THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

Guide to the Medicare Supplement Plan

THE BENEFITS PLAN
OF THE PRESBYTERIAN CHURCH (U.S.A.)

For retired members

Table of Contents

This guide is not a full description of benefits and limitations of Medicare Supplement. 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. Medicare Supplement is administered by Highmark Blue Cross Blue Shield and Express Scripts.

A Message from the Board of Pensions

Dear Retired Member,

Welcome to Medicare Supplement, a medical benefits program for retired members, offered through the Benefits Plan of the Presbyterian Church (U.S.A.) and reflecting our commitment to offer 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 Medicare Supplement builds on your Medicare coverage. Here you'll find information on eligibility for benefits, covered services, out-of-pocket costs, and more.

In 2022, the Board of Pensions introduced new benefits to Medicare Supplement Plan participants — at no additional cost. Vision coverage includes eye exam and vision eyewear benefits, while the Employee Assistance Plan provides access to emotional health and family support, financial and legal assistance, home life referrals, and more.

Medicare's preventive coverage includes annual well visits, or physicals, and a growing list of preventive screenings and related services. 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. Your Medicare Part D coverage also covers a shingles vaccine for you, provided the vaccine is administered through a pharmacy.

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 the 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.

Additional 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 XII of the Benefits Plan of the Presbyterian Church (U.S.A.).

We wish you the very best of health!

Sincerely,

Patricia M. Haines
Executive Vice President, Chief Benefits Officer

Overview

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 Medicare Supplement. 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 Medicare Supplement.

About Medicare Supplement

As its name implies, Medicare Supplement supplements, or adds to, the coverage provided under Original Medicare. 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.

Medicare Supplement 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 personal information; and
- link directly to certain service providers, such as Highmark, to view your medical claims.

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.

Pre- and post-retirement education

The Board of Pensions offers recorded seminars, e-learning, and webinars, at no cost to you, on a variety of retirement topics.

- Thinking Retirement: Identity, Vocation, Economics (THRIVE) (seminar) helps you focus on key questions for discernment as you prepare for retirement.
- How to Optimize Your Retirement Income Streams (pre-recorded webinar) shows how to create sustainable retirement income in the most efficient manner. This archived webinar is available on Benefits Connect.
- Retirement Conversations (e-learning) focus on identity, retirement income, medical options, housing considerations, vocation, and transitioning well.
- Beginning Anew: Finding Wholeness in Retirement (course) explores a range of topics to help you cross the threshold and embrace a new beginning, and offers opportunities for reflection and visualization.
- Estate Planning for Ministers (webinar) captures industry professionals providing best practices, stories, and answers to estate, legacy, and generosity questions that can help you plan for your financial and personal legacy.

For more information on these and other pre- and post-retirement seminars, webinars, e-learning, videos, and more from the Board of Pensions, visit pensions.org/boarduniversity. Keep in mind that webinar topics change each year, although pre-recorded webinars are available through Benefits Connect.

Eligibility and Enrollment

This section explains who may enroll in Medicare Supplement and how to enroll.

Who is eligible to enroll

You may enroll in Medicare Supplement if you

- are retired and Medicare-eligible (generally age 65 or older);
- are participating in the Medical Plan of the PC(USA) as an active member when you retire or have maintained continuous, qualified health plan coverage between the date you left employment and the date you want to enroll;
- 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 who has maintained continuous coverage and is enrolled in Original Medicare

Eligibility to postpone enrollment

You or your spouse (including a surviving 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 Medicare Supplement at a later date, if you are otherwise eligible. For more information, see *Waiving coverage*, later in this section.

You must meet a continuous coverage requirement to enroll in Medicare Supplement. Generally, you must be covered continuously by a qualified health plan or medical continuation coverage[1] until eligible for Medicare Supplement.

1 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, surviving spouses, and other eligible family members under the age of 65.

If you leave the Medical Plan of the PC(USA) and don't get other creditable prescription drug coverage (coverage that is at least as good as Medicare's coverage) for 63 or more days, you may have to pay a late enrollment penalty in addition to your premium for Medicare prescription drug coverage in the future.

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 Medicare Supplement. 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 and submit this form as soon as possible, but no later than 60 days after 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 Medicare Supplement, 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 no later than 60 days after your last day of coverage as an active member of the Medical Plan.

To waive coverage, complete the *Medicare Supplement Subscription, Waiver, or Withdrawal*, included in the packet you receive after notifying the Board of your upcoming retirement (preferably six months prior to your retirement date). Remember, you must send the Board your completed form by mail or fax so that it arrives no later than 60 days after your last day of coverage as an active member of the Medical Plan. (The form contains the Board's mailing address and fax number.) Please note that, if you are married, your spouse must also sign 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 Medicare Supplement.

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 Medicare Supplement if your coverage is lost for any of the following reasons:

- Your spouse retires or dies.
- Your employment, or your spouse's employment, is terminated.
- Your employer, or your spouse's employer, discontinues coverage.

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

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

Cost of coverage

Your cost of coverage (subscription rate) is 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 Medicare Supplement is partially subsidized by the federal government and the pharmaceutical industry (for the prescription drug portion of the plan).

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 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 through BoardLink, the Board's secure, online bill payment system. 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 payment is not received within 30 days of the due date, coverage is permanently terminated.

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 Medicare Supplement, you will receive new ID cards for medical and prescription drug coverage (members and spouses receive separate cards). 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.

You do not need an ID card to access vision coverage or the Employee Assistance Plan.

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 Medicare Supplement .

Show both your Medicare card and your Medicare Supplement card to hospital and medical care providers at the time of service.

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

Because Medicare Supplement 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 Express Scripts.

What's Covered

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, Medicare Supplement 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 coinsurance (see Hospital and Medical Benefits).

Expenses covered by Medicare Supplement

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
Cataract surgery
Surgical second opinions
Inpatient and outpatient mental health and substance abuse treatment, subject to program limits[1]
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[1]
Emergency room care for medical emergency
Medicare Part A deductibles
Skilled nursing facility stay, subject to 180-day annual limit[2]
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)
Telemedicine
Employee Assistance Plan (through Cigna) for emotional health and family support, financial and legal assistance, and home life referrals
Vision exam and eyewear benefit through VSP (includes temporary and initial permanent corrective lenses needed following cataract surgery or for diagnosis or treatment of a medical condition)

[1] See Limitations and Special provisions for inpatient limits on these services.

[2] 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.

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

> Benefit period – in Medicare Part A, a period of time that begins when you enter a hospital for an overnight inpatient stay and ends when you have been out of the hospital for 60 consecutive days.

Limitations on skilled nursing facility benefit

After a minimum 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.

Medicare Supplement has an annual limit of 180 days (including the 100 Medicare days noted above), for skilled nursing facility stays.

> Custodial care, whether in a nursing home or elsewhere, is not covered by either Medicare or Medicare Supplement. See Nursing home custodial care exclusion.

Maximum reimbursement for TMD Treatment

Medicare Supplement 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, Express Scripts. See *Prescription Drug Benefits* for details.

What's not covered

Medicare and Medicare Supplement 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 in 2023. 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

Nonparticipation in Medicare
Services of a provider that does not participate in the Medicare Program
Experimental or investigational medical treatment
Any experimental or investigational medical treatment, as determined by Medicare and Highmark
Dental
Dentures
Dental X-rays
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[1]
Hearing
Hearing aids and fittings
Vision
Vision surgery to alter the refractive character of the eye
Foot orthotics[2]
Orthopedic and podiatric foot care charges for treatment of or supplies for:
• weak, strained, flat, unstable, or unbalanced feet
• metatarsalgia or bunions, corns, calluses, or toenails
Other professional services and supplies
Services payable under any workers' compensation law or similar legislation
Services or supplies for personal hygiene, comfort, or convenience
Medical services provided by a U.S. government facility or received elsewhere for which the participant is not legally obligated to pay
Expenses for routine maintenance and repair of durable medical equipment
Custodial care
Cosmetic surgery, treatment, or supplies (except reconstructive surgery following a mastectomy, after an accident, or to correct a congenital anomaly)
Medical reports or telephone consultation charges
Services provided by a person who ordinarily resides in a participant's home or is related to the patient

[1] Benefits for TMD-related services are limited to $500 in a lifetime.

[2] 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 Medicare Supplement, 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.
- Log in to your Employee Assistance Plan account at my.Cigna.com (one-time registration required). On your homepage, select Coverage, then Employee Assistance Plan from the drop-down menu. Click the Work/Life Resources link in the Home Life Referrals box and enter key words in the Search box.

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.

For the plan to cover your expenses, you must use Medicare-participating providers. Participating providers accept the Medicare-approved amount as payment in full for their services.

Medicare-participating providers

Medicare Supplement 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.

What is the *Medicare-approved amount*

In Original Medicare, the Medicare-approved amount is the amount a doctor or supplier that accepts assignment can be paid.

It includes

- what Medicare pays; and
- any deductible, coinsurance, or copayment that you pay.

The Medicare-approved amount may be less than what a doctor or supplier actually charges, but he or she is obligated to accept it as payment in full.

Medicare Supplement does not pay in excess of the Medicare-approved amount.

Preventive 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.

Vision coverage

The Medicare Supplement Plan includes vision coverage — with an eye exam and vision eyewear benefit.

The vision exam benefit covers annual routine eye exams and screenings (for certain health conditions) through the VSP Choice network for a $25 copay. This benefit includes discounts on vision-related items and services purchased through the network. Visit **pensions.org** for a complete list of discounts available on prescription glasses, contact lens exams, lens options for glasses and sunglasses, and laser vision correction.

The vision eyewear benefit provides help with the cost of prescription eyewear (glasses or contact lenses) when purchased through the VSP Choice network with a $25 copay. This benefit also includes discounts on lens enhancements and extra glasses. Visit **pensions.org** for an overview of costs for services and materials when using VSP Choice network providers.

ID cards are not required to access vision exam and vision eyewear benefits through VSP providers. Medicare Supplement Plan participants will need to provide their name, date of birth, and the last four digits of their Social Security number.

Employee Assistance Plan (EAP)

As you transition into retirement, you can still enjoy all the benefits of the Employee Assistance Plan (EAP) — with emotional health and family support, financial and legal assistance, and home life referrals — through Cigna. All EAP services are confidential and offered at no cost to Medicare Supplement participants.

You, your family, and any member of your household may schedule up to six in-person or virtual counseling sessions per issue with a credentialed counselor. (If you need more support after your six complimentary sessions, check to see that your provider accepts Medicare before scheduling additional sessions.) Telephone consultations are available for immediate assistance with critical emotional needs, problem identification/problem solving, or help with behavioral health-related questions and concerns.

The EAP also provides consultations for financial, legal, and identity theft assistance; discounts on tax preparation assistance; home life referrals for parenting and childcare, education, elder care, or pet care; and an online resource library of seminars, e-learning, and articles on a wide range of topics.

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
- coinsurance, up to the annual out-of-pocket limits.

Deductible

Your deductible is the annual amount you pay before Medicare Supplement pays its portion. In 2023, your deductible is **one-half of 1 percent** of the congregational ministers' median salary, or **$325**.

Each participant pays an individual deductible.

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.

Coinsurance

After you pay your deductible each year, you are responsible for paying a defined percentage of your medical costs — your coinsurance — until you reach the annual out-of-pocket limit. Your coinsurance is 20 percent of the balance of the approved amount after Medicare has paid its portion.

Out-of-Pocket Limit

Your out-of-pocket limit 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 out-of-pocket maximum. See *Annual individual out-of-pocket maximum* under *Prescription Drug Benefits*.) The plan pays 80 percent of the balance of the approved amount after Medicare has paid its portion until you reach your out-of-pocket limit; after that, it pays 100 percent of eligible expenses for the rest of the calendar year.

Each participant has an individual out-of-pocket limit. In 2023, your out-of-pocket limit is **4 percent** of the annual churchwide median effective salary for pastors serving churches, or **$2,590**.

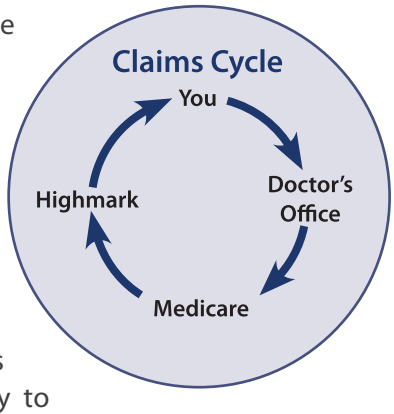
Out-of-pocket cost cap
Your annual out-of-pocket costs under Medicare Supplement are capped, as follows:

- You pay a deductible plus 20 percent of the balance after Medicare pays its portion, up to an annual out-of-pocket limit ($2,590 in 2023).
- The plan pays 80 percent of the balance, after Medicare pays its portion, until you reach your out-of-pocket limit; 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 out-of-pocket limit are credited toward your Medicare Supplement deductible and out-of-pocket limit 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.

If you are treated by a private contract doctor or you rent equipment from a supplier who does not participate in Medicare, the service or rental is not eligible for reimbursement.

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 2023. For Medicare coverage details, look at the *Medicare & You* handbook, available at medicare.gov or by calling Medicare.

Coverage under Medicare Supplement is based on Medicare-approved amounts and is subject to applicable plan deductibles and coinsurance. Additional limitations may apply. For Medicare Supplement coverage details, see What's Covered. For an illustration of costs and reimbursements, review *Medicare Supplement* in Action.

Services and supplies	Medicare pays[1]	Medicare Supplement pays[2]	You pay[3]
Part A Expenses (Part A is Medicare's hospital insurance plan)			
Hospital expenses: Semiprivate room and board, general nursing and miscellaneous services and supplies: • Days 1–60 • Days 61–90 • Days 91–150[4] with lifetime reserve • Days 91–150 without reserve days • Beyond 150 days	 All but $1,600 All but $400/day All but $800/day $0 $0	 $1,280 $320/day $640/day 80% of costs[5] 80% of costs[5]	 $320 $80/day $160/day 20% of costs[5] 20% of costs[5]
Skilled nursing facility (after hospitalization):[6] • Days 1–20 • Days 21–100 • Beyond 100 days	 100% All but $200/day $0	 $0 $160/day 80% of costs for days 101–180 (annual limit)	 $0 $40/day 20% for days 101–180; 100% after 180 days (per year)
Home healthcare[7]	100%	$0	$0
Hospice care	100%	$0	$0
Part B expenses (Part B is Medicare's medical services insurance plan)			
Calendar year deductible	$0	$0	$226, Medicare $325, Medicare Supplement
Preventive services such as annual wellness visits, mammograms, Pap smears, prostate cancer screenings, vaccinations.	100% of Medicare-approved expenses ($0 for routine vision exams)	80% of balance for approved expenses	20% of balance for approved expenses
Medical services and supplies, such as: • Physician's services, outpatient medical and surgical services and supplies, diagnostic tests, durable medical equipment, outpatient physical and occupational therapy, and other services	80% of Medicare-approved expenses	80% of the balance for Medicare-approved expenses	20% of the balance for Medicare-approved eligible expenses; costs above Medicare-approved amounts or not covered by Medicare
• Diagnostic clinical laboratory services	100% of Medicare-approved expenses	$0	Costs above Medicare-approved amounts or not covered by Medicare
• Outpatient mental health care	60% of Medicare-approved expenses	80% of the balance for Medicare-approved expenses	20% of the balance for Medicare-approved expenses
Additional Medicare Supplement benefits (expenses not covered by Medicare)			
Hospital and medical care while traveling outside the U.S.	$0	80% of billed charges	20% of billed charges
Outpatient prescription drugs	$0	See Prescriptions Drug Benefits section	See Prescriptions Drug Benefits section

[1] The Part A deductible of $1,600 and day rates are for 2023 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 2023 under Medicare Supplement is subject to a deductible of $325 and capped at $2,590; once you reach this out-of-pocket limit, your Medicare Supplement coverage pays 100% of eligible costs. Subject to change each year.

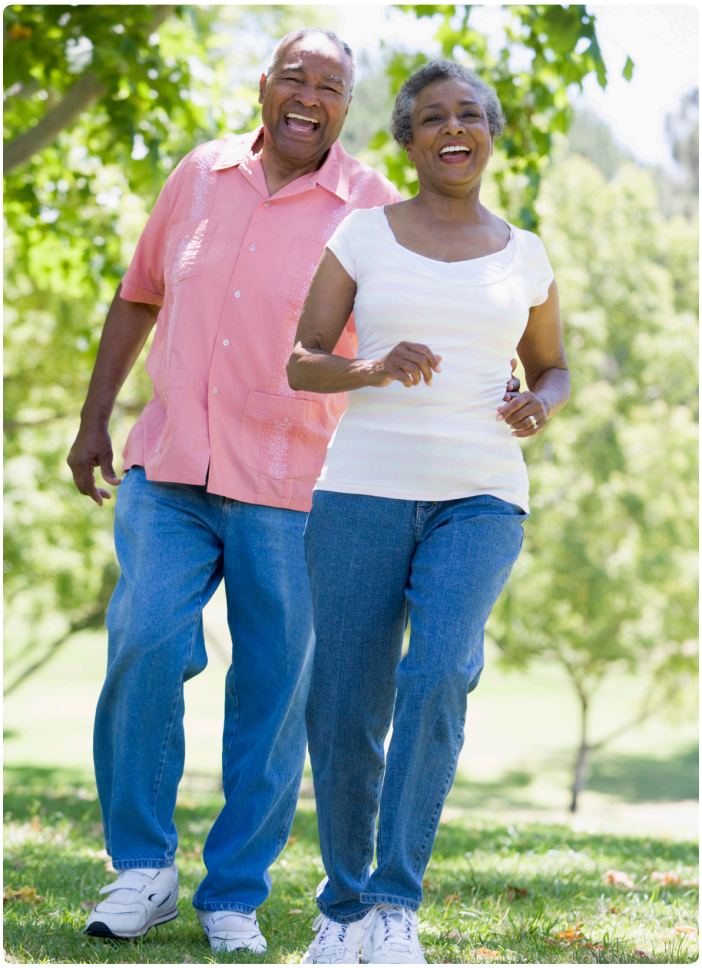
[4] Sixty reserve days may be used only once in a lifetime.

[5] Except for an inpatient stay for substance abuse treatment, for which Medicare Supplement has a 90-day maximum lifetime limit.

[6] Custodial care is not covered.

[7] Must be medically necessary and prescribed by a physician.

Prescription Drug Benefits



Express Scripts 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 [officially known as the Express Scripts Medicare® (PDP) for The Board of Pensions of the Presbyterian Church (U.S.A.) Medicare Supplement Plan] 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 Medicare Supplement 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 out-of-pocket 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 out-of-pocket 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.

Visit express-scripts.com* whenever you need to

- find participating pharmacies near you;
- see how much certain medications will cost;
- refill and renew home delivery prescriptions;
- check order status;
- receive timely medication alerts;
- find available lower-cost medication options; and
- ask questions of a pharmacist online.

To calculate your out-of-pocket cost for a covered drug, click **Price a Medication** in the menu under Prescriptions, enter the requested information, and click the **Get Prices** button.

*You'll need to register if it is your first visit; you will be asked to provide your email address and Express Scripts member ID number (shown on your prescription ID card). Or, you may call Express Scripts at 800-344-3896.

Your prescription drug costs

Type of pharmacy	When to use	Maximum fill	Your cost per prescription[1]		
			Generic drug	Formulary drug	Non-formulary drug
Retail pharmacy	• Medications for short-term use • First fill of a prescription for a maintenance (ongoing) medication	Up to a 30-day supply	$10	30% of cost: min. $20 to max. $100	50% of cost: min. $50 to max. $150
	Medications you use on an ongoing basis (maintenance medications)	Up to a 90-day supply	$30	30% of drug cost: min. $60 to max. $300	50% of drug cost: min. $150 to max. $450
Mail-order service	• Medications you use on an ongoing basis (maintenance medications)	Up to a 90-day supply	$25	30% of drug cost: min. $50 to max. $250	50% of drug cost: min. $125 to max. $375

[1]The maximum amount you pay each year in out-of-pocket prescription drug costs is $2,500. Any costs for non-formulary drugs do not count toward your out-of-pocket 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 Medicare Supplement are selected by Express Scripts 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 Express Scripts Medicare® 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. The formulary is also available at express-scripts.com/documents.

Note: The formulary for Medicare Supplement 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 equivalent 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 generally 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 Express Scripts Pharmacy 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 out-of-pocket 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 22 lists the copayments as well as the minimums and maximums for brand-name formulary and brand-name non-formulary drugs.

Annual individual out-of-pocket maximum

The Medicare Supplement prescription drug program has a $2,500 out-of-pocket 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 out-of-pocket maximum, Medicare Supplement pays 100 percent of all your remaining eligible prescription drug costs for the rest of the calendar year. The yearly out-of-pocket maximum does not apply to non-formulary (non-preferred brand) drugs.

Unlike the Medical Plan for active members, Medicare Supplement has an individual out-of-pocket 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 Express Scripts Medicare 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 Express Scripts Medicare network.

Who pays	Calculation	How much?
Mr. Smith	50% x $350 =	$150 maximum copayment[1]
Medicare Supplement	50% x $350 =	$175 benefit

[1] This copayment does not count toward his $2,500 annual individual out-of-pocket 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 Express Scripts Medicare Prescription Drug card at an Express Scripts Medicare network pharmacy. (You are also able to fill a 90-day supply at retail, but you will pay more than when using mail order.) The Express Scripts Medicare network includes both independent pharmacies and national chains. To find participating retail pharmacies, visit express-scripts.com.

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

Through mail order

Use the Express Scripts Pharmacy 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 Express Scripts Pharmacy home delivery. This is because, as part of ongoing efforts to help manage prescription drug costs, the Board has negotiated greater discounts with Express Scripts on medications filled through mail order.

Standard 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 Express Scripts Pharmacy home delivery service. To do this, complete an Express Scripts prescription order form, available at express-scripts.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 Express Scripts, 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 Express Scripts.

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

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 Express Scripts and speak with a service representative. The step therapy list is subject to change.

Prior authorization

A prior authorization requires you or your physician to get approval from Express Scripts 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 — migranes, 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 Express Scripts 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 Express Scripts and speak with a service representative. The formulary is also available at express-scripts.com/documents.

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.

Accredo is Express Script's specialty pharmacy, and can have these medications sent directly to your home.

To contact Accredo, call 800-803-2523.

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.

Medicare Supplement in Action

When you have coverage under Medicare Supplement, three parties pay for your hospital and medical care: Medicare, Medicare Supplement (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 Medicare Supplement 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 2023 deductible for Medicare Supplement 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 $14,620, leaving his Part A deductible of $1,600 for Mr. Smith to pay.

Mr. Smith's costs under Medicare Part A:

Medicare deductible	$1,600
Days 1 to 3 of hospital stay	$0
Total Mr. Smith owes (before Medicare Supplement)	$1,600

Medicare Supplement, through Highmark, deducts $325 (his Medicare Supplement deductible for the 2023 year), then pays 80% of the $1,275 balance, or $1,020.

Mr. Smith's final hospital bill (not including Part B charges) is **$580**, or his $325 Medicare Supplement deductible plus 20% of $1,275 ($255)

His costs after Medicare Supplement pays:

Medicare Supplement deductible	$325.00
Mr. Smith's coinsurance (20% of $1,275)	$255.00
Total Mr. Smith owes ($325 + $255)	$580.00

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 $226 (the Medicare Part B deductible), then pays 80% of the $2,414 balance, or $1,931.20, leaving a balance of $482.80.

Mr. Smith's costs under Medicare Part B:

Medicare deductible	$226.00
Mr. Smith's coinsurance (20% of $2,407)	$482.80
Total Mr. Smith owes	$708.80

Medicare Supplement then pays 80% of the remaining balance ($708.80), or **$567.04**. Mr. Smith's coinsurance for physician and anesthesiologist bills equals **$141.76**.

His costs after Medicare Supplement pays:

Medicare Supplement deductible	$0.00[1]
Mr. Smith's coinsurance (20% of $708.80)	$141.76
Total Mr. Smith owes	$141.76

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

Balance of hospital charges	$580.00
Balance of physician charges	$141.76
Grand total	**$721.76**

(roughly 3.75% of total approved charges)

[1] He satisfied his 2023 deductible for Medicare Supplement 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).

Ending Coverage, Re-Enrolling, and Special Circumstances

This section defines the rules for ending coverage and re-enrolling in Medicare Supplement, 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 Medicare Supplement, 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.

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.

Re-enrolling in Medicare Supplement

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

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 submit proof of prior Medicare Advantage coverage.

A move out of the service area
You may re-enroll in Medicare Supplement 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.

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

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 60 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.

You can choose to withdraw from and re-enroll in Medicare Supplement only one time.

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

- complete the related subscription form to enroll **within 60 days of the divorce or dissolution**;
- 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.

If your former spouse and eligible family members qualify for medical continuation coverage by virtue of their ages, meet the eligibility requirements, and are enrolled continuously, they may be eligible to enroll in Medicare Supplement coverage at age 65 (if they also enroll in Medicare Part A and Part B).

If you and your spouse are legally separated, your spouse may continue to enroll.

Death
If you die while covered under Medicare Supplement, your surviving spouse and/or eligible family members may continue their coverage by paying the monthly subscription charges for the program, or for medical continuation coverage, as appropriate.

If younger than 65, your surviving spouse can enroll for coverage under medical continuation until he or she is eligible for Medicare. Then, your spouse may enroll in Medicare Supplement if he or she has maintained continuous coverage under medical continuation coverage or if he or she has an approved waiver on file.

Your spouse also must meet the other key requirement for Medicare Supplement participation: enrollment in Medicare Part A and Part B.

For information about medical continuation coverage, visit pensions.org or call the Board of Pensions.

Appendix A Medicare Supplement contacts

Service provider	For assistance with	Phone number	Website
The Board of Pensions of the Presbyterian Church (U.S.A.)	Any Medicare Supplement or retirement benefit matter	800-773-7752 (800-PRESPLAN) International: 215-587-7200 Fax: 215-587-6215 8:30 a.m.–7 p.m. ET Monday through Friday	pensions.org
Highmark Blue Cross Blue Shield	Hospital, medical, and mental health/substance abuse coverage information and claims	888-835-2959 8 a.m.–5 p.m. ET Monday through Friday	highmarkbcbs.com
Express Scripts	Prescription drugs (retail and mail order) and claims Specialty medications	877-856-4694 TTY: 800-716-3231 24 hours a day, 7 days a week Accredo: 800-803-2523	express-scripts.com
Cigna	Employee Assistance Plan	866-640-2772 Employer ID: pcusa	my.cigna.com
VSP	Vision exam and vision eyewear benefits	800-877-7195	VSP.com
International SOS Assistance	Hospital and medical services when traveling outside the United States	Varies by location/ see pensions.org	Information/ID card in Benefits Overview: Medical Assistance during International Travel, on pensions.org

Appendix B Medicare and related contacts

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

[1] 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.

[2] 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.

Appendix C 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 Medicare Supplement, 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 Medicare Supplement'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 Express Scripts) 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)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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).

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

HIPAA forms

Form	Actions
Authorization to Release Medical Plan Information, HPA-001	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
Authorization for Use or Disclosure of Protected Health Information, HPA-002	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)
Benefits Plan of the Presbyterian Church (U.S.A.) Medical Plan — Request for Access to PHI, HPA-003	Allows a covered individual or personal representative access to his or her protected health information maintained by the Medical Plan (including Medicare Supplement)
Benefits Plan of the Presbyterian Church (U.S.A.) Medical Plan — Request to Amend PHI, HPA-004	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 Medicare Supplement)
Benefits Plan of the Presbyterian Church (U.S.A.) Medical Plan — Request for Accounting of Disclosures, HPA-005	Allows a covered individual or personal representative to request an accounting of disclosures of protected health information
Designation of Personal Representative, ENR-904	Provides limited powers of attorney to the personal representative of a covered person; authorizes the Board to provide information to that individual

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 D 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 Express Scripts). 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 **Express Scripts**. 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.

THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

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