Plan Document Handbook

Medicare Supplement Plans

Benefits effective as of January 2009

The Episcopal Church Medical Trust

Our Health, Our Members, Our Church

COVENTRY Health Care

THE EPISCOPAL CHURCH MEDICAL TRUST

ABOUT THE MEDICAL TRUST

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

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

SERVING OUR CHURCH

The mission of the Medical Trust is to "balance compassionate Christian care with financial stewardship." This is a unique mission in the world of health care benefits, and we believe that our experience and mission to serve the Church offer a level of expertise that is unparalleled.

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

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ABOUT THIS HANDBOOK

The Medical Trust has prepared this Plan Document Handbook ("Handbook") to help you understand the various benefits under the Medical Trust's Comprehensive, Plus, and Premium Medicare supplement plans. Please read it carefully. Your benefits are affected by certain limitations and conditions that require you to be a wise consumer of health services and to use only those services you need. Also, benefits are not provided for certain kinds of treatments or services, even if your health care provider recommends them.

Benefits described in this Handbook are effective from January 1, 2009 through December 31, 2009.

As used in this Handbook, the word "year" refers to the plan year, which is the 12-month period beginning January 1, 2009 and ending December 31, 2009. All annual benefit maximums and deductibles accumulate during the plan year. The word "lifetime", as used in this Handbook, refers to the period of time you or your eligible dependents participate in any Medicare supplement plan funded by the Medical Trust.

The Medical Trust intends the Plans to be permanent, but since future conditions affecting the Medical Trust, your employer or Medicare cannot be anticipated or foreseen, the Medical Trust reserves the right to amend, modify, or terminate the Plans in any manner, at any time, which may result in the termination or modification of your coverage. If the Plans are terminated, any plan assets will be used to pay for eligible expenses incurred prior to the Plans' termination, and such expenses will be paid as provided under the terms of the Plans prior to their termination.

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

ORIGINAL MEDICARE (PART A AND PART B)

ABOUT ORIGINAL MEDICARE

Medicare is a federal health insurance program provided for:

§ People age 65 or older who have paid Social Security taxes during their years of employment

§ Some people under age 65 with disabilities

§ People with End-Stage Renal Disease (ESRD)

In most cases, you are eligible for Medicare once you have turned age 65 or two years after the Social Security Administration determines that you have become permanently disabled. You should enroll in Original Medicare as soon as you qualify. When you retire and become Medicare-eligible, Original Medicare begins to pay most of your health care costs.

Original Medicare has two parts:

§ **Medicare Part A: Hospital Insurance**. In general, **Medicare Part A** covers much of your hospital or **skilled nursing facility** expenses. Most people do not have to pay for Part A.

§ **Medicare Part B: Medical Insurance**. In general, **Medicare Part B** pays for doctors' expenses and certain medical services and supplies. Most people pay monthly for Part B through an automatic deduction from their Social Security payment.

You are automatically eligible for **Medicare Part B** if:

§ You are eligible for a **premium**-free **Medicare Part A**

§ You are a United States citizen or permanent resident age 65 or older, under age 65 and disabled, or any age with End-Stage Renal Disease

ORIGINAL MEDICARE (PART A AND PART B)

SERVICES COVERED BY ORIGINAL MEDICARE

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

Medicare Part A helps pay for:

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

Medicare Part B helps pay for:

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

ORIGINAL MEDICARE (PART A AND PART B)

Original Medicare also helps cover:

§ Ambulance services
§ Chiropractic services
§ Clinical trials
§ Diabetic self-management training
§ Diabetic supplies
§ Durable medical equipment
§ Emergency room services
§ Eyeglasses (after cataract surgery)
§ Foot exams and treatment
§ Hearing and balance exams
§ Kidney dialysis services
§ Long-term care (only skilled care; not custodial)
§ Medical nutrition therapy services
§ Mental health care
§ Practitioner services
§ Prosthetic and orthotic items (with certain limitations)
§ Second surgical opinion
§ Smoking cessation counseling
§ Surgical dressings
§ Tests
§ Transplant services
§ Travel outside the United States*
§ Urgently needed care

* when in US but nearest treatment facility is outside the country, or when crossing international borders in order to get from one US territory to another.

SERVICES NOT COVERED BY ORIGINAL MEDICARE

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

- Acupuncture
- Cosmetic surgery
- Custodial care at home or in a nursing home
- Deductibles, coinsurance, copayments
- Dental care and dentures (with a few exceptions)
- Eye refractions
- Health care while outside the US—except in certain circumstances
- Hearing aids and hearing aid fitting exams
- Hearing tests without doctor's orders
- Long-term care (like custodial care in a nursing home)
- Orthopedic shoes (with only a few exceptions)
- Prescription drugs (with only a few exceptions). However, prescription drugs are covered under Medicare Part D. See "About Medicare Prescription Drug Coverage (Part D)" on page 6 for more information.
- Routine foot care (with only a few exceptions)
- Routine eye care and most eyeglasses
- Routine or yearly physical exams (Medicare will cover a one-time physical within the first six months that you have Part B.)
- Screening tests and screening laboratory tests (except certain preventive screenings)
- Shots (vaccinations) except certain preventive procedures
- Some diabetic supplies (syringes or insulin; except when used in an insulin pump)

OTHER MEDICARE PLANS (PART C)

IMPORTANT NOTE:

The following brief descriptions of Medicare Part C and Medicare Part D are for informational purposes only. You may or may not be enrolled in these parts of the Medicare program.

For more information about the prescription drug benefits through Medicare Prescription Drug Plans (PDPs), please contact Medicare at (800) 633-4227 or visit the website at **www.medicare.gov**.

A BRIEF NOTE

What is a Medicare Advantage Plan?

A Medicare Advantage Plan is a Medicare program that provides supplemental coverage to Original Medicare. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). They include:

- Medicare Managed Care Plans
- Medicare Preferred Provider Organization Plans (PPO)
- Medicare Private Fee-for-Service Plans
- Medicare Specialty Plans

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

MEDICARE PRESCRIPTION DRUG COVERAGE (PART D)

ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE (PART D)

What is Medicare Prescription Drug Coverage?

Everyone with Medicare can get Medicare prescription drug coverage under Medicare Part D that may help lower prescription drug costs and help protect against higher costs in the future. Medicare prescription drug coverage is insurance. Private companies sponsor Medicare prescription drug plans (PDPs) that provide the coverage. You choose the drug plan and pay a monthly premium. Like other insurance, if you decide not to enroll in a drug plan when you are first eligible, you may pay a penalty if you choose to join later (**unless you have employer coverage that meets Medicare's creditable coverage definition**).

IMPORTANT NOTE:

If you are enrolled in a Medicare Part D Prescription Drug Plan, you cannot have prescription drug coverage through the Medical Trust Medicare Supplement plans.

If you have your prescription drug coverage through a Medicare PDP, please know that the information on the following pages regarding the Medical Trust's prescription drug coverage does not apply to you.

MEDICAL TRUST MEDICARE SUPPLEMENT PLANS

THE MEDICAL TRUST MEDICARE SUPPLEMENT PLANS . . .

For the 2009 plan year, there are three different Medical Trust Medicare supplement plans (each available with or without prescription drug benefits) for you to choose from:

- **The Comprehensive Plan**
- **The Plus Plan**
- **The Premium Plan**

. . . WITH AND WITHOUT THE PHARMACY OPTION

For those individuals who choose to enroll in a Medicare Part D prescription drug plan, the above Plans without the pharmacy option are called ***Comprehensive II****,* ***Plus II****, and* ***Premium II****, respectively.*

Though benefits provided by the three Plans differ, it is important to note that each Plan provides valuable supplemental benefits to help you pay for health care expenses in retirement.

In general, these Plans provide you with additional health care coverage by helping you pay many of your out-of-pocket expenses after Medicare pays its portion. These Plans supplement Medicare by paying a portion of Medicare copayments, coinsurance, and deductibles, and by paying for some services not covered under Medicare, such as annual routine physical exams and vision care.

This Handbook provides information about your Medicare supplement plans. If you have additional questions about these plans, contact Coventry Health Care at the toll-free number on your ID card or at **www.mycoventryhealth.com** using access ID: **ECM**.

ELIGIBILITY

WHO IS ELIGIBLE

To purchase a Medicare supplement plan, you must be enrolled in Medicare Part A and Part B. In addition, you must be a beneficiary of the Church Pension Fund, or if you are a lay employee, you must have been employed by the Episcopal Church for five or more continuous years at the time of separation from employment, and, if a pension plan was made available by your employer, you must be eligible to receive a pension from that plan, even if you chose not to begin collecting a benefit at the time of separation. Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

Your spouse or domestic partner (including your surviving spouse or domestic partner) who is eligible for Medicare is also eligible to participate in the Medicare supplement plans.

A dependent child who is physically or mentally handicapped and is eligible for Medicare is also eligible to participate in these Plans. The Plans may require you at any time to obtain a physician's statement certifying the physical or mental handicap.

You may not participate in these Plans as both a retiree and a dependent, and your dependents may not participate in these Plans as dependents of more than one retiree.

Please call Member Services at (866) 273-4545 to determine your eligibility.

WHEN COVERAGE BEGINS

Your coverage begins on the first day of the month in which you become eligible for Medicare and enroll in one of the Medicare supplement plans.

Coverage for your eligible dependents begins on the later of the date your coverage begins or the date the dependents become eligible for Medicare.

WHEN COVERAGE ENDS

Your coverage ends on the earliest of:

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

Coverage for your dependents ends on the earliest of:

- the end of the month in which they are no longer eligible to participate in the Plans
- the end of the month in which required contributions cease
- the end of the month in which a clergy or lay employee's surviving spouse or domestic partner becomes eligible for non-Medical Trust employer-sponsored group coverage
- or the date the Plans end

COVERED MEDICAL EXPENSES

When all of the provisions of the Plans are satisfied, the Medicare supplement plans will provide benefits as outlined on the Schedule of Medical Benefits only for expenses eligible for coverage under Medicare, but which exceed the benefits provided by Medicare.

In addition, the services and supplies listed in this section will be covered:

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

See the "Services Covered by Original Medicare" section on pages 2 and 3 for information about Medicare-covered services.

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

ROUTINE PHYSICALS

Preventive care is an important and valuable part of your health care. Regular physical checkups and appropriate screenings can help you and your doctor detect illness early. When you treat an illness or condition early, you minimize the risk of a serious health problem and reduce the risk of incurring greater costs. That's why Medicare and the Medical Trust Medicare supplement plans provide benefits for many preventive care services at no cost to you. There are steps you can take to lower your risk of disease and illness. Medicare provides coverage for these preventive services to help you stay healthy:

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

In addition, the Medical Trust Medicare supplement plans will provide benefits for:

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

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

If you feel a diagnostic x-ray or lab should have been paid as part of the routine benefit instead of the diagnostic x-rays and laboratory services benefit, please contact Coventry Health Care.

EXCLUSIONS AND LIMITATIONS

In most cases, the Medical Trust Medicare supplement plans will not provide benefits for any health care costs not covered by Medicare. This list is intended to give you a general description of services and supplies not covered by Medicare *or the Plans*:

- Acupuncture
- Copayments, coinsurances, and deductibles when you receive health care services
- Dental care and dentures (in most cases). However, dental services are covered by the Episcopal Church Medical Trust dental plans. See the Dental Plan Document Handbook for more information.
- Cosmetic surgery
- Custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home
- Orthopedic shoes
- Routine foot care (with only a few exceptions)
- Screening tests (in most cases)
- Shots (vaccinations) (in most cases)

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

PHARMACY BENEFITS

If you are enrolled in a Medicare Supplement Plan *with* the pharmacy option, please note that your Plan has selected Medco for its Prescription Drug Program. The program is administered separately from the other components of your Medicare supplement plan.

YOUR PHARMACY BENEFITS PROGRAM*

There are three ways to fill your prescriptions under the Prescription Drug Program. You can use:

- one of the many participating retail pharmacies nationwide
- the mail-order pharmacy (for long-term needs)
- any nonparticipating retail pharmacy

You will receive the highest possible benefit under the Prescription Drug Program when you purchase medications at a participating retail pharmacy (you must present your Medco ID card) or through the mail-order pharmacy. Additional information about the Prescription Drug Program, including the location of participating pharmacies in your area, is available through the Medco web site at **www.medco.com** or Medco's member services department at (800) 841-3361.

You must present your ID card when receiving drugs and services from a network pharmacy. The network pharmacy will verify eligibility. You will be required to pay any applicable deductibles or copayments at the time the prescription is obtained. The pharmacist should notify you if a generic drug is available; however, it is in your best interest to also ask the pharmacist about generic equivalents that may be available. To obtain maximum benefits from the program, you should usually try to choose Tier 1 generic drugs when available.

DRUG FORMULARY

Medco includes a Formulary Management Program designed to control costs for you and the Plan. The formulary includes all U.S. Food and Drug Administration (FDA)-approved drugs that have been placed in tiers based on their clinical effectiveness, safety, and cost. Tier 1 includes generic drugs, Tier 2 includes formulary brand-name drugs, and Tier 3 includes non-formulary brand-name drugs and brand-name non-sedating antihistamines.

**Does not apply to members enrolled in Medicare Supplement Plans without the pharmacy option (i.e. Comprehensive II, Plus II, and Premium II).*

You should share the formulary with your physician or practitioner when the physician or practitioner prescribes a drug, and encourage the physician or practitioner to prescribe a Tier 1 or Tier 2 drug if possible. By choosing Tier 1 generic or Tier 2 formulary brand-name drugs, you may decrease your out-of-pocket expenses. While all currently FDA-approved drugs are included on the formulary list, your Plan excludes some drugs. Please review the provisions of your Plan for specific drug exclusions. See "What's Covered" and "What's Not Covered" in this section for further information.

It is always up to you and your doctor to decide which prescriptions are best for you. You are never required to use generic drugs or drugs that are on the Medco formulary list. If you prefer, you can use nonformulary brand-name drugs and pay a higher copayment.

It is also important to note that drugs included on the formulary list are routinely updated. To find the most up-to-date list of covered drugs, visit Medco at **www.medco.com**, or call their member services department at (800) 841-3361. It should be noted that some drugs listed on the formulary may not be covered due to plan exclusions and limitations.

GENERIC MEDICATIONS AND SUBSTITUTION

Generic medications and their brand-name counterparts have the same active ingredients and are manufactured according to the same strict federal regulations.

Generic drugs may differ in color, size, or shape, but the FDA requires that the active ingredients have the same strength, purity, and quality as their brand-name counterparts.

For this reason, the Plan will cover the cost of the generic equivalent if you purchase a brand-name medication when there is a generic available. You will be charged the generic copayment and the cost difference between the brand-name and the generic medication.

If you have questions or concerns about generic medication, speak to your physician or your pharmacist, and he or she will be able to help you.

WHAT'S COVERED

This section is intended to provide a general description of covered drugs and supplies under the retail and mail-order pharmacy programs. All FDA-approved drugs requiring a prescription to dispense are covered, unless specifically excluded under this Plan.

- Federal legend drugs (all drugs approved by the FDA and that require a prescription), except those listed under "What's Not Covered" in this section
- State-restricted drugs
- Compounded medications of which at least one is a legend drug
- Insulin
- Needles and syringes
- Diabetic supplies
- Legend contraceptive medications—oral, injectable, patch, ring
- Over-the-counter and legend prenatal vitamins
- Legend smoking cessation treatment

Brand non-sedating antihistamine drugs will be paid as Tier 3, regardless of the drug's formulary status of preferred or non-preferred. This is a result of the drug Claritin's over the counter availability.

YOUR PLAN MAY HAVE COVERAGE LIMITS

Your Plan may have certain coverage limits. For example, prescription drugs used for cosmetic purposes may not be covered, or a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period.

If you submit a prescription for a drug that has coverage limits, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use *Medco By Mail*, your doctor will be contacted directly.

When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets your Plan's coverage conditions. We will notify you and your doctor of the decision in writing. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

DRUGS REQUIRING AUTHORIZATION

Some medications are covered only for specific medical conditions or for a specific quantity and duration. A Medco pharmacist, in cooperation with your physician, determines coverage based on clinical guidelines and the manufacturer's specifications to review the appropriateness of the medication, dosage, and duration prescribed for certain conditions. Examples of medications that may require review are:

- Drugs to treat impotency for males only (except Yohimbine), drugs for treatment of impotence related to diabetes, peripheral vascular disease or side effects of the medications to treat it, post-prostatectomy/orchiectomy, post-radiation therapy related to treatment of prostate cancer, and syndromes affecting sexual functioning. Limited to six tablets per month.
- Myeloid stimulants
- Neumega

- Erythroid stimulants
- Interferons (i.e., Alpha, Beta, Gamma, Pegasys)
- Multiple Sclerosis therapy (i.e., Avonex, Copaxone, Betaseron)
- Retin-A (tretinoin) (co-brands—cream only)
- Reganex Gel
- Penlac solution
- Panrentin Gel
- Targretin Gel
- Protopic Ointment
- Elidel
- Lupron 1 mg
- Alzheimer's therapy (i.e., Cognex, Aricept, Exelon, Reminyl)
- Botox/Myobloc
- Gleevec
- Hepsera
- Lotronex for females only
- Xolair
- Migraine Agents (i.e., Imitrex, Zomig, Maxalt)
- COX II Medications (i.e., Bextra, Celebrex)

If your prescription requires review or authorization, Medco will work with you, your pharmacist, and your physician to determine if the medication, as prescribed by your physician, is covered under the Prescription Drug Program. If you have any questions regarding coverage of a specific drug, please check the Medco website or call Medco's member services department.

WHAT'S NOT COVERED

The Plan will not provide benefits for any of the items listed in this section, regardless of medical necessity or a prescription from a health care provider.

- Non-federal legend drugs
- Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law, or from any state or governmental agency

- Medication for which there is no legal obligation to pay, or medication furnished by a drug or medical service for which no charge is made to the individual
- Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home, or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Any prescription refilled in excess of the number of refills specified by the physician or practitioner, or any refill dispensed after one year from the physician's or practitioner's original order
- Drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine or Propecia) or for cosmetic purposes only (e.g., Renova or Vaniqa)
- Drugs labeled "Caution: Limited by federal law to investigational use" or other investigational/experimental drugs, even though a charge is made to the individual
- Immunization agents
- Blood products
- Immune globulins
- Topical dental fluorides
- Therapeutic devices or appliances
- Mifeprex
- Contraceptive devices
- Drugs to treat impotency for females only
- Yohimbine
- Accutane

- Human growth hormones
- Fertility agents
- Appetite suppressants and weight-loss agents
- Lamisil
- Seasonale at a retail pharmacy

USING A RETAIL PHARMACY

When you need a drug for a limited time, use a participating retail pharmacy to maximize your benefits. **The retail pharmacy program allows for a total of three fills of maintenance medications at a retail pharmacy (one original fill and two refills). Additional fills will not be covered by the Plan. Each fill can be for no more than a 30-day supply. Note that you are allowed a total of three fills, even if each fill is for less than 30 days.**

The amount you pay for prescription drugs depends on whether you use a Medco participating retail pharmacy or a non-participating pharmacy. At a participating pharmacy, there are no claim forms to file; you simply pay your portion at the pharmacy. Please refer to the Schedule of Pharmacy Benefits for details about retail copayments.

At a nonparticipating pharmacy, you must pay in full for your prescription and submit a claim for reimbursement. If the pharmacy charges you more than the allowable amount (based on pricing at a participating pharmacy), you will be reimbursed based on the allowable amount minus the copayment. You should mail your claims for reimbursement to the address on the form.

Any reimbursement will be sent directly to you and made according to the Plan's prescription drug benefit, as outlined on the Schedule of Prescription Drug Benefits. If any request for reimbursement is denied or reduced other than for copayments, please refer to the appeal provisions in the "How to Appeal a Denial of Benefits" section of this Handbook.

USING THE MAIL-ORDER PHARMACY

The mail-order pharmacy should be used for maintenance medications. You can receive up to a 90-day supply of medication for one copayment. Prescriptions must be filled as prescribed by your physician—refills cannot be combined to equal a 90-day supply. Please refer to the Schedule of Benefits for details about mail order copayments.

The Prescription Drug Program will maintain a retail refill limit policy. The retail refill limit requires that you use the mail-order pharmacy if you are prescribed a maintenance medication, rather than refilling multiple prescriptions for the same drug at a retail pharmacy. If you or a covered dependent receives a prescription for a maintenance medication and you do not use the mail-order pharmacy, your prescriptions may not be covered.

In some circumstances, you may not be required to use the mail-order pharmacy. For example, there are several categories of medications that are uniquely appropriate for multiple refills at your local pharmacy (and are therefore exempt from the retail refill limit provision, as outlined above). If you have a prescription for any of the following medications, the Medco Prescription Drug Program allows you to receive multiple refills at your local retail pharmacy:

- Anti-infectives, including antibiotics (Amoxicillin, Biaxin), antivirals (Zovirax, Famvir), antifungals (Diflucan), and drops used in the eyes and ears (Polsporin Opth, Cipro Otic). Please note that drops must be prescribed specifically to treat infection. An exception is maintenance glaucoma drops, which must be ordered through the mail-order program.

- Prescription cough medications, including Phenergan with Codeine, Tessalon, and Tussionex

- Medications to treat acute pain, both narcotic (Vicodin, Percodan, etc.) and non-narcotic (Darvocet). Please note that long-term pain medications such as NSAIDs do not meet the necessary retail requirements.
- Medications that require a new written prescription each time you need them, as refills are prohibited by federal law (e.g., Percodan, Ritalin, and Nembutal)
- Medications used to treat both attention deficit disorder (Ritalin, Cylert) and narcolepsy (Dexedrine)

To order medications from the mail-order pharmacy, simply log on to the Medco web site to request that the pharmacist contact your physician (to order prescriptions, you must be a registered member for security reasons). You will need to confirm your information and provide contact information for your physician. If you prefer, you can have your physician call (888) 327-9791 for instructions to fax your prescription. You will receive your medication in approximately seven to ten days. If you have a written prescription to mail in, you will need to complete an order form (available from the Medco web site or by calling their member services department) to include with your prescription. The prescription and order form should be mailed to the address on the form.

Once you have initiated your prescription delivery through mail-order, you can request refills online or via the member services department. Refills requested by 12:00 noon are filled and shipped the same day.

DRUG UTILIZATION REVIEW (DUR)

When you have your prescription filled, the pharmacist and/or Medco may access information about previous prescriptions electronically and check pharmacy records for drugs that conflict or interact with the medicine being dispensed. If there is a question, the pharmacist will work with you and your physician before dispensing the medication. This is an automatic feature available only with prescriptions purchased through a participating pharmacy and the mail-order pharmacy.

SPECIAL PRESCRIPTION PROGRAM SERVICES

Emergency Pharmacist Consultation
Access to a pharmacist is available 24 hours a day, 7 days a week, for emergency consultation.

Pharmacy Locator
A voice-activated system for locating participating retail pharmacies within specific ZIP codes; call the member services department at (800) 841-3361. This information is also available via the web site at **www.medco.com.**

Telecommunications for the Deaf
Call (800) 759-1089. Service is available Sunday through Friday, from 8:00 a.m. to 12:00 midnight EST, and on Saturday, from 8:00 a.m. to 6:00 p.m. EST.

Printed Materials for the Visually Impaired
Large-print or Braille labels are available upon request for prescriptions purchased through the mail-order pharmacy.

Health Education Programs

These programs, based on medical practices, promote good health care for cardiovascular health, respiratory health, and diabetes by providing in-depth education and support tools to members in order to improve their self-management skills.

The programs are designed to enhance communication between patients and physicians, decrease the rates of short-term and long-term disease complications, improve overall health outcomes (including quality of life), and improve patient satisfaction with medical care.

You will be contacted by Medco if participation in a health education program is appropriate for your condition.

WHAT IS HEALTH CARE MANAGEMENT?

The Medical Trust strives to provide you and your family with a health care benefit plan that financially protects you from significant health care expenses while helping you obtain quality care. While part of increasing health care costs results from new technology and important medical advances, another significant cause is the way health care services are used.

The Medical Trust has contracted with Coventry Health Care to identify and assist individuals with conditions requiring extensive or long-term care. The program is not intended to diagnose or treat medical conditions, guarantee benefits, make payments, or validate eligibility for Plan coverage. The program focuses on making recommendations regarding the appropriateness and medical necessity of specified health services. The final medical decisions regarding treatment are always made between you and your treating physician. Health care management services include a number of components, which are explained in more detail on the following pages. These components include case management for serious or extended illnesses, the care support program, and round-the-clock support.

CASE MANAGEMENT

If you or your dependent(s) have a serious or extended care illness or injury, a case manager will assist you or your dependent(s) in identifying and coordinating cost-effective medical care alternatives. The case manager will also coordinate communication among you and all health care providers involved in your or your dependent's care.

Benefits may be modified by the Medical Trust to permit a method of treatment not expressly provided for, but not prohibited by law, rules, or public policy, if it is determined that such modification is medically necessary and is more cost-effective than continuing a benefit to which you or your eligible dependents may otherwise be entitled. The Medical Trust also reserves the right to limit payment for services to those amounts that would have been charged had the services been provided in the safest and most cost-effective setting available.

CARE SUPPORT PROGRAM

The care support program is a voluntary program designed to help you manage a chronic condition successfully with outpatient treatment and avoid unnecessary emergency care or inpatient admissions. Examples of conditions that can be managed through this program include diabetes, asthma, heart failure, post-myocardial infarction, depression, atrial fibrillation, hepatitis C, and HIV.

Through interactions with you and your physician, or based on your pharmacy and/or medical claims data, you may be contacted by Coventry Health Care to participate in the program. A case manager will work closely with you to provide you with educational information about your condition, treatment plan, or medication support. As always, your final treatment plan will be decided between you and your physician.

If you have a chronic condition and would like more information, or if you have questions about your current treatment, call Coventry Health Care.

ROUND-THE-CLOCK SUPPORT

You may call Coventry Health Care toll-free at (800) 398-5654 at any time, day or night, to obtain general health care information or have your questions about health care issues answered. A nurse will provide you with information about your condition and self-care.

This 24/7 service is a benefit to you, allowing you to be informed about your health care options. There is no penalty for not using it. This service is not meant to replace physician care. If you require medical care, please be sure to see your physician or practitioner.

ABOUT YOUR BENEFITS

All benefits under these Plans must satisfy some basic conditions. The following conditions are commonly included in health benefit plans, but are often overlooked or misunderstood.

MEDICAL NECESSITY

The Plans provide benefits only for covered services and supplies that are medically necessary for the treatment of a covered illness or injury. Also, the treatment must not be investigational or experimental.

HEALTH CARE PROVIDERS

The Plans provide benefits only for covered services and supplies rendered by a physician, practitioner, nurse, hospital, or specialized treatment facility.

CUSTODIAL CARE

The Plans do not provide benefits for services and supplies that are furnished primarily to assist an individual in the activities of daily living. Activities of daily living include bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a health care provider.

BENEFIT PERIOD

A benefit period is the time during which a covered individual is an inpatient in an approved facility. If the covered individual is discharged and then readmitted, additional charges will be part of the original confinement, unless 60 days have elapsed since the date of discharge.

COPAYMENTS

Copayments are the initial dollar amounts you must pay for certain covered services under the Plans before the Plans will consider expenses for reimbursement (e.g., physician office visits, inpatient hospital admissions, outpatient hospital services).

The copayment amounts are shown on the Schedules of Benefits at the back of this Handbook.

COINSURANCE

Medicare pays only a specified percentage of certain covered expenses. Coinsurance percentages, defined in the Schedule of Benefits, represent the portion of covered expenses paid by you and the Plans, following any expenses paid by Medicare. These percentages apply only to covered expenses that do not exceed the Medicare-allowed amount. You are responsible for all noncovered expenses.

Use of the term "coinsurance" in this Handbook does not imply that Coventry Health Care insures the plans. The Plans are self-funded by the Medical Trust. Coventry Health Care acts as the contract administrator and is not financially responsible for any benefits under the Plans.

OUT-OF-POCKET MAXIMUM

An out-of-pocket maximum is the maximum amount of covered expenses you must pay during a plan year, before the coinsurance percentage of the Plan increases. Your coinsurances and copayments count toward your out-of-pocket maximum. The individual out-of-pocket maximum, defined in the Schedules of Benefits, applies separately to each covered individual. When a covered individual reaches the annual out-of-pocket maximum, the Plans will pay 100% of additional covered expenses for that individual during the remainder of that benefit year.

Once a covered individual has met the annual out-of-pocket maximum and the Plans' coinsurance has increased to 100%, no further coinsurances or copayments will be required during the remainder of the year. Health care providers may continue to require applicable coinsurances at the time of service after your out-of-pocket maximum has been met. If this occurs, you will be reimbursed after claims settlement has taken place. If you have reached your annual out-of-pocket maximum and coinsurances or copayments continue to be assessed on your Explanation of Benefits (EOB), or if you have not received your reimbursement in a timely manner, contact Coventry Health Care.

BENEFIT MAXIMUM

Total Plan payments for each covered individual are limited to certain maximum benefit amounts, defined in the Schedules of Benefits. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount also applies to a specific time period (for example, annual or lifetime). Whenever the word "lifetime" appears in these Plans in reference to benefit maximums, it refers to the period of time you or your eligible dependents participate in any Medicare supplement plan maintained by the Medical Trust.

MEDICARE DEDUCTIBLE

The Medicare deductible is the amount of covered expenses each covered individual must pay during a year or benefit period before Medicare will consider expenses for reimbursement.

The Medicare supplement plans will pay a portion of the deductible for Medicare Part A and Medicare Part B, as outlined on the Schedules of Benefits. Please note, the Medicare Part B deductible will be considered as part of the covered service, not as a separate benefit. For example, laboratory services applied to the Part B deductible will be considered under the Diagnostic X-Rays and Laboratory Services provision.

COORDINATION OF BENEFITS

GENERAL PROVISION

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

When a Medical Trust Plan is the secondary payor, it will reimburse, subject to all Plan provisions and at the eligible coinsurance percentage under the Plan, the balance of remaining expenses.

COORDINATION OF BENEFITS EXAMPLE

For example, if a covered service falls under All Other Covered Medicare Part B Expenses as shown on the Schedule of Benefits for the Comprehensive Plan on page 51, then the Plan will coordinate benefits as follows:

$1,000 = Submitted eligible amount

–$500 = Amount paid by Medicare (primary plan)

$ 500

$ 500 = Considered amount (by secondary plan)

T 70% = Multiplied by coinsurance percentage

$ 350 = Benefit paid by Comprehensive Plan (secondary plan)

Based on this example, for an initial eligible charge of $1,000, your out-of-pocket cost after both plans have paid would be $150 ($500 – $350). The Comprehensive Plan's payment may be reduced if you have other group health coverage.

COORDINATION OF BENEFITS

GOVERNMENT PROGRAMS AND OTHER GROUP HEALTH PLANS

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

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

AUTOMOBILE INSURANCE

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

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

COORDINATION OF BENEFITS

ORDER OF PAYMENT WHEN COORDINATING WITH OTHER GROUP HEALTH PLANS

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

1. The plan covering an individual other than as a dependent (for example, as an active employee or retiree) will be primary to a plan covering the same individual as a dependent.
2. The plan that covers an individual as an employee who is neither laid-off nor retired (or as that employee's dependent) is primary. However, the order of benefit determination for an individual covered as both a retiree and as a dependent of that individual's spouse will be determined under section No. 1 above.
3. The plan covering the individual as an employee or retiree (or as that individual's dependent) will be primary to the plan providing continuation coverage under federal (COBRA) or state law.
4. The plan that has covered the individual for the longer period of time will be considered primary.
5. If none of the above rules determine the primary plan, the allowable expenses will be shared equally between the plans.

RIGHT TO MAKE PAYMENTS TO OTHER ORGANIZATIONS

Whenever payments that should have been made by the Medicare supplement plans have been made by any other plan(s), these Plans have the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision. Amounts paid will be considered benefits paid under the Medicare supplement Plans and, to the extent of such payments, the other plan will be fully released from any liability regarding the person for whom payment was made.

OTHER IMPORTANT PLAN PROVISIONS

ASSIGNMENT OF BENEFITS

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

REIMBURSEMENT TO THE PLANS

This section applies whenever another party (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you or your dependent, by settlement, verdict, or otherwise, for an illness or injury. This section reflects the equitable obligation to reimburse the Plans from any recovery by you, your dependent, or your representative. If another party is legally responsible or agrees to provide any compensation, you or your dependent (or legal representatives, estate, heirs, or trusts established on behalf of either you or your dependent) must promptly reimburse the Plans for any benefits they paid relating to that illness or injury, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized and regardless of whether you or your dependent has been made whole). If the Plans have not yet paid benefits relating to that illness or injury, the Plans may reduce or deny future benefits on the basis of the compensation received or constructively received by you, your dependent, or your representative.

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

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

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

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

OTHER IMPORTANT PLAN PROVISIONS

The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation, unless separately agreed to, in writing, by the Medical Trust, in the exercise of its sole discretion. If the Plans incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plans have the right to recover those fees and costs from you. You may not accept any settlement that does not fully reimburse the Plans without their prior written approval.

SUBROGATION

This section applies whenever another party (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you or your dependent for your or your dependent's illness or injury, and the Plans have paid benefits related to that illness or injury. This section reflects the equitable right of the Plans to restore plan assets to the Plans for the benefit of all participants. The actions of another party caused the Plans to incur expenses they would not normally have incurred; therefore, the Plans are entitled to pursue any cause of action or pursue any remedy available to you or your dependents (regardless of how that action may be characterized and regardless of whether you or your dependent has been made whole).

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

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

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

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

RECOVERY OF EXCESS PAYMENTS

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

If excess payments were made for services rendered to your dependent(s), the Plans have the right to withhold payment on your future benefits until the overpayment is recovered.

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

Consistent with any applicable privacy requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended and other applicable law, the Plans may, without the consent of or notice to any person, release to or obtain from any organization or person information needed to implement Plan provisions, including medical information. When you request benefits, you must either furnish or authorize the release of all the information required to implement Plan provisions. Your failure to fully cooperate will result in a denial of the requested benefits, and the Plans will have no further liability for such benefits.

OTHER IMPORTANT PLAN PROVISIONS

ALTERNATE PAYEE PROVISION

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

RELIANCE ON DOCUMENTS AND INFORMATION

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

NO WAIVER

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

OTHER IMPORTANT PLAN PROVISIONS

PHYSICIAN/ PATIENT RELATIONSHIP

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

RIGHT TO AMEND OR TERMINATE THE PLANS

The Medical Trust reserves the right to amend, modify, or terminate the Plans in any manner, for any reason, at any time.

ADDITIONAL INFORMATION ON COVERED AND EXCLUDED BENEFITS

If you would like to receive additional information regarding a specific drug, medical test, device, or procedure that is either a covered or excluded benefit under these plans, you may contact Coventry Health Care at (800) 398-5654 or via the Internet by logging on to **www.mycoventryhealth.com** and entering your access ID: **ECM**.

HOW TO FILE A CLAIM

MEDICARE CLAIMS

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

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

HOSPITAL CLAIMS

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

PHYSICIAN AND OTHER MEDICAL EXPENSES

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

HOW TO FILE A CLAIM

MEDICARE SUPPLEMENT PLAN CLAIMS

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

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

Please send completed claims to:

Coventry
P.O. Box 8400
London, KY 40742

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

If you have any questions regarding your claim, please call Coventry Health Care. You may also check the status of your claim or download any necessary forms via the Internet by logging on to **www.mycoventryhealth.com** and entering access ID: **ECM**.

All claims must be received by the Plans within 180 days following the end of the year in which expenses were incurred.

HOW TO APPEAL A DENIAL OF BENEFITS

To request a clarification of a benefit determination, you or your authorized representative may call the contract administrator at (800) 398-5654, or submit the request by logging on to **www.mycoventryhealth.com**. However, if you believe a claim denial was improper, the following process is available.

CLAIM APPEAL PROCESS

Within 180 days of receipt of the notice of the claim denial, you may request, in writing, that the Plans conduct a review of the processed claim. All requests for a review of claim denial should include a copy of the initial denial letter and any other relevant information (e.g., written comments, documents, articles, or records). Any discrepancies between a benefit description in the Plan document and the way a claim was processed will be corrected promptly. The party reviewing the appeal will:

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

Send all written information to the contract administrator:

Coventry
P.O. Box 8400
London, KY 40742

Requests for appeals that do not comply with these procedures will not be considered, except in extraordinary circumstances. You will be notified if the appeal request has not been considered, and you will be allowed to present evidence of why the appeal should be considered.

HOW TO APPEAL A DENIAL OF BENEFITS

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

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

Your written request should include:

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

Please submit this information to:

The Episcopal Church Medical Trust
445 Fifth Avenue
New York, NY 10016
Attn: Clinical Department

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

TIME PERIOD FOR FILING LEGAL ACTIONS

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

YOUR PRIVACY RIGHTS

As a participant in the Medical Trust Medicare supplement plans, you are entitled to certain rights concerning your protected health information under the Health Insurance Portability and Accountability Act (HIPAA). The plans are permitted to make certain types of uses and disclosures of protected health information under applicable law for treatment, payment, and health care operations purposes. The following describes how health information about you may be used and disclosed and how you may access this information.

USE AND DISCLOSURE OF INFORMATION TO AND FROM THE MEDICAL TRUST

The Plans may disclose protected health information to the Church Pension Group Services Corporation (the "plan sponsor") under limited circumstances. The Plans will disclose protected health information to the plan sponsor only upon receipt of a certification by the plan sponsor that the Plan documents have been amended to incorporate and to abide by these privacy provisions.

The Plans may disclose summary health information to the plan sponsor for the purposes of obtaining premium bids, insurance coverage, or modifying, amending, or terminating the Plans.

The Plans may disclose protected health information to carry out plan administration functions that are consistent under applicable law. The Plans may not disclose protected health information to the plan sponsor for the purpose of employment-related actions or decisions or in connection with other benefits or employee benefit plans of the plan sponsor.

A limited number of employees of the plan sponsor will have access to protected health information for the purposes of carrying out plan administration functions in the ordinary course of business. These employees are in the following areas: Human Resources, Information Services, Mailroom/Fax Delivery, Legal Department, Medical Trust Member Services, and Medical Trust Plan Administration.

These employees will only use protected health information for plan administration functions, consistent with the Plans' Privacy Policies and Procedures, the Standards for Privacy of Individually Identifiable Health Information, other applicable federal or state privacy law, and the departments' privacy policies. Should an employee of the plan sponsor not comply with the Plans' Privacy Policies and Procedures, the Standards for Privacy of Individually Identifiable Health Information, or other federal or state privacy law, the employee will be subject to corrective action. The plan sponsor will promptly implement the contingency plans to mitigate any deleterious effect of improper use or disclosure of protected health information by CPGSC employees or by the Plans' business associates.

If feasible, the plan sponsor must return or destroy all protected health information received from the Plans that the plan sponsor maintains in any form. The plan sponsor cannot retain copies of such information when it is no longer needed for the purpose for which disclosure was made. If the return or destruction of protected health information is not feasible, the plan sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible. The plan sponsor has an obligation under the law to retain records for its plan administrative functions and will retain the required records, which may or may not contain protected health information, as required under the law. The plan sponsor must report to the Plans any use or disclosure of protected information that is inconsistent with the uses or disclosures provided for of which the plan sponsor becomes aware.

The plan sponsor must make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plans available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance with the Standards for Privacy of Individually Identifiable Health Information.

YOUR PRIVACY RIGHTS

USE AND DISCLOSURE OF HEALTH INFORMATION BY THE PLAN

The Plans will not use or disclose protected health information other than as permitted or required by the plan documents or as required by law. For instance, the Plans are permitted to disclose minimum necessary protected health information without your authorization for public health activities, health oversight activities, research, and judicial and administrative proceedings. The Plans are permitted to disclose protected health information to law enforcement officials as required by law. The Plans are also required to disclose protected health information to you or your personal representative to the extent you have a right of access to the information, and to the U.S. Department of Health and Human Services on request for complaint investigation or compliance review.

The Plans' business associates are permitted to use protected health information received from the Plans for the specific activities for which those business associates are contracted. Before receiving your protected health information, the Plans' business associates must agree to the same restrictions and conditions that apply to the Plans and plan sponsor under the Standards for Privacy of Individually Identifiable Health Information and other applicable federal or state privacy laws. The contract administrator is considered a business associate of the Plans.

ACCESS, AMENDMENT, AND ACCOUNTING OF HEALTH INFORMATION

You have a right to request access to inspect and obtain a copy of your protected health information that the Plans and the Plans' business associates maintain in a designated record set. The Plans have established procedures in their Privacy Policies and Procedures to grant access to your protected health information. The Plans have a right to deny your request for access, and you have the right to request a review of that denial under certain circumstances, pursuant to the provisions of 45 CFR § 164.524.

The designated record set that the Plans maintain includes documentation about enrollment, payment, claims adjudication, or case/medical management. To request access to your protected health information, contact the plan sponsor.

YOUR PRIVACY RIGHTS

You have a right to request that the Plans amend your protected health information that the Plans and the Plans' business associates maintain in a designated record set. The Plans have established procedures in their Privacy Policies and Procedures to allow amendment to your protected health information. The Plans have a right to deny your request for amendment, and you have the right to attach a statement of disagreement, pursuant to the provisions of 45 CFR § 164.526. To request an amendment to your protected health information, contact the plan sponsor.

Pursuant to 45 CFR § 164.528, you have a right to request an accounting of disclosures of your protected health information made by the Plans six years prior to the date on which the accounting is requested, beginning with the effective date of the Standards for Privacy of Individually Identifiable Health Information, which is April 14, 2003.

Example 1: You request an accounting on September 14, 2003. The Plans are obligated to account for disclosures made from April 14, 2003 through September 14, 2003.

Example 2: You request an accounting on September 14, 2010. The Plans are obligated to account for disclosures made from September 14, 2004 through September 14, 2010.

The Plans do not have to account for disclosures made:

- To you
- To carry out treatment, payment, and health care operations
- Pursuant to your authorization
- Incident to a use or disclosure otherwise permitted under the Standards for Privacy of Individually Identifiable Health Information
- For national security or intelligence purposes
- As part of a limited data set
- Prior to April 14, 2003
- For other reasons listed in 45 CFR § 164.528

YOUR PRIVACY RIGHTS

To request an accounting of disclosures of your protected health information, contact the plan sponsor at Church Pension Group Services Corporation, 445 Fifth Avenue, New York, NY 10016, or at (212) 592-1800.

COMPLAINTS

If you believe your privacy rights have been violated, you may complain to the Chief Privacy Officer at Church Pension Group Services Corporation, 445 Fifth Avenue, New York, NY 10016, or at (212) 592-1800. You also may complain to the Secretary of the Department of Health and Human Services at Hubert H. Humphrey Building, 200 Independence Ave., SW, Washington, DC 20201. You will not be retaliated against for filing a complaint.

YOUR HEALTH INFORMATION AND PRIVACY

Your health information is confidential, and your privacy will be protected. Medical information obtained through administrative services, including medical claims and pharmacy claims, may be used to help identify the appropriate level of Care Support, Case Management, or other programs available to you as described in the plans. You may receive prescription drug refill reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your health information also may be used for quality assessment and improvement activities related to your medical benefits. Medical information obtained through these administrative services will not be used to make employment and personnel decisions.

Note: The following terms, as used in this section, are defined in the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164): “protected health information,” “summary health information,” “business associates,” “personal representative,” “designated record set,” and “limited data set.”

GENERAL INFORMATION

Name and Address of Plan Sponsor and Administrator

The Episcopal Church Medical Trust
445 Fifth Avenue
New York, NY 10016

Name and Address of Designated Agent for Service of Legal Process

The Episcopal Church Medical Trust
445 Fifth Avenue
New York, NY 10016

Name and Address of the Third-Party Contract Administrator

Coventry Management Services, Inc.
P.O. Box 8400
London, KY 40742

Method of Funding Benefits

Health benefits are self-funded by the Medical Trust from accumulated assets and are provided directly from the Episcopal Church Clergy and Employees' Benefit Trust ("ECCEBT"). Payments out of the Plans to health care providers on behalf of the covered person will be based on the provisions of the Plan.

SCHEDULES OF BENEFITS

The following schedules summarize coinsurance amounts paid by you and the Plans, copayments, benefit maximums, and any additional explanation needed regarding your benefits. Please refer to the text for additional Plan provisions that may affect your benefits.

COMPREHENSIVE MEDICARE SUPPLEMENT PLAN

PLUS MEDICARE SUPPLEMENT PLAN

PREMIUM MEDICARE SUPPLEMENT PLAN

PRESCRIPTION DRUG BENEFITS

VISION BENEFITS

COMPREHENSIVE MEDICARE SUPPLEMENT PLAN

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

BENEFIT DESCRIPTION	YOU PAY*	COMPREHENSIVE PLAN PAYS**	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Medicare Part A Deductible	$390 per benefit period	100% of remaining eligible expenses	You must pay the first $390 per benefit period. Expenses in excess of Medicare-approved days will be your responsibility. Subject to the annual and lifetime Medicare Part A benefit maximums.
Skilled Nursing Facility *Days 21–100*	0%	100%	Expenses in excess of Medicare-approved days will be your responsibility. Subject to the annual and lifetime Medicare Part A benefit maximums.
Outpatient Hospital Services (Facility)	Up to $275 per visit	100% of remaining eligible expenses	You must pay the first $275 per visit, which applies to the facility only. Benefits include medical or surgical care for which Medicare Part B helps pay, but which does not include an overnight hospital stay, including blood transfusions; certain drugs; mental health care; medical supplies such as splints and casts; emergency room or outpatient clinic, including same-day surgery; and radiation services. Physician services will be considered as All Other Covered Medicare Part B Expenses or as outlined on this schedule. Hospital-billed x-rays and laboratory tests will be considered as Diagnostic X-Rays and Laboratory Services.
Physician Office Visit	Up to $20 per visit	100% of remaining eligible expenses	You must pay the first $20 per visit of any Medicare coinsurance for the office visit only. Any covered services performed during the visit will be considered as All Other Covered Medicare Part B Expenses.
Outpatient Mental Health and Substance Abuse Treatment	Up to $20 per visit	100% of remaining eligible expenses	You must pay the first $20 per visit. Benefits include doctor and professional fees for mental health/substance abuse treatment. Facility charges will be considered as Outpatient Hospital Services.
Blood Not Covered by Medicare	0%	100%	Limited to the first three pints per cause.
Routine Physicals Not Covered by Medicare	0%	100%	$200 individual annual maximum for physician office visit charges. Any routine or diagnostic tests, x-rays, or laboratory services performed in conjunction with the visit will be considered under Preventive Services.

COMPREHENSIVE MEDICARE SUPPLEMENT PLAN

BENEFIT DESCRIPTION	YOU PAY*	COMPREHENSIVE PLAN PAYS**	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Preventive Services, Including Services Not Covered by Medicare**	0%	100%	Benefits include routine or diagnostic x-rays, labs, or tests associated with your routine physical (e.g., bone mass measurements, colorectal cancer screenings, diabetes services and supplies, and mammogram screenings); vaccinations, inoculations and immunizations not covered by Medicare, limited to tetanus, hepatitis A and meningococcal; and vaccinations, inoculations and immunizations covered by Medicare (e.g. hepatitis B). Flu and pneumonia shots are covered 100% by Medicare when your provider accepts Medicare assignment. If your provider does not accept assignment, Medicare will only pay a portion of the cost and the remainder will be considered under this benefit.
Diagnostic X-Rays and Laboratory Services	0%	100%	Benefits include covered Part B services received in a physician's office, an independent facility, or an outpatient hospital. If service occurred on the same day and as part of an Outpatient Hospital Service, then your coinsurance may be waived. Please call Coventry Health Care if you receive an EOB for a diagnostic x-ray or lab service that falls into this category.
Durable Medical Equipment	0%	100%	Examples of durable medical equipment include wheelchairs, hospital beds, oxygen, and walkers.
Chiropractic Services	30%	70%	See your Medicare carrier for information about covered services
All Other Covered Medicare Part B Expenses	30%	70%	Limited to expenses eligible for coverage under Medicare, but which exceed the benefits provided by Medicare, excluding any amounts over the Medicare-allowable amount.

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

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

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

PLUS MEDICARE SUPPLEMENT PLAN

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

BENEFIT DESCRIPTION	YOU PAY*	PLUS PLAN PAYS**	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Medicare Part A Deductible	Up to $150 per benefit period	100% of remaining eligible expenses	You must pay the first $150 per benefit period. Expenses in excess of Medicare-approved days will be your responsibility. Subject to the annual and lifetime Medicare Part A benefit maximums.
Skilled Nursing Facility *Days 21–100*	0%	100%	Expenses in excess of Medicare-approved days will be your responsibility. Subject to the annual and lifetime Medicare Part A benefit maximums.
Outpatient Hospital Services (Facility)	Up to $275 per visit	100% of remaining eligible expenses	You must pay the first $275 per visit, which applies to the facility only. Benefits include medical or surgical care for which Medicare Part B helps pay, but which does not include an overnight hospital stay, such as blood transfusions; certain drugs; mental health care; medical supplies such as splints and casts; emergency room or outpatient clinic, including same-day surgery; and radiation services. Physician services will be considered as All Other Covered Medicare Part B Expenses or as outlined on this schedule. Hospital-billed x-rays and laboratory tests will be considered as Diagnostic X-Rays and Laboratory Services.
Physician Office Visit	Up to $15 per visit	100% of remaining eligible expenses	You must pay the first $15 per visit of any Medicare coinsurance for the office visit only. Any covered services performed during the visit will be considered as All Other Covered Medicare Part B Expenses.
Outpatient Mental Health and Substance Abuse Treatment	Up to $15 per visit	100% of remaining eligible expenses	You must pay the first $15 per visit. Benefits include doctor and professional fees for mental health/substance abuse treatment. Facility charges will be considered as Outpatient Hospital Services.
Blood Not Covered by Medicare	0%	100%	Limited to three pints per cause.
Routine Physicals Not Covered by Medicare	0%	100%	$200 individual annual maximum for physician office visit charges. Any routine or diagnostic tests, x-rays, or laboratory services performed in conjunction with the visit will be considered under Preventive Services.

PLUS MEDICARE SUPPLEMENT PLAN

BENEFIT DESCRIPTION	YOU PAY*	PLUS PLAN PAYS**	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Preventive Services, Including Services Not Covered by Medicare**	0%	100%	Benefits include routine or diagnostic x-rays, labs, or tests associated with your routine physical (e.g., bone mass measurements, colorectal cancer screenings, diabetes services and supplies, and mammogram screenings); vaccinations, inoculations and immunizations not covered by Medicare, limited to tetanus, hepatitis A and meningococcal; and vaccinations, inoculations and immunizations covered by Medicare (e.g. hepatitis B). Flu and pneumonia shots are covered 100% by Medicare when your provider accepts Medicare assignment. If your provider does not accept assignment, Medicare will only pay a portion of the cost and the remainder will be considered under this benefit.
Diagnostic X-Rays and Laboratory Services	0%	100%	Benefits include covered Part B services received in a physician's office, an independent facility, or an outpatient hospital. If service occurred on the same day and as part of an Outpatient Hospital Service, then your coinsurance may be waived. Please call Coventry Health Care if you receive an EOB for a diagnostic x-ray or lab service that falls into this category.
Durable Medical Equipment	0%	100%	Examples of durable medical equipment include wheelchairs, hospital beds, oxygen, and walkers.
Chiropractic Services	20%	80%	See your Medicare carrier for information about covered services.
All Other Covered Medicare Part B Expenses	20%	80%	Limited to expenses eligible for coverage under Medicare, but which exceed the benefits provided by Medicare, excluding any amounts over the Medicare-allowable amount.

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

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

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

PREMIUM MEDICARE SUPPLEMENT PLAN

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

BENEFIT DESCRIPTION	YOU PAY*	PREMIUM PLAN PAYS**	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Medicare Part A Deductible	0%	100% of remaining eligible expenses	Expenses in excess of Medicare-approved days will be your responsibility. Subject to the annual and lifetime Medicare Part A benefit maximums.
Skilled Nursing Facility *Days 21–100*	0%	100% of remaining eligible expenses	Expenses in excess of Medicare-approved days will be your responsibility. Subject to the annual and lifetime Medicare Part A benefit maximums.
Outpatient Hospital Services (Facility)	Up to $175 per visit	100% of remaining eligible expenses	You must pay the first $175 per visit, which applies to the facility only. Benefits include medical or surgical care for which Medicare Part B helps pay, but which does not include an overnight hospital stay, including blood transfusions; certain drugs; mental health care; medical supplies such as splints and casts; emergency room or outpatient clinic, including same-day surgery; and radiation services. Physician services will be considered as All Other Covered Medicare Part B Expenses or as outlined on this schedule. Hospital-billed x-rays and laboratory tests will be considered as Diagnostic X-Rays and Laboratory Services.
Physician Office Visit	Up to $15 per visit	100% of remaining eligible expenses	You must pay the first $15 per visit of any Medicare coinsurance for the office visit only. Any covered services performed during the visit will be considered as All Other Covered Medicare Part B Expenses.
Outpatient Mental Health and Substance Abuse Treatment	Up to $15 per visit	100% of remaining eligible expenses	You must pay the first $15 per visit. Benefits include doctor and professional fees for mental health/substance abuse treatment. Facility charges will be considered as Outpatient Hospital Services.
Blood Not Covered by Medicare	0%	100%	Limited to the first three pints per cause.
Routine Physicals Not Covered by Medicare	0%	100%	$200 individual annual maximum for physician office visit charges. Any routine or diagnostic tests, x-rays, or laboratory services performed in conjunction with the visit will be considered under Preventive Services.

PREMIUM MEDICARE SUPPLEMENT PLAN

BENEFIT DESCRIPTION	YOU PAY*	PREMIUM PLAN PAYS**	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Preventive Services, Including Services Not Covered by Medicare**	0%	100%	Benefits include routine or diagnostic x-rays, labs, or tests associated with your routine physical (e.g., bone mass measurements, colorectal cancer screenings, diabetes services and supplies, and mammogram screenings); vaccinations, inoculations and immunizations not covered by Medicare, limited to tetanus, hepatitis A and meningococcal; and vaccinations, inoculations and immunizations covered by Medicare (e.g. hepatitis B). Flu and pneumonia shots are covered 100% by Medicare when your provider accepts Medicare assignment. If your provider does not accept assignment, Medicare will only pay a portion of the cost and the remainder will be considered under this benefit.
Diagnostic X-Rays and Laboratory Services	0%	100%	Benefits include covered Part B services received in a physician's office, an independent facility, or an outpatient hospital. If service occurred on the same day and as part of an Outpatient Hospital Service, then your coinsurance may be waived. Please call Coventry Health Care if you receive an EOB for a diagnostic x-ray or lab service that falls into this category.
Durable Medical Equipment	0%	100%	Examples of durable medical equipment include wheelchairs, hospital beds, oxygen, and walkers.
Chiropractic Services	0%	100%	See your Medicare carrier for information about covered services.
All Other Covered Medicare Part B Expenses	20%	80%	Limited to expenses eligible for coverage under Medicare, but which exceed the benefits provided by Medicare, excluding any amounts over the Medicare-allowable amount.

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

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

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

PRESCRIPTION DRUG BENEFITS

Please Note: The information on this page does not apply to plans without the pharmacy option (i.e., Comprehensive II, Plus II, Premium II)

COMPREHENSIVE PLAN

Retail Prescriptions Annual Deductible	$50 Individual
Smoking Cessation Annual Maximum	One cycle of therapy

FEATURE	WHAT YOU PAY FOR EACH PRESCRIPTION OR REFILL AT A RETAIL PHARMACY	WHAT YOU PAY FOR EACH PRESCRIPTION OR REFILL AT A MAIL-ORDER PHARMACY
Generic Drug Copayment	You pay $10	You pay $25
Formulary Brand-Name Copayment	You pay $30	You pay $70
Non-Formulary Brand-Name and All Non-Sedating Antihistamines Copayment	You pay $50	You pay $120
Dispensing Limits Per Copayment	up to 30-day supply	up to 90-day supply

PREMIUM AND PLUS PLANS

Retail Prescriptions Annual Deductible	$50 Individual
Smoking Cessation Annual Maximum	One cycle of therapy

FEATURE	WHAT YOU PAY FOR EACH PRESCRIPTION OR REFILL AT A RETAIL PHARMACY	WHAT YOU PAY FOR EACH PRESCRIPTION OR REFILL AT A MAIL-ORDER PHARMACY
Generic Drug Copayment	You pay $5	You pay $12
Formulary Brand-Name Copayment	You pay $25	You pay $60
Non-Formulary Brand-Name and All Non-Sedating Antihistamines Copayment	You pay $40	You pay $100
Dispensing Limits Per Copayment	up to 30-day supply	up to 90-day supply

PRESCRIPTION DRUG BENEFITS

Please Note: The information on this page does not apply to plans without the pharmacy option (i.e., Comprehensive II, Plus II, Premium II)

Generic Substitution Requirement: If you or your physician requests a brand-name drug with a generic equivalent, you must pay the generic copayment and the cost difference between the brand-name and generic drug.

For example, at a participating retail pharmacy, the Generic Substitution Requirement would work as follows:

PLAN	COST OF BRAND-NAME DRUG	COST OF GENERIC DRUG	COST DIFFERENCE	PARTICIPATING RETAIL GENERIC COPAYMENT	TOTAL YOU PAY
Comprehensive	$80	$20	$60	$10	$70
Premium and Plus	$80	$20	$60	$5	$65

Maintenance Drugs Requirement: Keep in mind, the Retail Pharmacy Program allows for a total of three fills of a maintenance medication at a retail pharmacy (one original fill and two refills). Additional fills will not be covered by the Plan. If the total cost of the drug is less than the copay listed on the Schedule of Benefits, you will pay the actual cost of the drug. Each fill can be for no more than a 30-day supply. Note that you are allowed a total of three fills, even if each is for less than 30 days.

Nonparticipating Pharmacies: If you fill your prescription at a nonparticipating pharmacy, you must pay the full cost of the prescription at the pharmacy, complete a direct reimbursement claim form, and mail it to Medco. You will be reimbursed based on the amount the medication would have cost if you had used a participating pharmacy, less your applicable copayment.

Refilling Mail-Order Prescriptions: Since your medication can take 7 to 11 days to be delivered, you should have at least a 14-day supply of that medication on hand to hold you over. If you do not have enough medication, you may need to ask your doctor for another prescription for a 14-day supply that you can fill at your local retail network pharmacy.

Note: The Prescription Drug Program is an independent program administered by Medco. Prescription deductibles and copayments do not apply to the medical plan out-of-pocket maximum.

VISION BENEFITS

If you are enrolled in a Medical Trust Medicare Supplement Plan, you will receive vision benefits through EyeMed. You can receive care from providers participating in the network, or you can choose to use out-of-network providers. However, you will be reimbursed at a higher level if you use providers who participate in the EyeMed network. The services described below are covered as described **once per calendar year.**

Benefit Description	Network	Out-of-Network
Eye Examinations	You pay $0	Plan pays up to $30 for ophthalmologists or optometrists
Lenses*	You pay $10 for single, bifocal or trifocal	Plan pays up to: $32—single vision $46—bifocal $57—trifocal
Lens Options		You are responsible for the cost of any lens options that you elect from out-of-network providers
UV Coating	You pay up to $15	
Tint (Solid and Gradient)	You pay up to $15	
Standard Scratch Resistance	You pay up to $15	
Standard Polycarbonate	You pay $0	
Standard Anti-Reflective Coating	You pay up to $45	
Standard Progressive (Add-On to Bifocal)	You pay up to $65	
Other Add-Ons and Services	20% off retail price	
Frames*	$130 allowance, 20% off balance over $130	Plan pays up to $47
Contact Lenses*		
Conventional	$130 allowance, 15% off balance over $130	Plan pays up to $100
Disposable	$130 allowance, then you pay balance over $130	Plan pays up to $100

** You are eligible to receive lenses and frames* ***or*** *contact lenses once every 12 months.*

When you use EyeMed network providers, you will not need to submit a claim. Your EyeMed provider will submit claims on your behalf. You will pay the copayment and for any noncovered expenses at the time you receive services.

For more information about EyeMed, and to see a list of EyeMed providers, please visit **www.eyemedvisioncare**, or call EyeMed toll-free at (866) 723-0513.

HOW TO CONTACT US

To enroll or ask questions about the Medical Trust Medicare supplement plans, contact your diocesan administrator or Member Services at (866) 273-4545, Monday through Friday, from 8:30 a.m. to 5:30 p.m. Eastern Time.

Important Phone Numbers

Resource	Phone Number and Web Site
Post-Retirement Health Benefits Member Services Center	(866) 273-4545 **www.cpg.org/healthcare/retirees** email: mtcustserv@cpg.org
Medicare	(800) 633-4227 **www.medicare.gov**
Coventry Health Care	(800) 398-5654 **www.mycoventryhealth.com** Access ID: **ECM**
Medco	(800) 841-3361 **www.medco.com**
EyeMed Vision Care	(866) 723-0513 **www.eyemedvisioncare.com**

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

This document contains only a partial, general description of the Plans. It is provided for informational purposes only and should not be viewed as a contract, an offer of coverage, or investment, tax, medical, or other advice. In the event of a conflict between this document and the official Plan documents (schedule of benefits, summary Plan description, booklet, booklet-certificate), the official Plan documents will govern. The Church Pension Fund and CPGSC (collectively, "CPG"), retain the right to amend, terminate, or modify the terms of the Plans, as well as any post-retirement health subsidy, at any time, without notice and for any reason.

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

All benefits under the Plans are subject to applicable laws, regulations, and policies. Except for the Preventive Dental PPO Plan, and the Travel Protection Benefit, all such benefits are subject to coordination of benefits. The Plans are subrogated to all of the rights of a Plan participant against any party liable for such participant's illness or injury, to the extent of the reasonable value of the benefits provided to such participant under the Plans. The Plans may assert this right independently of a Plan participant, and such participant is obligated to cooperate with the Medical Trust in order to protect the Plans' subrogation rights.

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

If you are a Plan participant, call the number on your ID card for more information about the Plan in which you are enrolled. All other individuals should call (866) 273-4545.

THE EPISCOPAL CHURCH MEDICAL TRUST

445 Fifth Avenue
New York, NY 10016