specifically for the Medicare Supplement Plan.

What to do if you lose your other coverage
If you file a waiver and subsequently lose your other healthcare coverage, you and your spouse (if Medicare-eligible) may enroll in the Medicare Supplement Plan if your coverage is lost for any of the following reasons:

- Your spouse retires or dies.
- Your spouse’s or your employment is terminated.
- The employer discontinues coverage.

The Board will not require a health statement from you or your spouse, and there are no limitations or exclusions for pre-existing conditions. Of course, you must meet the other eligibility criteria for enrolling in Medicare Supplement. (See Who is eligible to enroll.)

Note: You must notify the Board within 60 days of one of the life-change events listed above to enroll in the Medicare Supplement Plan.

Subscription rates
You pay a subscription rate, or premium, set annually by the Board of Directors of the Board of Pensions. The rate charged is lower than the actual cost to cover you, because the Medicare Supplement Plan is partially subsidized by the federal government and the pharmaceutical industry (for the prescription drug portion of the plan) and by Presbyterian Church (U.S.A.) churches through vacancy and post-retirement dues.
You pay a **maximum of two subscriptions**:
- one for yourself
- one for your spouse and/or eligible children

Even if multiple family members are on medical continuation and you are on Medicare Supplement, you pay a maximum of one Medicare Supplement subscription and one medical continuation subscription.

The two subscription rates are charged as follows:
- If you and your spouse are both eligible for Medicare, each month you pay two Medicare Supplement subscription charges.
- If you and your spouse are both eligible for Medicare but still have eligible children covered for medical benefits, each month you pay one subscription for Medicare Supplement and one for medical continuation.
- If you are eligible for Medicare but your spouse and children are not, each month you pay the Member + Child(ren) medical continuation rate.

To get **current subscription rate information**, go to pensions.org or contact the Board of Pensions.

Each Medicare Supplement subscription covers only one person. There is no family coverage option.

**How to pay your subscription**
You pay your subscription for Medicare Supplement — and, if applicable, medical continuation — in one of two ways:

1. The monthly subscription charge is automatically deducted from your pension payment.
2. If your pension does not cover the full subscription cost, you receive a monthly invoice.

**Pension check deduction**
If you are receiving a pension benefit, the Board of Pensions deducts the monthly subscription charges for you and any other covered family members from your pension payment.

**Invoice payment**
If you are not receiving a pension benefit or your monthly pension benefit does not cover your total monthly subscriptions, the Board of Pensions sends you an invoice. You pay monthly, in advance, for this coverage. You can pay by check or arrange for electronic payment using BoardLink, the Board’s secure, online bill payment system.

If the Board does not receive your payment by the due date, your Medicare Supplement coverage will be temporarily suspended. Your claims may be denied during this period of nonpayment. You must pay the full account balance within 30 days of the due date to reinstate coverage. Once your payment is received and coverage is reinstated, you may resubmit your claims.

If the Board does not receive your payment within 30 days of the due date, coverage is permanently terminated.

**Your ID cards**
After you enroll in the Medicare Supplement Plan, you will receive new ID cards for medical and prescription drug coverage. You should destroy your old cards and carry the new cards with you — in addition to your Medicare card — so that you have them for emergency and routine use.

**Note:** If you or your spouse is covered under Medicare Supplement while the other is covered under medical continuation, each of you will have your own medical and prescription drug ID cards with unique identification numbers.

Although your new Medicare Supplement ID cards look very similar to your ID cards as an active member of the Medical Plan, the benefits they access are defined by the Medicare Supplement Plan.
Show both your Medicare card and your Medicare Supplement card to hospital and medical care providers at the time of service.

Show this card when you purchase prescriptions at a participating retail pharmacy. Use the information on this card when you order prescription drugs directly from OptumRx. Be sure to give your physician a copy of your ID card if he/she submits prescriptions on your behalf.

Because the Medicare Supplement Plan is a self-funded plan with finite resources, it is in everyone’s interest not to permit expenses to be incurred by individuals who are not eligible for coverage. Protect your ID cards as you would any other personal identification. This helps ensure that no one other than you and your eligible dependents accesses your benefits.

If for any reason you believe your Medicare Supplement benefits have been accessed inappropriately, please call Highmark or the Board of Pensions immediately.

Whenever you receive new ID cards, shred the old ones. You may request additional or replacement cards at any time by contacting Highmark or OptumRx.
The Medicare Supplement Plan of the PC(USA) covers the same medical services and supplies that are covered by Medicare Part A and Part B. This means you can be reimbursed only for services and supplies that Medicare deems either **preventive** or **medically necessary**.

Medicare Part B covers certain preventive care, which it defines as “health care to prevent illness (like the flu) or detect it at an early stage, when treatment is most likely to work best.”

Medicare defines medically necessary services or supplies as those that are “needed to diagnose or treat your medical condition and that meet accepted standards of medical practice.” Both Medicare Part A and Part B cover medically necessary services and supplies.

For more information about preventive care and medically necessary services and supplies, visit medicare.gov or call Medicare.

How it works

After Medicare pays its share, the Medicare Supplement Plan covers its portion of preventive care services and medically necessary services and supplies. The Expenses covered by Medicare Supplement chart lists many of the services and supplies covered by Medicare, and therefore by Medicare Supplement; however, it is not all-inclusive. If you are unsure whether a service or supply is covered, check medicare.gov or contact Medicare before incurring the expense.

Coverage is for amounts up to the Medicare-approved allowance and subject to applicable plan deductibles and copayments (see Hospital and Medical Benefits).
### Expenses covered by Medicare Supplement

<table>
<thead>
<tr>
<th><strong>Preventive care services up to $125 annually (with Medicare MSN)</strong>&lt;sup&gt;1&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine tests associated with well visits that are not fully covered by Medicare</td>
</tr>
<tr>
<td>Routine eye exams</td>
</tr>
</tbody>
</table>

**Professional services**

- Physician fees; inpatient and outpatient surgery (except as limited by the *Expenses not covered by Medicare Supplement* chart)
- Chemotherapy and radiation therapy
- Medicare Part B deductibles
- Surgical second opinions
- Inpatient and outpatient mental health and substance abuse treatment, subject to program limits<sup>2</sup>
- Mastectomy-related benefits, including reconstruction, surgery, prostheses, and treatment of physical complications (Women's Health and Cancer Rights Act)
- Outpatient imaging services, including CT scans, MRIs, EKGs, and X-rays
- Outpatient rehab, including physical, occupational, and speech therapy

**Hospital or other facility services**

- Inpatient stay for medical and surgical care, including semiprivate accommodations, intensive care, and additional medically necessary services
- Inpatient stay for mental health and substance abuse treatment, subject to program limits<sup>2</sup>
- Emergency room care for medical emergency
- Medicare Part A deductibles
- Skilled nursing facility stay, subject to 180-day annual limit<sup>3</sup>

**Other services and supplies**

- Ambulance
- Artificial limbs and eyes
- Blood and blood plasma
- Drugs and medications (see *Prescription Drug Benefits*)
- Medical and surgical equipment rental or purchase (at the Board’s discretion)
- Defibrillator
- Durable medical equipment and supplies (purchase and rentals only; maintenance costs are not covered)

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<sup>1</sup> A Medicare Summary Notice (MSN) is Medicare’s explanation of benefits, showing how much Medicare paid for services and any amount remaining.

<sup>2</sup> See Limitations and Special provisions for inpatient limits on these services.

<sup>3</sup> Admission must be within 14 days of discharge following at least a three-day hospital stay. Reimbursement for medical costs will not exceed 50% of the hospital daily room rate for the prior stay.
Limitations

Limitations on inpatient mental health and/or substance abuse treatment
Medicare Part A has a lifetime limit of 190 days for inpatient mental healthcare at a specialty psychiatric hospital.

The Medicare Supplement Plan does not limit the number of days of inpatient care at a specialty psychiatric hospital.

Limitations on skilled nursing facility benefit
After a minimum of a three-day inpatient stay in the hospital, Medicare Part A helps cover a subsequent skilled nursing facility stay, up to 100 days in a benefit period, as defined by Medicare.

The Medicare Supplement Plan has an annual limit of 180 days for skilled nursing facility stays.

Maximum reimbursement for TMD Treatment
The Medicare Supplement Plan has a $500 lifetime maximum for treatment of temporomandibular joint disorder (TMD).

Special provisions

Coverage and costs when traveling outside the United States
Original Medicare does not cover medical services and supplies provided to you when you travel outside the United States. To fill this coverage gap, Medicare Supplement provides primary coverage for medically necessary services and supplies when traveling outside the United States.

The Board of Pensions contracts with International SOS to provide assistance to Medicare Supplement participants who are traveling outside the United States. This organization has clinics and 24-hour Assistance Centers throughout the world. Although International SOS refers travelers to local healthcare services when possible, depending on the availability of local treatment options and the severity of the medical condition, International SOS can assist a traveler with a medical evacuation to the nearest appropriate provider. It maintains its own air ambulance fleet or will arrange an assisted flight on a commercial airline, depending on the situation.

Visit pensions.org or call the Board for information that describes International SOS services and contains an identification card and emergency contact numbers. If you have questions before you leave, call the Board of Pensions.

Note: Medicare Supplement does not cover medical services for retired members who reside outside the United States.

Outpatient prescription drugs
Original Medicare does not cover outpatient prescription drugs; it simply sets standards for participating Part D plans. To fill this significant gap in coverage, Medicare Supplement provides a Part D prescription drug program through a service provider, OptumRx. See Prescription Drug Benefits for details.
What’s not covered

Medicare and the Medicare Supplement Plan do **not** cover the medical expenses listed in the following chart, even if they are for services and related supplies ordered or provided by your doctor. The following chart lists most of the services and supplies excluded from coverage under the plan for 2018. However, the chart does not list every item that is excluded from coverage.

If you are unsure whether an item is covered, contact Medicare before incurring the expense.

### Expenses not covered by Medicare Supplement

<table>
<thead>
<tr>
<th>Nonparticipation in Medicare</th>
<th>Services of a provider that does not participate in the Medicare Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experimental or investigational medical treatment</strong></td>
<td>Any experimental or investigational medical treatment, as determined by Medicare and Highmark</td>
</tr>
<tr>
<td>Dental</td>
<td>Dentures</td>
</tr>
<tr>
<td></td>
<td>Dental X-rays</td>
</tr>
<tr>
<td></td>
<td>Dental services (including orthodontic services related to a covered medical cost), except for services related to the removal of bony, impacted wisdom teeth; injury to sound natural teeth; and treatment for TMD&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Hearing</td>
<td>Hearing aids and fittings</td>
</tr>
<tr>
<td>Vision</td>
<td>Vision surgery to alter the refractive character of the eye</td>
</tr>
<tr>
<td></td>
<td>Eyeglasses, except for temporary and initial permanent corrective lenses needed following cataract surgery or for diagnosis or treatment of a medical condition</td>
</tr>
<tr>
<td>Foot orthotics&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Orthopedic and podiatric foot care charges for treatment of or supplies for:</td>
</tr>
<tr>
<td></td>
<td>• weak, strained, flat, unstable, or unbalanced feet</td>
</tr>
<tr>
<td></td>
<td>• metatarsalgia or bunions, corns, calluses, or toenails</td>
</tr>
<tr>
<td>Other professional services and supplies</td>
<td>Services payable under any workers' compensation law or similar legislation</td>
</tr>
<tr>
<td></td>
<td>Services or supplies for personal hygiene, comfort, or convenience</td>
</tr>
<tr>
<td></td>
<td>Marital counseling</td>
</tr>
<tr>
<td></td>
<td>Medical services provided by a U.S. government facility or received elsewhere for which the participant is not legally obligated to pay</td>
</tr>
<tr>
<td></td>
<td>Expenses for routine maintenance and repair of durable medical equipment</td>
</tr>
<tr>
<td></td>
<td>Custodial care</td>
</tr>
<tr>
<td></td>
<td>Cosmetic surgery, treatment, or supplies (except reconstructive surgery following a mastectomy, after an accident, or to correct a congenital anomaly)</td>
</tr>
<tr>
<td></td>
<td>Medical reports or telephone consultation charges</td>
</tr>
<tr>
<td></td>
<td>Services provided by a person who ordinarily resides in a participant’s home or is related to the patient</td>
</tr>
</tbody>
</table>

<sup>1</sup> Benefits for TMD-related services are limited to $500 in a lifetime.

<sup>2</sup> Foot orthotics are covered if prescribed by a physician for treatment of metabolic, peripheral-vascular disease, or other medical conditions if not specifically excluded.
Nursing home custodial care exclusion

Nearly all healthcare plans, including Medicare and the Medicare Supplement Plan, exclude custodial care (i.e., help with bathing, dressing, and eating as well as the cost of room and meals, among other things) when you reside in a nursing home or when care is provided in your home.

To protect yourself against potential financial exposure for nursing home custodial care, the Board of Pensions urges you to consider getting long-term care insurance well before a need arises. That’s because medical underwriting is required in order to enroll, and a serious cognitive or physical impairment is likely to preclude you from coverage.

Major insurers offer long-term care plans you should explore.

Prepare an advance directive, living will, or durable power of attorney for health purposes if you haven’t already done so.
For more information, consult the Board of Pensions booklet Preparing Living Wills and Healthcare Powers of Attorney, available on pensions.org.
Hospital and Medical Benefits

Your out-of-pocket costs for medical services and supplies are discussed in this section. Costs for the prescription drug program under Medicare Supplement are explained under Prescription Drug Benefits.

Your share of the cost
For medical expenses, the amount you pay generally depends on whether you are getting preventive care or seeking treatment for an illness, injury, or health condition.

Medicare-participating providers
The Medicare Supplement Plan does not pay for services of a provider that does not participate in Medicare or for charges in excess of the Medicare-approved amount. Providers enrolled in Medicare — i.e., participating providers — accept the Medicare-approved amount as payment in full. Many providers participate in Medicare, and this guide assumes you receive services from a Medicare-participating provider.

Predective care
When you go to your primary care physician for a physical and have an exam, health screenings, and immunizations without any signs or symptoms of illness, this qualifies as a preventive care exam or wellness visit.

Medicare provides certain preventive care benefits, including covering the full cost of an annual wellness visit with a participating provider, and many health screenings and immunization costs.
Medicare does not cover routine vision exams. To fill this gap in coverage, the Medicare Supplement Plan includes an annual preventive care benefit of up to $125. This benefit can be applied to any routine screenings associated with your wellness visit that are not fully covered by Medicare and/or an annual vision exam.

Your preventive care costs

<table>
<thead>
<tr>
<th>Preventive care</th>
<th>Plan pays</th>
<th>You pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine health screenings and immunizations that are associated with an annual wellness visit but that are not fully covered by Medicare, and/or a routine vision exam</td>
<td>Up to $125</td>
<td>$0</td>
</tr>
</tbody>
</table>

A preventive care visit is reimbursed as such even if a health condition is discovered or diagnosed during your exam. After you exhaust the $125 benefit, subsequent tests related to a detected health condition are subject to normal plan provisions. Thus, if the approved charges are $175, the plan pays $125 without deductible. Then, if you have not yet met your deductible for the year, the $50 balance is applied to your deductible so you pay $50.

Routine vision exams

If you see your eye doctor for a routine vision exam (even if you already wear glasses), but have no signs or symptoms of illness, up to $125 of your preventive care benefit can be used for this service.

Note: The cost of prescribed eyeglasses or contact lenses is not covered under the preventive care benefit.

To ensure that you get the maximum benefit without having to file a claim, choose a vision care professional who participates in Medicare (i.e., a participating provider). If you visit an ophthalmologist or optometrist who participates in Medicare and/or is willing to submit vision exam claims to Medicare, you will not have to pay for your exam up front. Once Medicare receives your claim, it will pass it electronically to Highmark, which will pay up to $125, depending on how much of your annual preventive care benefit you have already used.

If you visit an eye doctor who cannot or will not submit claims to Medicare, you will have to submit your vision claim manually to Medicare (not Highmark). Medicare will pass the claim electronically to Highmark, which will then reimburse you up to $125 of your annual preventive care benefit. (Highmark cannot accept Medicare Supplement claims directly from you or your provider, even though Medicare does not cover routine vision exams.)

Under Medicare Supplement, your preventive care benefit is $125 annually, regardless of how it is applied. It could be used to pay a non-Medicare-covered preventive care test costing $50, for example, and the remaining $75 could be used to cover a routine vision exam.

If you think a claim for preventive care was not paid properly, contact the Board.

Other medical care and treatment

For other covered medical services and supplies, the plan pays 80 percent of eligible expenses up to a certain amount; after that, it pays 100 percent of your eligible medical expenses for the rest of the calendar year.

Your out-of-pocket costs consist of

- a deductible; and
- copayments, up to the annual copayment maximum.

Deductible

Your deductible is the annual amount you pay before the Medicare Supplement Plan pays its portion. In 2018, your deductible is one-half of 1 percent of the congregational teaching elders' median salary for pastors serving churches, or $290.

Each participant (up to two participants per family) pays an individual deductible. For example, if you, your spouse, and an eligible child all participate, you pay just two deductibles annually.

Your deductible applies to all medically related services, including but not limited to inpatient hospital care, outpatient surgery, and mental health and/or substance abuse treatment. It does not apply to outpatient prescription drugs; there is no deductible for the prescription drug program.
Copayment
After you pay your deductible each year, you are responsible for paying a defined percentage of your medical costs — your copayment — until you reach the annual copayment maximum. Your copayment is 20 percent of the balance of the approved amount after Medicare has paid its portion.

Copayment maximum
Your copayment maximum is the most you will pay in a calendar year for eligible medical services and supplies. It includes your deductible, but not your subscription costs or costs for outpatient prescription drugs. (The prescription drug program has a separate copayment maximum. See Annual individual copayment maximum under Prescription Drug Benefits.) The plan pays 80 percent until you reach your copayment maximum; after that, it pays 100 percent of eligible expenses for the rest of the calendar year.

Each participant has an individual copayment maximum. In 2018, your copayment maximum is 4 percent of the annual churchwide median effective salary for pastors serving churches, or $2,320. This means you pay about 4 percent of Medicare-approved charges until you reach your copayment maximum.

Out-of-pocket cost cap
Your annual out-of-pocket costs under Medicare Supplement are capped, as follows:

- You pay a deductible plus 20 percent of the balance after Medicare pays its portion, up to an annual copayment maximum ($2,320 in 2018).
- The plan pays 80 percent until you reach your copayment maximum; after that, it pays 100 percent for the rest of the calendar year.

Effect on out-of-pocket costs of transferring coverage
When you and/or your spouse transfer from active membership in the Medical Plan or medical continuation coverage to Medicare Supplement coverage, any amounts you already paid toward your annual deductible and copayment maximum are credited toward your Medicare Supplement deductible and copayment maximum for that year.

How claims are paid
To get claims paid under Medicare Supplement, you usually don’t need to do anything. Because Medicare provides your primary medical coverage, all of your medical claims (except for prescription drugs and medical services while traveling outside the United States) go to Medicare first. Your doctor’s office or the supplier usually submits your claim to Medicare for you. Medicare processes your claim, paying its portion, and then passes the claim electronically to Highmark Blue Cross Blue Shield for secondary payment under Medicare Supplement.

Next, Highmark pays the plan’s portion of the claim to the provider and sends you an explanation of benefits statement. Your provider then bills you for your share.

Claims filing deadline
To be eligible for reimbursement, all claims must be submitted electronically within 12 months of the date of service, unless you are able to show that an earlier filing was not possible. It’s important to monitor your benefits statements to make sure your providers have been properly paid so that you are not billed more than your fair share.

Summary of coverage
The following chart can help you determine the types of charges for which you are responsible.

The Medicare cost-sharing amounts shown are for 2018. For Medicare coverage details, look at the Medicare & You handbook, available at medicare.gov or by calling Medicare.

Coverage under the Medicare Supplement Plan is based on Medicare-approved amounts and is subject to applicable plan deductibles and copayments. Additional limitations may apply. For Medicare Supplement coverage details, see What’s Covered. For an illustration of costs and reimbursements, review The Medicare Supplement Plan in Action.
<table>
<thead>
<tr>
<th>Services and supplies</th>
<th>Medicare pays¹</th>
<th>Medicare Supplement Plan pays²</th>
<th>You pay³</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part A Expenses (Part A is Medicare’s hospital insurance plan)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital expenses: Semiprivate room and board, general nursing and miscellaneous services and supplies:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Days 1–60</td>
<td>All but $1,340</td>
<td>$1,072</td>
<td>$268</td>
</tr>
<tr>
<td>• Days 61–90</td>
<td>All but $335/day</td>
<td>$268/day</td>
<td>$67/day</td>
</tr>
<tr>
<td>• Days 91–150 with lifetime reserve</td>
<td>All but $670/day</td>
<td>$536/day</td>
<td>$134/day</td>
</tr>
<tr>
<td>• Days 91–150 without reserve days</td>
<td>$0</td>
<td>80% of costs⁵</td>
<td>20% of costs⁴</td>
</tr>
<tr>
<td>• Beyond 150 days</td>
<td>$0</td>
<td>80% of costs⁴</td>
<td>20% of costs⁴</td>
</tr>
<tr>
<td>Skilled nursing facility (after hospitalization):⁶</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Days 1–20</td>
<td>100%</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>• Days 21–100</td>
<td>All but $167.50/day</td>
<td>$134/day</td>
<td>$33.50/day</td>
</tr>
<tr>
<td>• Beyond 100 days</td>
<td>$0</td>
<td>80% of costs for days 101–180 (annual limit)</td>
<td>20% for days 101–180; 100% after 180 days (per year)</td>
</tr>
<tr>
<td><strong>Home healthcare⁷</strong></td>
<td>100%</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Hospice care</strong></td>
<td>100%</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Part B expenses (Part B is Medicare’s medical services insurance plan)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar year deductible</td>
<td>$0</td>
<td>$0</td>
<td>$183, Medicare $290, Medicare Supplement</td>
</tr>
<tr>
<td>Preventive services such as annual wellness visits, mammograms, Pap smears, prostate cancer screenings, vaccinations.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% of Medicare-approved expenses ($0 for routine vision exams)</td>
<td>$125 toward annual wellness visit-related expenses not covered by Medicare and/or routine vision exam, without deductible; 80% of balance for approved expenses</td>
<td>20% of balance for approved expenses</td>
<td></td>
</tr>
<tr>
<td>Medical services and supplies, such as:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician’s services, outpatient medical and surgical services and supplies, diagnostic tests, durable medical equipment, outpatient physical and occupational therapy, and other services</td>
<td>80% of Medicare-approved expenses</td>
<td>80% of the balance for Medicare-approved expenses</td>
<td>20% of the balance for Medicare-approved eligible expenses; costs above Medicare-approved amounts or not covered by Medicare</td>
</tr>
<tr>
<td>• Diagnostic clinical laboratory services</td>
<td>100% of Medicare-approved expenses</td>
<td>$0</td>
<td>Costs above Medicare-approved amounts or not covered by Medicare</td>
</tr>
<tr>
<td>• Outpatient mental health care</td>
<td>60% of Medicare-approved expenses</td>
<td>80% of the balance for Medicare-approved expenses</td>
<td>20% of the balance for Medicare-approved expenses</td>
</tr>
<tr>
<td><strong>Additional Medicare Supplement benefits (expenses not covered by Medicare)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital and medical care while traveling outside the U.S.</td>
<td>$0</td>
<td>80% of billed charges</td>
<td>20% of billed charges</td>
</tr>
<tr>
<td>Outpatient prescription drugs</td>
<td>$0</td>
<td>See Prescriptions Drug Benefits section</td>
<td>See Prescriptions Drug Benefits section</td>
</tr>
</tbody>
</table>

¹ The Part A deductible of $1,340 and day rates are for 2018 only and are subject to change each year. Services must be medically necessary and eligible under the plan.
² Subject to annual Medicare Supplement Plan deductible first; example assumes this deductible has already been met.
³ The amount you pay for all Part A and Part B services in 2018 under the Medicare Supplement Plan is subject to a deductible of $290 and capped at $2,320; once you reach this maximum, your Medicare Supplement coverage pays 100% of eligible costs. Subject to change each year.
⁴ Sixty reserve days may be used only once in a lifetime.
⁵ Except for an inpatient stay for substance abuse treatment, for which the Medicare Supplement Plan has a 90-day maximum lifetime limit.
⁶ Custodial care is not covered.
⁷ Must be medically necessary and prescribed by a physician.
OptumRx administers the Medicare Supplement prescription drug program on behalf of the Board of Pensions. It’s important to know that this is a separate program from the prescription drug benefits provided under the Medical Plan for active members. The Medicare Supplement prescription drug program is a qualified Medicare Part D plan. As such, it uses a different formulary drug listing, and some benefits and limitations may be different from what you were used to as an active member.

Unlike many other Medicare Part D plans, the prescription drug program does not have a coverage gap (sometimes called a donut hole). You pay a share of the cost for covered drugs — your copayment — until your out-of-pocket prescription drug costs reach the annual copayment maximum. Then, the plan pays 100 percent of your eligible prescription drug costs for the rest of the calendar year. For more details, see Annual individual copayment maximum.

As shown in the following chart, your copayment amounts vary depending on the type of drug and whether you fill prescriptions at a retail pharmacy or through the plan’s mail-order service.
# Your prescription drug costs

<table>
<thead>
<tr>
<th>Type of pharmacy</th>
<th>When to use</th>
<th>Maximum fill</th>
<th>Generic drug</th>
<th>Formulary drug</th>
<th>Non-formulary drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail pharmacy</td>
<td>• Medications for short-term use</td>
<td>Up to a 30-day supply</td>
<td>$10</td>
<td>30% of cost: min. $20 to max. $100</td>
<td>50% of cost: min. $50 to max. $150</td>
</tr>
<tr>
<td></td>
<td>• First fill of a prescription for a maintenance (ongoing) medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medications you use on an ongoing basis (maintenance medications)</td>
<td>Up to a 90-day supply</td>
<td>$30</td>
<td>30% of drug cost: min. $60 to max. $300</td>
<td>50% of drug cost: min. $150 to max. $450</td>
</tr>
<tr>
<td>Mail-order service</td>
<td>• Medications you use on an ongoing basis (maintenance medications)</td>
<td>Up to a 90-day supply</td>
<td>$25</td>
<td>30% of drug cost: min. $50 to max. $250</td>
<td>50% of drug cost: min. $125 to max. $375</td>
</tr>
</tbody>
</table>

1The maximum amount you pay each year in out-of-pocket prescription drug costs is $2,500. Any costs for non-formulary drugs or for prescriptions for other family members do not count toward your copayment maximum.

## Formulary listing of covered drugs

A formulary is a listing of generic and brand-name drugs that are covered by the prescription drug program. Drugs on the formulary listing used by the Medicare Supplement Plan are selected by OptumRx in consultation with a team of healthcare providers, based on the drugs’ safety, effectiveness, and cost.

Each time you visit your doctor, share the Medicare Supplement formulary listing with him or her. The plan will generally cover the drugs listed on the formulary as long as the drug is medically necessary, the prescription is filled at an OptumRx network pharmacy (or through the mail-order service), and other plan rules are followed.

To access the *Abridged Formulary* for the Medicare Supplement prescription drug program, enter Drug Formulary in the search box on the home page of pensions.org, or call the Board and speak with a service representative to request a copy.

**Note:** The formulary for the Medicare Supplement Plan is subject to annual approval by the Centers for Medicare & Medicaid Services (CMS), and may change from year to year.

## Brand name or generic?

When you need a prescription, ask your doctor if a generic is available and appropriate for you. When you choose a generic drug instead of the brand-name, you’ll pay less — sometimes a lot less — for essentially the same drug.

### Generic drugs

The brand name of a drug is the product name under which it is advertised and sold. A generic drug is sold under its chemical name, but has the same active ingredients and is subject to the same Food and Drug Administration (FDA) standards for quality, safety, purity, and effectiveness as its brand-name counterpart. **Generics cost less** than brand-name drugs, mostly because manufacturers of generic drugs do not have the expense of research, development, and advertising related to a new drug.

Under the prescription drug program, your cost is as follows:

- $10 for up to a 30-day supply of a generic drug filled at a participating retail pharmacy when you use your prescription ID card
- $25 for up to a 90-day supply of a generic drug filled through OptumRx mail order (home delivery)

These flat copayment amounts apply to all covered generic drugs.

**Generic drugs are regulated by the FDA, just like their brand-name counterparts. They are proven to be safe and effective. Trademark laws do not allow generic drugs to look exactly like their brand-name counterparts, but these differences don’t affect performance.**
Formulary and non-formulary drugs
Sometimes generics are not available or may not be the best choice for your condition. If you need to take a brand-name drug, ask your physician if he or she can prescribe one that’s listed on the formulary. These drugs have been selected based on various factors, including proven treatment effectiveness.

If you fill a prescription for a brand-name formulary drug, you pay 30 percent of the cost (up to a maximum amount). If you fill a prescription for a brand-name non-formulary drug, you pay 50 percent of the cost (up to a maximum amount), and that amount does not count toward your annual copayment maximum.

Both brand-name formulary and brand-name non-formulary drugs also have a minimum amount you must pay. If the actual cost of your prescription is less than the minimum amount, you pay the actual cost.

The Your prescription drug costs chart on page 23 lists the copayments as well as the minimums and maximums for brand-name formulary and brand-name non-formulary drugs.

Annual individual copayment maximum
The Medicare Supplement prescription drug program has a $2,500 copayment maximum, which limits your out-of-pocket costs. This means you will not pay more than $2,500 a year for all covered prescriptions (both generic and brand-name) for yourself. Once you reach the copayment maximum, Medicare Supplement pays 100 percent of all your remaining eligible prescription drug costs for the rest of the calendar year.

Unlike the Medical Plan for active members, the Medicare Supplement Plan has an individual copayment maximum for each participant.

Generic versus brand-name example
Mr. Smith develops an illness. His doctor prescribes a brand-name formulary drug that costs $100; no generic equivalent exists. Mr. Smith is to take the drug twice a day for 14 days, so he fills it at a retail pharmacy that participates in the OptumRx network.

Who pays Calculation How much?
Mr. Smith 30% x $100 = $30 copayment
Medicare Supplement 70% x $100 = $70 benefit

Brand non-formulary example
Mr. Smith contracts an illness, for which his doctor prescribes a brand-name non-formulary drug that costs $350. No generic equivalent exists, but there is a brand-name formulary drug his doctor could have prescribed. Mr. Smith is to take the drug once a day for 10 days, so he fills it at a retail pharmacy that participates in the OptumRx network.

Who pays Calculation How much?
Mr. Smith 50% x $350 = $150 maximum copayment1
Medicare Supplement 50% x $350 = $175 benefit

1 This copayment does not count toward his $2,500 annual individual copayment maximum.

How to get prescriptions filled
You can access your prescription drug benefits in one of two ways:
1. at your local participating pharmacy
2. through mail order

At your local participating pharmacy
When you need to fill short-term prescriptions — those for 30 days or less — simply present your OptumRx Medicare Prescription Drug card at an OptumRx network pharmacy. The OptumRx network includes both independent pharmacies and national chains. To find participating retail pharmacies, visit optumrx.com.

If a local pharmacy does not accept your OptumRx ID card, that means it does not participate in the OptumRx network, and any prescriptions you have filled there will likely cost more than at a participating pharmacy.

When you fill a prescription at a nonparticipating pharmacy, you also will need to pay the full cost of the prescription yourself and then submit a claim for reimbursement.

Through mail order
Use the OptumRx home delivery service to fill prescriptions for medications you need to take on a regular basis — for example, medications to treat high blood pressure, diabetes, or high cholesterol. Although you may choose to fill ongoing prescriptions at a participating retail pharmacy, you typically will pay less if you use OptumRx home delivery. This is because, as part of ongoing efforts to help manage prescription drug costs, the Board has negotiated greater discounts with OptumRx on medications filled through mail order.

Shipping is free, and you also enjoy the convenience of having your medication sent directly to your home.
To start a new maintenance medication
If you need to start taking a medication on an ongoing basis, ask your doctor to write two prescriptions: one for 30 days and one for 90 days.

Take the 30-day prescription and have it filled immediately at a participating retail pharmacy, so you can see if the medication is right for you.

Once you are certain this is the correct medication, submit the 90-day prescription (to follow the 30-day supply) through the OptumRx home delivery service. To do this, complete an OptumRx prescription order form, available at optumrx.com or pensions.org, and mail the form and the written prescription from your doctor to the address on the form.

Be sure to promptly return calls from OptumRx, since they are required to obtain your consent before filling any mail-order prescription not received directly from you — for example, if your doctor’s office faxes the prescription directly to OptumRx.

Be sure to promptly respond to calls from OptumRx. They may be calling to verify mail-order prescriptions they received directly from your doctor.

Prior authorization
A prior authorization requires you or your physician to get approval from OptumRx before you fill prescriptions for certain drugs. If you do not get approval, the drug may not be covered.

Drugs that require prior authorization typically are drugs that are very costly or have significant potential for negative side effects. When you present a prescription for one of these drugs — growth hormones, for instance — the pharmacy receives notice that certain clinical information must be obtained from your physician before it can fill the prescription. You can find out if a drug requires prior authorization by checking the Abridged Formulary available on pensions.org, or call the Board and speak with a service representative.

Quantity Limits
For certain drugs, there is a limit on the amount of the drug that will be covered. Drugs that have quantity limits are noted in the Abridged Formulary available on pensions.org, or call the Board and speak with a service representative.

Specialty medications
Specialty medications typically are used to treat complex conditions, including cancer, hepatitis, and multiple sclerosis, among others. They include high-cost injectable and oral medications and often have special product handling and distribution requirements.

BriovaRx is OptumRx’s specialty pharmacy, and can have these medications sent directly to your home.

To contact BriovaRx, call 855-427-4682.

Drugs not covered
The prescription drug program does not cover medications that

- are not approved by the FDA;
- have over-the-counter equivalents;
- are appetite suppressants;
- are approved or prescribed for cosmetic purposes only; or
- are lost, stolen, spilled, or otherwise damaged.

If you want to take a prescription that is not covered under the prescription drug program, you will pay the full (unreduced) cost of the drug and the amount you pay will not count toward your out-of-pocket maximum.

Special programs designed to limit costs
Some drugs your doctor may prescribe are subject to special programs, including step therapy, prior authorization, and quantity limits, that are designed to help limit costs while providing you with safe and effective medications.

Step therapy
In some cases, it will be required that you first try certain drugs to treat your medical condition before the plan will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the plan will then cover Drug B.

Drugs that require step therapy are noted in the Abridged Formulary available on pensions.org, or call the Board and speak with a service representative. The step therapy list is subject to change.
When you have coverage under the Medicare Supplement Plan, three parties pay for your hospital and medical care: Medicare, the Medicare Supplement Plan (through Highmark), and you, typically in that order. To understand how these three parties work together — and what your share of the costs may be — it’s best to look at an example.

The following example looks at how much each party may pay for a hypothetical member’s claims for hip surgery. As you review the example, keep in mind that it is for illustrative purposes only; actual costs for the same type of surgery could be higher or lower than those shown here.

Assumptions
The Reverend Douglas Smith has Original Medicare (i.e., Part A and Part B coverage), is enrolled in the Medicare Supplement Plan offered by the Board of Pensions, and undergoes hip surgery in early January. The following example assumes he uses participating providers and has not previously satisfied any portion of his 2018 deductible for the Medicare Supplement Plan or Medicare Part B. Following discharge from the hospital, he is admitted to a skilled nursing facility for intensive physical therapy, which is not addressed in this example.

1. Medicare Part A-related costs
Mr. Smith spends three days in the hospital. His total Medicare-approved charges for anesthesia, supplies, medication, lab tests, X-rays, physical and occupational therapy, and operating and recovery room use amount to $16,220.

Medicare pays the hospital $14,880, leaving his Part A deductible of $1,340 for Mr. Smith to pay.

**Mr. Smith’s costs under Medicare Part A:**

<table>
<thead>
<tr>
<th>Medicare deductible</th>
<th>$1,340</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days 1 to 3 of hospital stay</td>
<td>$0</td>
</tr>
<tr>
<td>Total Mr. Smith owes</td>
<td>$1,340</td>
</tr>
</tbody>
</table>

The Medicare Supplement Plan, through Highmark, deducts $290 (his Medicare Supplement deductible for the year), then pays 80% of the $1,050 balance, or $840.

Mr. Smith’s final hospital bill (not including Part B charges) is **$500**, or his $290 Medicare Supplement deductible plus 20% of $1,050 ($210)

**His costs after the Medicare Supplement Plan pays:**

<table>
<thead>
<tr>
<th>Medicare Supplement deductible</th>
<th>$290</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Smith’s copayment (20% of $1,050)</td>
<td>$210</td>
</tr>
<tr>
<td>Total Mr. Smith owes ($290 + $210)</td>
<td>$500</td>
</tr>
</tbody>
</table>
2. Part B-related costs

During Mr. Smith’s three-day hospitalization, he incurs surgeon, assistant surgeon, and anesthesiologist Medicare-approved charges totaling $2,640. Medicare Part B deducts $183 (the Medicare Part B deductible), then pays 80% of the $2,457 balance, or $1,966, leaving a balance of $491.

Mr. Smith’s costs under Medicare Part B:
- Medicare deductible $183
- Mr. Smith’s coinsurance (20% of $2,457) $491
- Total Mr. Smith owes $674

The Medicare Supplement Plan then pays 80% of the remaining balance, or $539. Mr. Smith’s copayment for physician and anesthesiologist bills equals $135.

His costs after the Medicare Supplement Plan pays:
- Medicare Supplement deductible $0.00
- Mr. Smith’s copayment (20% of $674) $135
- Total Mr. Smith owes $135

3. Summary: Mr. Smith’s total out-of-pocket costs

Balance of hospital charges $495
Balance of physician charges $135
Grand total $630
(roughly 3.5% of total approved charges)

1He satisfied his 2018 deductible for the Medicare Supplement Plan in Step 1 above. For any covered hospital or medical services he receives during the remainder of the year, the plan will pay 80% of the balance (after Medicare pays its portion).
This section defines the rules for ending coverage and re-enrolling in the Medicare Supplement Plan, as well as the coverage implications of death and legal separation, divorce, or dissolution of a marriage.

Ending your coverage
Your Medicare Supplement coverage continues as long as you make timely payments for your coverage. If you want to cancel your coverage or wish to withdraw from the program so that you can join a Medicare Advantage plan, notify the Board of Pensions as follows.

Cancellation
You may cancel your coverage, but once you have done so, you cannot re-enroll at a later date except under the terms of the Medicare Advantage plan (see Withdrawal to enroll in Medicare Advantage).

To cancel your coverage, send the Board of Pensions a written request at least one month in advance of the date you want your coverage to end. This ensures that the Board has time to stop deducting your subscription charge from your pension benefit.

Withdrawal to enroll in Medicare Advantage
Because Medicare Advantage plans are offered by private insurers, rates, benefits, and even networks tend to be more dynamic than those under Original Medicare. A plan may have suited a participant’s needs when he or she joined but a year later may not. For this reason, Medicare allows participants to join or leave Medicare Advantage plans annually.

After enrolling in the Medicare Supplement Plan, you may choose to withdraw in order to try a Medicare Advantage plan. If you do, you will have limited opportunities to re-enroll in Medicare Supplement should you wish to return (see Re-enrolling in Medicare Supplement). You can choose to withdraw from and re-enroll in Medicare Supplement only one time.

To withdraw from Medicare Supplement coverage so that you may join a Medicare Advantage plan, complete only Parts A and E of the Medicare Supplement Subscription, Waiver, or Withdrawal form and return it to the Board of Pensions.

Note: The Board must receive your withdrawal form by the 15th of the month before your Medicare Advantage coverage begins so that it can stop deducting a subscription charge for Medicare Supplement before your next monthly pension payment is issued.

Re-enrolling in Medicare Supplement
After you have withdrawn from the Medicare Supplement Plan to join a Medicare Advantage plan, you may be eligible to re-enroll. The conditions under which you may re-enroll in the Medicare Supplement Plan are as follows.

First get Part A and Part B
To re-enroll in Medicare Supplement, you must also re-enroll in Medicare Part A and Part B. Contact your local Social Security office for information on re-enrolling in Original Medicare.
During the first 12 months
You may re-enroll in Medicare Supplement coverage at any time during the first 12 months of your participation in a Medicare Advantage plan. The Board of Pensions requires you to send proof of prior Medicare Advantage coverage.

A move out of the service area
You may re-enroll in the Medicare Supplement Plan if you permanently move out of your Medicare Advantage plan’s service area. The Board of Pensions requires you to send proof of prior Medicare Advantage coverage and confirmation of your new address.

A significantly modified or discontinued plan
You may re-enroll in Medicare Supplement coverage if your Medicare Advantage plan significantly modifies premiums or benefits, or discontinues its coverage to Medicare-eligible participants. The Board of Pensions requires you to send proof of prior Medicare Advantage coverage and a copy of the notification you received from the plan.

Special circumstances
Divorce, legal separation, or dissolution of a marriage
If you divorce or dissolve your marriage while covered under Medicare Supplement, your former spouse and eligible family members may continue their coverage.

To do so, they must
• provide the Board with a copy of the divorce or dissolution decree;
• pay the monthly subscription charges for either Medicare Supplement or medical continuation coverage, as appropriate, with subscription charges starting the day after the effective date of the divorce or dissolution; and
• complete the related subscription form to enroll within 30 days of the divorce or dissolution.

Former spouses also can waive coverage upon divorce or dissolution if they have other qualified health plan coverage (see Postponing enrollment).

How to re-enroll
To apply for re-enrollment in Medicare Supplement coverage, you must provide the Board with certain information, if not in advance, then within 30 days of disenrollment from or termination of your previous plan.

First, complete the subscription section of the Medicare Supplement Subscription, Waiver, or Withdrawal form. Be sure to include the name and Social Security number of each person to be re-enrolled. Second, provide the Board with the following:

• the termination date for the Medicare Advantage plan or the other employer-sponsored plan (include a copy of the notification you received from the plan, if any);
• the date you wish your re-enrollment to begin (must be the first day of the month); and
• a copy of each participant’s Medicare card showing enrollment in both Part A and Part B.

Remember, your Original Medicare coverage must be restored before re-enrollment in Medicare Supplement can begin.

For information about Medicare Advantage plans, read Medicare & You, available at medicare.gov.

How to re-enroll

For information about medical continuation coverage, visit pensions.org or call the Board of Pensions.
### Appendix A Medicare Supplement Plan contacts

<table>
<thead>
<tr>
<th>Service provider</th>
<th>For assistance with</th>
<th>Phone number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Board of Pensions of the Presbyterian Church (U.S.A.)</td>
<td>Any Medicare Supplement or retirement benefit matter</td>
<td>800-773-7752 (800-PRESPLAN) TTY: 877-522-7948 International: 215-587-7200 Fax: 215-587-6215 8:30 a.m.–5 p.m. ET Monday through Friday</td>
<td>pensions.org</td>
</tr>
<tr>
<td>Highmark Blue Cross Blue Shield</td>
<td>Hospital, medical, and mental health/ substance abuse coverage information and claims</td>
<td>888-835-2959 8 a.m.–5 p.m. ET Monday through Friday</td>
<td>highmarkbcbs.com</td>
</tr>
<tr>
<td>OptumRx</td>
<td>Prescription drugs (retail and mail order) and claims Specialty medications</td>
<td>855-234-3908 BriovaRx: 855-427-4682</td>
<td>optumrx.com</td>
</tr>
<tr>
<td>International SOS Assistance</td>
<td>Hospital and medical services when traveling outside the United States</td>
<td>Varies by location/ see pensions.org</td>
<td>Information/ID card in Benefits Overview: Medical Assistance during International Travel, on pensions.org</td>
</tr>
</tbody>
</table>
# Appendix B Medicare and related contacts

<table>
<thead>
<tr>
<th>Contact</th>
<th>For information about</th>
<th>Phone number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security</td>
<td>Enrolling in Medicare or replacing a lost Medicare card; help paying for Medicare prescription drug coverage; general questions about Social Security and Medicare</td>
<td>800-772-1213</td>
<td>socialsecurity.gov</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TTY: 800-325-0778</td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>Medicare coverage details; Medicare health and prescription drug plan choices in your area</td>
<td>800-633-4227</td>
<td>medicare.gov</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(800-Medicare)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>TTY: 877-486-2048</td>
<td></td>
</tr>
<tr>
<td>State Insurance Department</td>
<td>Medicare Advantage and Medigap plans in your region; consumer complaints filed against private insurers</td>
<td>Varies by state&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Varies by state&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>National Council on Aging</td>
<td>Advocacy for seniors and caregivers; referrals for services</td>
<td>202-479-1200</td>
<td>ncoa.org</td>
</tr>
<tr>
<td>State or County Office on Aging</td>
<td>Advocacy for seniors and caregivers; referrals for services</td>
<td>Varies by state&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Varies by state&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>1</sup>To locate this information, enter the name of your state followed by insurance department in an Internet search engine, or contact Medicare to get the telephone number for your local state insurance department.

<sup>2</sup>To find this information, enter the name of your state or county followed by Office on Aging in an Internet search engine. For example, if you live in Pennsylvania, enter PA Office on Aging.
Below is a sample explanation of benefits (EOB) for Medicare Supplement claims. You will receive a statement like this after your benefits claim has been processed. In order to understand this example, match the field number on the EOB to the corresponding number in the legend below.

**Member Responsibility**

<table>
<thead>
<tr>
<th>Provider Name / Type of Service</th>
<th>Provider's Charges</th>
<th>New Balance to Member</th>
<th>Plan Allowance (Covered Charges)</th>
<th>Medicare</th>
<th>Type of Member Liability</th>
<th>Member Liability Amount</th>
<th>Health Plan Pays</th>
<th>Amount You Owe Provider (Total of Shaded Column)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC HOSPITAL</td>
<td>3327.00</td>
<td>2139.36</td>
<td>1137.36</td>
<td>1044.36</td>
<td>Coinsurance</td>
<td>10.27</td>
<td>73.87</td>
<td>18.27</td>
</tr>
<tr>
<td>ABC HOSPITAL</td>
<td>1048.00</td>
<td>659.71</td>
<td>318.32</td>
<td>320.95</td>
<td>Coinsurance</td>
<td>5.77</td>
<td>23.02</td>
<td>5.77</td>
</tr>
<tr>
<td>ABC HOSPITAL</td>
<td>1273.69</td>
<td>535.22</td>
<td>435.47</td>
<td>400.51</td>
<td>Coinsurance</td>
<td>6.99</td>
<td>27.97</td>
<td>6.99</td>
</tr>
<tr>
<td>TOTALEST</td>
<td>5648.72</td>
<td>737.16</td>
<td>1911.29</td>
<td>1776.22</td>
<td>38.61</td>
<td>129.84</td>
<td>38.61</td>
<td></td>
</tr>
</tbody>
</table>

**Explanation of Remark Codes**

| 010.0 [ ] | This is the difference between the provider's charge and our allowance.

We provide administrative claims payment services only and do not assume any financial risk or obligation regarding claims.

**Subscriber Information** – this section contains information about the subscriber who received services.

**Dates of Service** – date range of services explained on this EOB.

**We Sent Payment to** – individual/facility to whom reimbursement was sent.

**Provider May Bill You** – summary of what you owe the provider. The breakdown of charges is shown in the Member Responsibility block.

**Provider** – the name of the facility or professional performing or supplying the services.

**Date of Service** – date the service(s) was performed or supplied.

**Type of Service** – e.g., surgery, office visit, etc.

**Service Code** – code to identify which service was performed.

**Provider’s Charges** – the amount the provider actually charged for the services.

**Non-Billable to Member** – the difference between “Provider’s Charges” and “Plan Allowance.” (For covered services, if you use a provider that accepts Medicare assignment, they must accept the “Plan Allowance” as payment in full and cannot bill you for the difference between the “Provider’s Charges” and the “Plan Allowance.”)

**Plan Allowance** – Medicare-allowed amount on which reimbursement is based.

**Medicare** – amount that Medicare paid.

**Type of Member Liability** – description of your liability. For example, coinsurance or deductible

**Member Liability Amount** - the actual dollar amount of your member liability.

**Health Plan Pays** – the dollar amount the Medicare Supplement Plan pays.

**Amount You Owe Provider** – the total of all of your responsibilities related to this claim. This includes any deductible or coinsurance amounts, and, if applicable, the cost of any non-covered services.

**Explanation of Remark Codes** – explains why certain charges were not covered.
Appendix D Administrative and compliance provisions

Amendments to the plan and reservation of right to terminate benefits

Although The Board of Pensions of the Presbyterian Church (U.S.A.) expects to continue the Medicare Supplement Plan, it reserves the right to modify, terminate, or suspend this plan and its provisions, including, but not limited to, benefits and contributions for coverage, at any time by action of the Board of Directors of the Board of Pensions, and to report such action to the General Assembly.

Confidentiality and privacy practices

Ensuring the privacy of member information is a long-standing tradition of the Board of Pensions. Medicare Supplement participants and their family members are asked to cooperate with the Board's policies concerning confidentiality. The privacy of the health plan records of Medicare Supplement participants and their covered family members may also be protected by special security and privacy regulations under HIPAA (the Health Insurance Portability and Accountability Act of 1996).

The Board of Pensions HIPAA privacy policy notice (Notice of Privacy Practices of Medical Plans) describes the Medicare Supplement Plan’s privacy practices and your rights to access your records.

The notice is available on pensions.org or by calling the Board at 800-773-7752 (800-PRESPLAN).

For example, under HIPAA, Board employees and the plan representatives (such as Highmark and OptumRx) may not release a participant’s protected health information, known as PHI (other than enrollment information), to a spouse unless the participant authorizes this by completing a power of attorney or an authorization form and filing it with the plan.

The Board will require your written authorization before sharing your protected health information for any reason other than payment, treatment, or healthcare operations with anyone other than you or your personal representative (that is, your guardian or named representative in a power of attorney). You may be asked to fill out and return authorization forms and to provide verification of information. Please remember that these and other actions are being taken to safeguard your privacy and that of your family.

For an authorization form or more information, visit pensions.org or call the Board at 800-773-7752 (800-PRESPLAN) and speak with a service representative.

Discrimination is against the law

The Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity, or recorded gender.

Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual’s sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Plan:

- provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - qualified sign language interpreters
  - written information in other formats (large print, audio, accessible electronic formats, other formats)
- provides free language services to people whose primary language is not English, such as:
  - qualified interpreters
  - information written in other languages

If you need these services, contact the Civil Rights Coordinator. If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building, Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)


**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call 800-773-7752 (800-PRESPLAN).

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-773-7752 (800-PRESPLAN).

주주: 한국어로 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-773-7752 (800-PRESPLAN)번으로 전화해 주십시오.

### HIPAA forms

<table>
<thead>
<tr>
<th>Form</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization to Release Medical Plan Information, HPA-001</td>
<td>Allows the Board of Pensions to release the protected health information to other specified persons, including a spouse; an organization, including a presbytery representative; or an internal Board department</td>
</tr>
<tr>
<td>Authorization for Use or Disclosure of Protected Health Information, HPA-002</td>
<td>Allows another health plan, a physician, practice, hospital, or healthcare provider or organization to release protected health information to the Board for purposes other than treatment, payment, or healthcare operations (for which no authorization is required)</td>
</tr>
<tr>
<td>Benefits Plan of the Presbyterian Church (U.S.A.) Medical Plan — Request for Access to PHI, HPA-003</td>
<td>Allows a covered individual or personal representative access to his or her protected health information maintained by the Medical Plan (including the Medicare Supplement Plan)</td>
</tr>
<tr>
<td>Benefits Plan of the Presbyterian Church (U.S.A.) Medical Plan — Request to Amend PHI, HPA-004</td>
<td>Allows a covered individual or personal representative to request an amendment to his or her protected health information maintained by or for the Medical Plan (including the Medicare Supplement Plan)</td>
</tr>
<tr>
<td>Benefits Plan of the Presbyterian Church (U.S.A.) Medical Plan — Request for Accounting of Disclosures, HPA-005</td>
<td>Allows a covered individual or personal representative to request an accounting of disclosures of protected health information</td>
</tr>
<tr>
<td>Designation of Personal Representative, ENR-904</td>
<td>Provides limited powers of attorney to the personal representative of a covered person; authorizes the Board to provide information to that individual</td>
</tr>
</tbody>
</table>
Subrogation recovery and other reimbursement
If a participant incurs medical costs as a result of an accident or negligent act for which he or she will recover medical costs from insurance, a damage award or settlement, other medical coverage, or otherwise, the Medicare Supplement does not pay the medical costs incurred unless the participant agrees to reimburse the plan for the medical costs advanced if the medical expenses are subsequently recovered from an insurance settlement, a lawsuit, or other source.

The participant should contact the Board to coordinate the reimbursement to the plan when the case is settled.

For further information, refer to the Benefits Plan document, available on pensions.org or by calling the Board of Pensions.

Appendix E Appeal procedures
If your claim for a benefit is denied, you receive a written notice.

The content of the notice depends on the type of claim or service, whether the claim has been incurred or the service is pending, and whether the denial comes from the Board or from one of its service providers (Highmark Blue Cross Blue Shield or OptumRx). The notice may contain

- the specific reasons for the denial and/or the specific references to the provisions of the Benefits Plan of the Presbyterian Church (U.S.A.) on which the denial is based;
- a description of any additional information needed by the plan to reconsider the claim; and
- an explanation of the plan's appeal procedures.

If the notice you receive does not contain all of this information, you may request further details from the Board of Pensions.

Time limits are imposed for filing appeals. The notice will state the time before which your appeal must be filed.

After you receive the plan's denial notice, you may appeal the claim denial by

- requesting a claim review in writing (recommended) or by phone;
- submitting pertinent documents for review; and
- submitting issues and comments in writing.

In most cases, a review of your appeal is made within 30 days of the receipt of all pertinent information.

Your initial appeal
Your initial appeal for all medical and mental health/substance abuse claims is directed to Highmark Blue Cross Blue Shield. **The initial appeal must be made to Highmark within 180 days of the initial claim denial.**

For prescription drug program appeals, your initial appeal should be submitted directly to OptumRx. The timing requirements are the same as for medical and mental health/substance abuse claims, above.

Final appeal
If you are not satisfied with the results of the initial review, you may appeal a final time. Your final appeal will be referred to an external Independent Review Organization (IRO).

The appeal must be filed with the service provider **within four months of the date of the notice of the review decision.** The provider will, randomly or by rotation, select one of at least three IROs to perform an external review of your appeal.

Once you have exhausted the plan's appeal process, you have the right to challenge the decision in a court of law.