

The Episcopal Church Medical Trust
Benefit Guide

Your Health Care Options
January 1, 2009 - December 31, 2009

About the Medical Trust

The Episcopal Church Medical Trust¹ 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, or other bodies subject to the authority of the church. The benefit plans maintained by the Medical Trust are intended to qualify as “church plans” within the meaning of Section 414(e) of the Internal Revenue Code, and are exempt from the requirements of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”).

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

Serving the Church

The 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.

¹*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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Important!

To participate in a Medical Trust Medicare supplement plan, you must:

- Be enrolled in Medicare Part A and Medicare Part B; and
- Meet the eligibility requirements established by the Medical Trust (see page 16).

For questions regarding eligibility or plan details, please call Customer Engagement at (866) 273-4545, or email us at mtcustserv@cpg.org.

Introduction

The Medical Trust has prepared this Guide to help you understand the various benefits available to you and to aid you in making an informed choice regarding your health care needs. Please read through this information carefully, and share it with your family. It is your responsibility to be a wise consumer of health care services, to understand your benefit limitations, and to use only those services you need. It is also important to understand that sometimes some medical plans do not provide benefits for certain kinds of treatments or services, even if your health care provider recommends them.

After you enroll in an Episcopal Church Medical Trust Plan, you will receive a Handbook. The Handbook will contain additional details about the Plans offered by the Medical Trust.

How This Guide Can Help You

This Guide describes the Medical Trust Medicare supplement plans and explains how these Plans coordinate with your Original Medicare plan (Medicare Part A and Medicare Part B) benefits.

This Guide also provides descriptions of:

- Medicare Advantage plans (and other similar plans)
- The Medicare prescription drug program (also known as Medicare Part D)
- The Medical Trust dental plans
- The benefits provided through MEDEX, EyeMed Vision Care, Health Advocate, and the Employee Assistance Program (EAP)

Understanding Medicare Supplement Plans

Choosing a Medicare supplement plan is a very important decision. You may wish to compare these supplement plans with plans offered by a local insurance company—often referred to as Medigap insurance policies. Whether you use one of the Plans described in this Guide or a Medigap policy purchased from a local insurance company, these Medicare supplement plans are designed to help you pay the costs of health care that Medicare does not cover.

We hope this Guide will help you understand:

- What Medicare is
- What Medicare supplement plans are
- What Medicare supplement plans are not
- How Medicare supplement plans can help you
- What you need to do to enroll in one of the Medical Trust Medicare supplement plans

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

Important Note About Medicare Advantage Plans

You generally don't need a Medicare supplement plan if you are in a Medicare Advantage plan, such as a Medicare managed care plan (like an HMO) or a Medicare Private Fee-for-Service plan. You also do not need a Medicare supplement plan if you are enrolled in TRICARE for Life as a uniformed services retiree or an eligible dependent.

Understanding Dental Benefits

You may also decide to enroll in one of three dental plans. All three plans offer in- and out-of-network benefits and are designed to encourage preventive care. The dental plans are administered by CIGNA Dental. For more information, turn to page 29.

Glossary

Several terms used throughout this Guide may be new to you. If you see a word or phrase in **bold text**, you'll find its definition in the glossary beginning on page 47.

Medicare Basics

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

Services Covered by Original Medicare

Different services and supplies are covered under Medicare Part A and Part B when they are 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

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 US)*
- 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.*

Medicare Basics

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 11 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)

More Information

You can find more information in the *Medicare & You* handbook. Visit www.medicare.gov to view the handbook or call (800) 633-4227 to request a copy.

Original Medicare Costs

Most people receive Medicare Part A automatically when they reach age 65. They do not have to pay a monthly payment, called a "premium," for Part A because they or a spouse paid Medicare taxes while they were working.

If you (or your spouse, if applicable) did not pay Medicare taxes while you worked and you are age 65 or older, you still may be able to purchase Part A.

If you are not sure whether you have Part A, look on your red, white, and blue Medicare card. If you have Medicare Part A, “Hospital (Part A)” is on the lower left corner of the card. You can also call the Social Security Administration for more information about purchasing Part A.

You pay the Medicare Part B premium on a monthly basis. Enrolling in Part B is your choice. The premium is usually taken out of your monthly Social Security payment. In this case, you won't receive a bill for your premium. If you do not receive a Social Security payment, Medicare sends you a bill for your Medicare Part B premium every three months.

Your Part B premium is based in part on your income. If your income is above \$85,000 (single) or \$170,000 (married couple), Social Security will use the income reported two years ago on your IRS income tax return to determine your premium (if unavailable, SSA will use data from three years ago). For example, the income reported on your 2007 tax return will be used to determine your monthly Part B premium in 2009.

If your income has decreased since 2007, you can ask that the income from a more recent tax year be used to determine your premium. At the end of 2008, Social Security will send you a letter if your Part B premium will increase based on the level of your income and tell you what you can do if you disagree.

How to Enroll in Original Medicare

Part A

Most people are enrolled in Medicare Part A automatically when they turn age 65.

Part B

Just before you turn age 65, you must decide whether to enroll in Medicare Part B.

If you delay your enrollment past your 65th birthday, the cost of Medicare Part B may be higher by 10% or more for each 12-month period during which you are not enrolled, except in special cases.

If you did not sign up for Medicare Part B when you were first eligible, you may sign up during special enrollment periods.

For more detailed information about Original Medicare Enrollment please see CMS Publication No. 11036.

Medicare Basics

About Medicare Advantage Plans (Part C) and Other Medicare Health Plans

What are Medicare Advantage Plans?

Medicare Advantage Plans are health plan options that are part of the Medicare Program. If you join one of these plans, you generally get all your Medicare-covered health care through that plan. This coverage can include prescription drug coverage. Medicare pays a set amount of money for your care every month to these private health plans whether or not you use services. In most of these plans, generally there are extra benefits and lower copayments than in the Original Medicare Plan. However, you may have to see doctors that belong to the plan or go to certain hospitals to get services.

What are the other Medicare Health Plans?

There are some types of Medicare Health Plans that are not part of Medicare Advantage. However, they are still part of the Medicare Program. In some of these plans, you generally get all your Medicare-covered health care from that plan. This coverage can include prescription drug coverage. Medicare pays a set amount of money for your care every month to these private health plans.

Medicare Preferred Provider Organization (PPO) Plans

Regional PPOs are available in most areas of the country to give choices for Medicare health care coverage. Also, local PPOs are available in more areas of the country. Unlike local PPOs, which serve individual counties, regional PPOs will serve an entire region, which may be a single state or multi-state area. This will help bring more plan options to people with Medicare. Just like local PPOs, regional PPO members also will be able to get their Medicare prescription drug coverage from the PPO plan. In a regional PPO, members will have an added protection for Medicare Part A and Part B benefits. There will be an annual limit on their out-of-pocket costs. This limit will vary depending on the plan.

About Medicare Prescription Drug Coverage (Part D)

What is Medicare Prescription Drug Coverage?

As of January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. This coverage may help lower prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. You choose the drug plan and pay a monthly premium. Like other insurance, if you decide not to enroll in a drug plan when you are first eligible, you may pay a penalty if you choose to join later (only if you do not have employer coverage that meets Medicare's creditable coverage definition).

There are two types of Medicare plans that provide insurance coverage for prescription drugs. There is prescription drug coverage that is a part of Medicare Advantage Plans and other Medicare Health Plans. You would get all of your Medicare health care through these plans. There is also Medicare prescription drug coverage that adds coverage to the Original Medicare Plan, some Medicare Cost Plans and Medicare Private Fee-for-Service Plans.

These plans are offered by insurance companies and other private companies approved by Medicare. Both types of plans are referred to as drug plans in this section.

Like other insurance, if you join a plan offering Medicare drug coverage there is a monthly premium. If you have limited income and resources, you may get extra help to cover prescription drugs for little or no cost. The amount of the monthly premium is not affected by your health status or how many prescriptions you need. You will also pay a share of the cost of your prescriptions. All drug plans must provide coverage at least as good as the standard coverage, which Medicare has set. However, some plans might also offer more coverage and additional drugs for a higher monthly premium.

Medicare Basics

The Prescription Drug Coverage You Choose Affects:

- **Coverage.** Medicare drug plans cover generic and brand-name drugs. Plans may have rules about what drugs are covered in different drug categories. This makes sure people with different medical conditions can get the treatment they need. Most plans will have a formulary, which is a list of drugs covered by the plan. This list must always meet Medicare's requirements, but it can change when

If your doctor thinks you need a drug that isn't on the list, or if one of your drugs is being removed from the list, you or your doctor can apply for an exception or appeal the decision.

The prescription drug coverage provided under the Medical Trust's Medicare supplement plans is considered creditable prescription drug coverage. Individuals are eligible for the prescription drug coverage offered under the Medical Trust's Medicare supplement plans only if they are not enrolled in another Medicare Part D prescription drug plan.

- **Cost.** Monthly premiums and your share of the cost of your prescriptions will vary depending on which plan you choose. If you have limited income or resources, you may qualify for extra help paying your drug plan costs.

What you need to know if you have prescription drug coverage from a former or current employer (the Medical Trust) or union:

Your (or your spouse's) former or current employer or union will send you information annually about how your current coverage compares to the Medicare standard prescription drug coverage. This information is important because it can affect your decision on whether or not to sign up for Medicare prescription drug coverage.

If your (or your spouse's) employer has determined that your current coverage, on average, is at least as good as the Medicare standard prescription drug coverage (called **creditable prescription drug coverage**):

- You can keep it as long as it is still offered by your employer; and
- You won't have to pay a penalty if your employer stops offering prescription drug coverage as long as you join a Medicare drug plan within 63 days after the coverage ends.

How to Enroll in Medicare Part D

To enroll in Medicare Part D, you must have Part A or Part B. You can change your plan during the open enrollment period, which is from November 15 through December 31 *each year*. Your Medicare prescription drug plan will begin January 1 of the following year. To join, you will need to decide how you want to get your prescriptions. You can do any of the following:

- Get all your health care benefits and prescriptions through a Medicare Advantage Managed Care Plan that offers optional coverage for prescription drugs
- Get your health care benefits through the Original Medicare Plan and choose a Medicare prescription drug plan
- Get your health care benefits through another type of Medicare Advantage health plan or a Medicare Managed Care Plan that isn't a Medicare Advantage Plan. In these plans, you may be able to choose a Medicare prescription drug plan.

Joining Medicare Part D is your choice. However, if you don't join when you are first eligible, you may have to pay a higher premium if you choose to join later. You will have to pay this higher premium for as long as you have a Medicare prescription drug plan.

Note: If you already have prescription coverage through The Episcopal Church Medical Trust, you can keep that coverage. As our coverage offers the same or better benefits as described above, you will not have to pay a higher premium if you decide to join a Medicare Part D prescription drug plan later. If you are not with the Medical Trust, check with your other insurance to see how your coverage compares.

Medicare Supplement Plan Basics

About Medicare Supplements

The Medical Trust plans are referred to as “Medicare supplement plans.”

Medicare supplement plans provide you with additional health care coverage by helping you pay many of your out-of-pocket expenses after Medicare pays its portion. They *supplement* Medicare by paying a portion of Medicare copayments, coinsurances, and deductibles, and by paying for some services not covered under Medicare, such as annual routine physical exams.

Medicare supplement plans are similar to Medigap policies in that they fill the “gaps” in Medicare coverage. The supplement plans offered through the Medical Trust use *Medicare-approved medical treatment* as a guideline for covered services.

When Medicare Supplement Plans Can Help

Medicare supplement plans only help pay health care costs if you are covered by Medicare. You must be enrolled in Medicare Part A and Part B to enroll in a Medicare supplement plan.

Benefits of a Medicare Supplement Plan

You may want to purchase a Medicare supplement plan because Medicare does not pay for all of your health care expenses... meaning there are gaps or costs that you must pay under Medicare. The chart on the next page provides some examples of these gaps.

If you are covered by Medicare, a Medicare supplement plan may help you lower your out-of-pocket costs and increase your level of health care coverage.

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

- Whether your doctor or supplier accepts assignment or takes Medicare’s approved amount as payment in full
- How often you need health care
- What type of health care you need
- Whether you enroll in a Medicare supplement plan
- Which Medicare supplement plan you enroll in
- Whether you have other health care coverage

Gaps in Medicare

Examples of What Medicare Asks You to Pay in 2009		Medical Trust Medicare Supplement Plans Help Pay
Hospital Stays	<ul style="list-style-type: none"> ▪ \$1,068 for the first 60 days ▪ \$267 per day for days 61–90 ▪ \$534 per day for days 91–150 	✓
Skilled Nursing Facility Days	Up to \$133.50 per day for days 21–100	✓
Blood	Cost of the first three pints	✓
Medicare Part B Deductible	\$135	✓
Medicare Part B Covered Services	<ul style="list-style-type: none"> ▪ 20% of the Medicare-approved amount for most covered services ▪ 50% of the Medicare-approved amount for outpatient mental health services ▪ Copayment for outpatient hospital services 	✓
Medicare Part B Premium	\$96.40 if your income is below \$85,000 (single) or \$170,000 (married couple). If your income is above \$85,000/\$170,000, your Medicare Part B premium may be higher.	

Medicare Supplement Plan Basics

Three Medical Trust Medicare Supplement Plans

The Medical Trust is offering three Medicare supplement plans for the 2009 benefit year:

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

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

These Medicare supplement plans are not:

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

Important Legal Notice Regarding Medicaid and Medicare Advantage

If you have Medicaid, it is illegal for an insurance company to sell you a Medicare supplement plan, except in certain situations. In addition, you don't need to purchase a Medicare supplement plan if you are in a Medicare Advantage plan. In fact, it is illegal to sell you a Medicare supplement plan if you are in one of these plans.

Eligibility

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. Your spouse or domestic partner who is also enrolled in Medicare Parts A and B is also eligible to enroll.

Covered Benefits

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

Prescription drug benefits are only available to individuals not enrolled in a Medicare Part D prescription drug plan.

All three Plans include some member cost sharing. This means you will be responsible for some out-of-pocket expenses, such as copayments, coinsurances, and deductibles. For example, if you choose supplemental coverage under the Comprehensive Plan, you will pay a copayment of up to \$20 for a visit to the doctor. Unlike Medicare, these Plans have an individual annual out-of-pocket maximum. For the Comprehensive Plan, this means you will never pay more than \$2,000 in a given benefit year for hospital stays, doctor's office visits, and other covered medical expenses.

Your prescription drug deductible and copayments, as well as your vision and hearing aid benefit copayments, do not count toward the annual out-of-pocket maximums.

Turn to page 23 to better understand how the three plans differ.

Benefit Exclusions

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

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

Provider Choice

The Medical Trust Medicare supplement plans allow you to go to any doctor or provider that accepts Medicare. If you decide to use a provider that does not accept Medicare, the provider may charge more than Medicare allows for services, and the Medicare supplement plans will not cover the excess charges.

Finding a Provider That Accepts Medicare

Most doctors accept Medicare assignment. If you need help finding a provider that accepts Medicare assignment, visit www.medicare.gov/physician/home.asp, or contact Medicare directly at (800) 633-4227.

Medicare Supplement Plan Basics

Prescription Drug Benefits

When you enroll in one of the Medical Trust Medicare supplement plans, you'll automatically have coverage for prescription drugs through the Medco Prescription Drug Program.

This program includes a Formulary Management Program, which uses a "three-tier" copayment approach to covered drugs and is designed to control costs for you and the Plan.

The formulary includes all FDA-approved drugs that have been placed in tiers based on their clinical effectiveness, safety, and cost. Tier 1 includes primarily generic drugs (lowest copayment); Tier 2 includes preferred drugs (middle copayment); and Tier 3 includes non-preferred drugs and brand non-sedating antihistamines (highest copayment).

Prescription Drug Benefits

	Comprehensive Plan		Plus and Premium Plans	
	Retail Copayment	Mail-Order Copayment	Retail Copayment	Mail-Order Copayment
Annual Prescription Retail Deductible	\$50	N/A	\$50	N/A
Tier 1: Generic	\$10	\$25	\$5	\$12
Tier 2: Formulary Brand-Name	\$30	\$70	\$25	\$60
Tier 3: Non-Formulary Brand-Name and Brand Non-Sedating Antihistamines	\$50	\$120	\$40	\$100
Dispensing Limits per Copayment	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply	Up to a 90-day supply
Prescription Smoking Cessation Drugs Annual Maximum	1 cycle of therapy per individual			

Coverage of Non-Sedating Antihistamines

The non-sedating antihistamine drug category has the highest copayment, regardless of the drug's formulary status. This is due to the fact that drugs in this category are available over the counter.

For example, if you enroll in the Comprehensive Plan and you prefer to take the medication Clarinex rather than buying Claritin over the counter, you will pay the Tier 3 copayment of \$50 for retail prescriptions or \$120 for mail-order prescriptions. This coverage rule applies to all three Medicare supplement plans.

Prescription Deductible

The Prescription Drug Program has a *separate* annual deductible of \$50 per individual for retail prescriptions. This annual retail deductible does not apply to mail-order prescriptions, so you can begin receiving full mail-order program benefits without first meeting the annual retail deductible. You may want to keep this in mind if you or a covered dependent will be receiving any maintenance medications during the coming calendar year.

Retail Refill Limit

To help manage overall program costs and limit dramatic increases to prescription drug copayments, the Prescription Drug Program maintains a retail refill limit policy. The retail refill limit requires that you participate in the mail-order program if you are prescribed a maintenance medication, rather than refilling multiple prescriptions for the same drug at a retail pharmacy. The Plans allow for a total of three fills of maintenance medication at a retail pharmacy (one fill and up to two refills).

If you or a covered dependent receives a prescription for a maintenance medication and you do not use the mail-order program, your prescriptions will not be covered after the second refill at a retail pharmacy.

Medicare Supplement Plan Basics

*When the Retail Refill Limit May Be Waived**

In some circumstances, however, you may not be required to use the mail-order program. 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. If you have a prescription for any of the following medications, the Medco Prescription Drug Program will waive the mandatory mail-order requirement and allow 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. For example, maintenance glaucoma drops 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 do not meet the necessary retail requirements and must be filled through the mail-order program.)
- 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)
- Medications whose sole use is to treat cancer

**Residents of nursing homes or long-term care facilities that have specific requirements for handling prescription drugs should contact Customer Engagement at (866) 273-4545 to request instructions for obtaining a waiver.*

Generic Drugs

Generic drugs 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 U.S. Food and Drug Administration (FDA) requires that the active ingredients have the same strength, purity, and quality as their brand-name counterparts.

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

Generic Substitution Requirement

The Plans 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.

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.

Medicare Supplement Plan Basics

Paper Claims Reimbursement for Non-Network Retail Purchases

You must pay the full price at the pharmacy and file a claim for reimbursement. You will be reimbursed according to what the Plan would have paid at a participating pharmacy, less your applicable copayment. See the “Pharmacy Benefits” section of your Plan Handbook for more information about filing claims for reimbursement for prescription drugs purchased at retail pharmacies.

Additional 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 **non-formulary 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, or to locate the retail pharmacy nearest you, visit Medco at www.medco.com, or call (800) 841-3361.

Please note that a list of drugs that are covered, excluded, or that require prior authorization will be included in the Plan document Handbook. This Handbook will be mailed to you if you enroll in one of the three Medicare supplement plans.

The charts on the following pages show you what is covered by the Plans and the differences in out-of-pocket costs among them. Changes for 2009 are indicated by bold print and underlined.

Detailed Summary of Plan Benefits*

Benefits	What Medicare Asks You to Pay in 2009	What You'll Pay in the Comprehensive Plan	What You'll Pay in the Plus Plan	What You'll Pay in the Premium Plan
Annual Out-of-Pocket Maximums	No maximum limit	For Part A and Part B benefits: Individual: \$2,000	For Part A and Part B benefits: Individual: \$1,750	For Part A and Part B benefits: Individual: \$1,500
Medicare Limitations	Expenses are approved when Medicare deems the benefits to be medically necessary. Care not covered/ approved by Medicare will not be covered.	All medical benefits are limited to expenses approved by Medicare.		
Inpatient Days 1–60**	For each benefit period, you pay the first \$1,068 . This is your Part A deductible.	You pay up to \$390 per benefit period. All other costs are covered at 100%.	You pay up to \$150 per benefit period. All other costs are covered at 100%.	You pay nothing.
Inpatient Days 61–90**	\$267 per day	You pay nothing.		
Inpatient Days 91–150**	\$534 per day	You pay nothing.		

*This chart contains only a partial, general description of the Plans.

** Limited to expenses approved by Medicare.

Medicare Supplement Plan Basics

Benefits	What Medicare Asks You to Pay in 2009	What You'll Pay in the Comprehensive Plan	What You'll Pay in the Plus Plan	What You'll Pay in the Premium Plan
Skilled Nursing Facility Days 1–20**	You pay nothing.	You pay nothing.	You pay nothing.	You pay nothing.
Skilled Nursing Facility Days 21–100**	\$133.50 per day; 100-day benefit limit	You pay nothing.	You pay nothing.	You pay nothing.
Home Health Care	You pay nothing.	You pay nothing for services approved by Medicare.		
Durable Medical Equipment	You pay 20% of the Medicare-approved amount.	You pay nothing.	You pay nothing.	You pay nothing.
Medicare Part B Physician Office Visits	You pay 20% after the \$135 deductible.	You pay up to \$20 per office visit.	You pay up to \$15 per office visit.	You pay up to \$15 per office visit.
Diagnostic Laboratory Services	You pay 100% of the Medicare-approved amount after the annual Part B deductible.	You pay nothing.	You pay nothing.	You pay nothing.

** Limited to expenses approved by Medicare.

Benefits	What Medicare Asks You to Pay in 2009	What You'll Pay in the Comprehensive Plan	What You'll Pay in the Plus Plan	What You'll Pay in the Premium Plan
Other Medicare Part B Services	You pay a coinsurance or copayment amount, which may vary according to the service.	You pay 30% of the remaining Medicare coinsurance.	You pay 20% of the remaining Medicare coinsurance.	You pay 20% of the remaining Medicare coinsurance
Outpatient Hospital Services	You pay a coinsurance/copay amount, which may vary according to the service.	You pay up to \$275 of any Medicare coinsurance/copayment.	You pay up to \$275 of any Medicare coinsurance/copayment.	You pay up to \$175 of any Medicare coinsurance/copayment.
Routine Physical Exam Office Visit	Not covered (You pay 100%.)	You pay nothing up to \$200.		
Routine Clinical Laboratory Services and Diagnostic Tests (Performed With Your Routine Physical)	You pay a coinsurance or copayment amount, which may vary according to the service and may or may not be subject to the Part B deductible.	You pay nothing for clinical laboratory services associated with your routine physical, including, but not limited to, bone mass measurements, colorectal screening, mammograms, Pap smears, pelvic exams, and prostate cancer screening.		
Medicare-Approved Chiropractic Services	You pay 20% of the Medicare-approved amount.	You pay 30% of the remaining Medicare coinsurance (i.e., 6% of the total Medicare-approved amount).	You pay 20% of the remaining Medicare coinsurance (i.e., 4% of the total Medicare-approved amount).	You pay nothing.

Medicare Supplement Plan Basics

Benefits	What Medicare Asks You to Pay in 2009	What You'll Pay in the Comprehensive Plan	What You'll Pay in the Plus Plan	What You'll Pay in the Premium Plan
Prescription Drugs: Medco	Please see Medicare prescription drug plan information	Please see the Prescription Drug Benefits section starting on page 18.		
Vision: EyeMed	Not covered (You pay 100%.)	12-month benefit for: <ul style="list-style-type: none"> ▪ Eye exam—\$0 copayment ▪ Lenses—\$10 copayment ▪ Frames—\$130 allowance, plus 20% off balance 		

NOTES: The Prescription Drug Benefit information is only applicable to the Medicare Supplement Plans with the pharmacy benefit option.

This vision information describes the in-network benefit. See the Plan Document Handbook for details about non-network vision benefits.

Vision copayments and the prescription drug deductibles & copayments do not apply to the annual out-of-pocket maximum.

Additional Benefits

Four benefit riders are provided to you at no additional cost when you enroll in one of the Medical Trust Medicare supplement plans. These riders provide additional benefits to Medicare, and we are pleased that we have the resources to add them as riders to our supplement plans. However, they are separate riders and are not integral to the supplement plans. This means there may be a monthly charge for them in future benefit years.

Travel Protection Benefit Rider

The travel plan rider covers health care costs associated with medically necessary treatment for an accidental injury or acute illness you may incur while you or any of your covered dependents are traveling outside of the United States on a trip that consists of no more than 365 days. This benefit includes services that are not covered by Medicare and is provided through a partnership with MEDEX Assistance Corporation. Through a partnership with MEDEX Assistance Corporation. For more details, please contact the Medical Trust.

MEDEX will also provide travel assistance services when you travel more than 100 miles from home, either in the United States or abroad.

An example of a travel assistance service is assistance with replacement of lost or stolen travel documents. While MEDEX is available to help coordinate these services, keep in mind that you are responsible for any associated costs.

Hearing Aid Benefit Rider

This rider provides coverage for the purchase and maintenance of hearing aids. It also provides reimbursement for hearing diagnostic services. There is a benefit maximum of \$1,000 per ear every five years.

While it is not required that you use a network provider, the HearPO Network is available to you. If you go to a network provider, you can purchase hearing services and hearing aids at a discounted price. To find a provider in the network, contact HearPO.

Health Advocate Rider

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

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

Additional Benefits

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

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

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

Employee Assistance Program (EAP) Rider

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

EAP services are available 24 hours a day through the CIGNA Behavioral Health website or by phone. All services are free and confidential. EAP staff members are trained to provide you with a multitude of services including: help finding counseling services, support for managing stress, information on grief and loss, assistance in researching nursing homes, etc. Life can be challenging and stressful. Everyone needs support from time to time.

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

Dental Plan Basics

Eligibility

To purchase a dental plan, 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. Your spouse or domestic partner is also eligible to enroll.

Plan Network

All plans use the CIGNA Dental network, giving you access to dentists who provide services at discounted fees. The qualifications of each dental care provider have been reviewed so that you and your dependents will be provided quality care at a fee less than is common in the geographic area in which you live.

You can receive care from providers participating in the network, or you can choose to use out-of-network providers. You will be reimbursed at a higher level if you use providers who participate in the CIGNA network.

You can access the dental provider directory via the Internet at www.cigna.com, or by calling CIGNA.

Dental Plan Basics

You may choose from the three dental Plans described below. Please refer to this chart to compare the coverage levels available in each Plan.

Dental Plan Comparison Chart*

Feature	Dental & Orthodontia PPO Plan	Basic Dental PPO Plan	Preventive Dental PPO Plan
Non-Network Annual Deductible	\$25 Individual/ \$75 Family	\$50 Individual/ \$150 Family	No deductible
Annual Benefit Maximum	\$1,500 Individual	\$1,500 Individual	\$1,500 Individual
Preventive & Diagnostic Services <i>(e.g., oral exams, cleanings, x-rays, emergency care to relieve pain)</i>	You pay 0% (not subject to the annual deductible)	You pay 0% (not subject to the annual deductible)	You pay 0%
Basic Restorative Services	You pay 15% (and all amounts above the annual benefit maximum) <i>Includes fillings, root canal therapy, periodontal scaling and root planing, denture adjustments and repairs, extractions, and anesthetics.</i>	You pay 15% (and all amounts above the annual benefit maximum) <i>Includes fillings, root canal therapy, periodontal scaling and root planing, denture adjustments and repairs, extractions, and anesthetics.</i>	You pay 20% (and all amounts above the annual benefit maximum) <i>Includes only fillings, denture adjustments and repairs.</i>
Major Restorative Services	You pay 15% (and all amounts above the annual benefit maximum) <i>Includes crowns, dentures, oral surgery, osseous surgery, and bridges.</i>	You pay 50% (and all amounts above the annual benefit maximum) <i>Includes crowns, dentures, oral surgery, osseous surgery, and bridges.</i>	You pay 99% (and all amounts above the annual benefit maximum) <i>Includes crowns, dentures, oral surgery, osseous surgery, bridges and root canal therapy.</i>
Orthodontia	You pay 50% (\$1,500 individual lifetime maximum).	Not covered	You pay 99% and all amounts above the annual benefit maximum.

*This chart contains only a partial, general description of the Plans.

Open Enrollment

About Open Enrollment

Open enrollment is a period of time during which you may choose the health plan you will be enrolled in for the following 12 months. For example, if you are enrolled in the Premium Plan and you would like to switch to the Comprehensive Plan, you may do so during the open enrollment period. Once you have enrolled and the benefit year has

begun, you will remain in the Plan you've elected until the next open enrollment period (as long as premiums are paid, if any are due).

For the 2009 benefit year, you do not have to submit your enrollment form unless you want to update your personal information, change your Medicare supplement plan and/or dental plan, or enroll with the Medical Trust for the first time.

Open Enrollment Timeline

Date	Event
November 17, 2008	Open enrollment period begins
December 31, 2008*	Forms due to the Medical Trust**
December 2008***	January bills and pension check statements mailed
January 1, 2009	2009 Medical Trust health plan coverage begins
January 2009	ID cards and Plan Document Handbooks mailed

**If your diocese or former employer is billed for any portion of your coverages, then the group administrator must sign your form before it is returned to the Medical Trust.*

***Unfortunately, forms postmarked after December 31, 2008 will not be accepted for the 2009 benefit year.*

****To ensure that your January 2009 bill or pension check deduction is accurate, please try to submit form in November. Forms received in December may result in billing inaccuracies, which will need to be corrected on your February bill or pension check deduction.*

Open Enrollment

Making Your Enrollment Decision: Five Easy Steps

As described in this Guide, the levels of benefits differ among the three Medical Trust Medicare supplement plans, as well as among the three dental plans. Therefore, your out-of-pocket costs will vary based on which plans you select.

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

Before enrolling, we suggest you take the following steps:

1. Look at how much you have been spending on medical care each year.
2. Think about your future health care needs, review these Medicare supplement plans, and decide which level of benefits you want or need.
3. Choose the Medicare supplement plan that suits your needs. You will need to determine whether you want your Medicare supplement plan to include prescription drug coverage or whether you are going

to enroll in a separate Medicare Part D prescription drug plan for your prescription drug coverage. If you enroll in a separate Medicare Part D prescription drug plan, your Medicare supplement plan choices will be limited to plans without the prescription drug option (i.e., Comprehensive II, Plus II, Premium II).

4. Think about your future dental care needs, review the dental plans, and decide which level of benefits you want or need.
5. Complete and return your open enrollment form if you want to:
 - Update personal information
 - Change your Medicare supplement or dental plan
 - Sign up with the Medical Trust for the first time

You may also access your personalized enrollment form using the username and password in your enrollment welcome letter to enroll online.

Step 1: Review Your Health Care Spending

We suggest you consider the following factors to help make your choice:

- Who pays the monthly premium for the plan? How much will you have to pay?

- On average, how much will you spend out-of-pocket on copayments, coinsurances, and deductibles each month based on your present or predicted health care needs?
- Can you afford the Medicare Part A, Part B and Part D deductibles in the event an illness requires you to pay them all at the same time?
- Which out-of-pocket maximums do you feel comfortable with?
- How often do you expect to see doctors in the next year?
- How many prescription drugs do you use? Are you using a number of maintenance medications whose costs you can predict? How does the prescription drug coverage offered by the Medical Trust compare to the coverage offered through Medicare Part D?

How to Use the Worksheets

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

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

Note that the vision benefit is the same for all three Medicare supplement plans.

Column 1

Column 1 lists types of health care costs and services that you may have paid for last year. You can also add other health care costs or services that you paid for last year (or previous years) that you may want to think about when choosing a Medicare supplement plan. Write down those costs or services in the row marked “Other.”

Column 2

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

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

After completing the worksheets, you should have a better sense of the benefits you’re looking for in a Medicare supplement plan.

Open Enrollment

Use this worksheet for medical expenses under the Comprehensive Plan.

Column 1	Column 2	Comprehensive Plan
Medical Services	Enter the number of times you received the services in Column 1 in the last year.	
Hospital admissions where a Medicare Part A deductible was applied		(Column 2) × \$390 = \$ _____
Number of days beyond 21 in a skilled nursing facility		(Column 2) × \$35 = \$ _____
Number of office visits to a provider (physician or other provider)		(Column 2) × \$20 (the maximum copay) = \$ _____
Number of outpatient surgeries or services you had (include day surgeries, chemotherapy treatment visits, etc.)		(Column 2) × \$275 (the maximum copay) = \$ _____
Estimate the amount (in dollars) Medicare said you owed for physician care when you were in the hospital in 2006		(Column 2) × 30% = \$ _____
Other		\$ _____
Preliminary Subtotal		\$ _____ (Sum of amounts above)
Medical Subtotal		\$ _____
<ul style="list-style-type: none"> If the Preliminary Subtotal is <i>less than</i> \$2,000 (the out-of-pocket maximum), enter the Preliminary Subtotal here. If the Preliminary Subtotal is <i>greater than</i> \$2,000, enter \$2,000 here. 		(Subtotal cannot be greater than \$2,000)

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

Column 1	Column 2	Comprehensive Plan
Prescription Medications		
Did you purchase prescription medications at a retail pharmacy?	YES NO	\$ _____ (If Column 2 is YES, enter \$50 [the maximum deductible])
Enter the number of generic prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) × \$10 = \$ _____
Enter the number of formulary brand-name prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) × \$30 = \$ _____
Enter the number of non-formulary brand-name prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) × \$50 = \$ _____
Enter the number of generic prescriptions (including refills) purchased through mail order.		(Column 2) × \$25 = \$ _____
Enter the number of formulary brand-name prescriptions (including refills) purchased through mail order.		(Column 2) × \$70 = \$ _____
Enter the number of non-formulary brand-name prescriptions (including refills) purchased through mail order.		(Column 2) × \$120 = \$ _____
Prescription Subtotal		\$ _____ (Sum of amounts above)
TOTAL (Add the Medical Subtotal from the previous page and the Prescription Subtotal from this page.)		\$ _____ (Sum of both Subtotals)

*Does not apply to plans without the pharmacy option.

Open Enrollment

Use this worksheet for medical expenses under the Plus Plan.

Column 1	Column 2	Plus Plan
Medical Services	Enter the number of times you received the services in Column 1 in the last year.	
Hospital admissions where a Medicare Part A deductible was applied		(Column 2) × \$150 (the maximum copay) = \$ _____
Did you stay more than 21 days in a skilled nursing facility?	YES NO	\$ _____ (If Column 2 is YES, enter \$150)
Number of office visits to a provider (physician or other provider)		(Column 2) × \$15 (the maximum copay) = \$ _____
Number of outpatient surgeries or services you had (include day surgeries, chemotherapy treatment visits, etc.)		(Column 2) × \$275 (the maximum copay) = \$ _____
Estimate the amount (in dollars) Medicare said you owed for physician care when you were in the hospital in 2006		(Column 2) × 20% = \$ _____
Other		\$ _____
Preliminary Subtotal		\$ _____ (Sum of amounts above)
Medical Subtotal		
<ul style="list-style-type: none"> If the Preliminary Subtotal is <i>less than</i> \$1,750 (the out-of-pocket maximum), enter the Preliminary Subtotal here. If the Preliminary Subtotal is <i>greater than</i> \$1,750, enter \$1,750 here. 		\$ _____ (Subtotal cannot be greater than \$1,750)

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

Column 1	Column 2	Plus Plan
Prescription Medications		
Did you purchase prescription medications at a retail pharmacy?	YES NO	\$ _____ (If Column 2 is YES, enter \$50 [the maximum deductible])
Enter the number of generic prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) × \$5 = \$ _____
Enter the number of formulary brand-name prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) × \$25 = \$ _____
Enter the number of non-formulary brand-name prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) × \$40 = \$ _____
Enter the number of generic prescriptions (including refills) purchased through mail order.		(Column 2) × \$12 = \$ _____
Enter the number of formulary brand-name prescriptions (including refills) purchased through mail order.		(Column 2) × \$60 = \$ _____
Enter the number of non-formulary brand-name prescriptions (including refills) purchased through mail order.		(Column 2) × \$100 = \$ _____
Prescription Subtotal		\$ _____ (Sum of amounts above)
TOTAL (Add the Medical Subtotal from the previous page and the Prescription Subtotal from this page.)		\$ _____ (Sum of both Subtotals)

*Does not apply to plans without the pharmacy option.

Open Enrollment

Use this worksheet for medical expenses under the Premium Plan.

Column 1	Column 2	Premium Plan
Medical Services	Enter the number of times you received the services in Column 1 in the last year.	
Hospital admissions where a Medicare Part A deductible was applied		\$0
Number of days beyond 21 in a skilled nursing facility		\$0
Number of office visits to a provider (physician or other provider)		(Column 2) × \$15 (the maximum copay) = \$ _____
Number of outpatient surgeries or services you had (include day surgeries, chemotherapy treatment visits, etc.)		(Column 2) × \$175 (the maximum copay) = \$ _____
Estimate the amount (in dollars) Medicare said you owed for physician care when you were in the hospital in 2006		(Column 2) × 20% = \$ _____
Other		\$ _____
Preliminary Subtotal		\$ _____ (Sum of amounts above)
Medical Subtotal		
<ul style="list-style-type: none"> If the Preliminary Subtotal is <i>less than</i> \$1,500 (the out-of-pocket maximum), enter the Preliminary Subtotal here. If the Preliminary Subtotal is <i>greater than</i> \$1,500, enter \$1,500 here. 		\$ _____ (Subtotal cannot be greater than \$1,500)

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

Column 1	Column 2	Premium Plan
Prescription Medications		
Did you purchase prescription medications at a retail pharmacy?	YES NO	\$ _____ (If Column 2 is YES, enter \$50 [the maximum deductible])
Enter the number of generic prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) × \$5 = \$ _____
Enter the number of formulary brand-name prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) × \$25 = \$ _____
Enter the number of non-formulary brand-name prescriptions (including refills) purchased at a retail pharmacy.		(Column 2) × \$40 = \$ _____
Enter the number of generic prescriptions (including refills) purchased through mail order.		(Column 2) × \$12 = \$ _____
Enter the number of formulary brand-name prescriptions (including refills) purchased through mail order.		(Column 2) × \$60 = \$ _____
Enter the number of non-formulary brand-name prescriptions (including refills) purchased through mail order.		(Column 2) × \$100 = \$ _____
Prescription Subtotal		\$ _____ (Sum of amounts above)
TOTAL (Add the Medical Subtotal from the previous page and the Prescription Subtotal from this page.)		\$ _____ (Sum of both Subtotals)

*Does not apply to plans without the pharmacy option.

Open Enrollment

Step 2: Think, Review, and Decide

When deciding whether to purchase or enroll in a Medicare supplement plan, you should think about benefits you may need in the future and your financial situation. Consider your individual medical history, your family medical history, and your health risks when thinking about future health care costs.

Remember that these Plans offer several core benefits to supplement what Medicare provides, including:

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

If you have questions about these plans and want to be sure you understand the benefits, please call Customer Engagement toll-free at (866) 273-4545.

Step 3: Choose Your Medicare Supplement Plan

By now you have had a chance to review the benefits offered through these plans. You should have a sense of what your out-of-pocket costs would be under each plan.

Now it's time to choose the Medicare supplement plan that is best for you. But, before you make your final choice, make sure:

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

Step 4: Choose Your Dental Plan

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

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

Step 5: Complete and Return Your Form

Please remember to submit your form to the Medical Trust by December 31, 2008. You may also access your personalized enrollment form online by using the username and password in your enrollment welcome letter.

You do not need to submit your enrollment form unless you want to update your personal information, change your Medicare supplement or dental plan, or enroll with the Medical Trust for the first time.

Please remember that when enrolling, you may choose a different Medicare supplement plan each year or waive coverage. As your health care needs change, you will be able to change your plan choices during each annual open enrollment period.

Administrative Information

Enrollment and Significant Life Events

You are allowed to change your enrollment elections during a benefit year if you have a **significant life event** by notifying your group/diocesan administrator or the Medical Trust within 30 days of the event and completing and returning any required forms. Your change in enrollment must be consistent with your **significant life event**. A **significant life event** may be:

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

Pre-Existing Conditions

Unlike other Plans, pre-existing conditions do not apply for these plans. This means that the Medical Trust will not require you to submit a doctor’s note or any statements from previous health plans explaining your health status.

Your Costs for the Medicare Supplement Plans

This Guide can't tell you definitively how much you will have to pay for the Plans. The full cost per person per month for Plans *with prescription drug benefits* are as follows:

- Comprehensive Plan = \$265
- Plus Plan = \$340
- Premium Plan = \$375

The full cost per person per month for Plans *without prescription drug benefits* are as follows:

- Comprehensive Plan II = \$135
- Plus Plan II = \$155
- Premium Plan II = \$190

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

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

You will need to contact your diocese or former employer to determine what portion, if any, they may pay on your behalf.

When you enroll in one of the Medicare supplement Plans, the Medical Trust will charge you, your former employer, or The Church Pension Fund a monthly premium. Your coverage will continue, as long as the premium is paid. This premium is different and separate from the Medicare Part B premium. You must also pay your monthly Medicare Part B premium (and, if you have enrolled in a separate Medicare Part D prescription drug plan, your monthly Medicare Part D premium).

Comparing the Cost of a Medicare Supplement Plan With a Medigap Policy

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

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

The cost of the Medical Trust's Medicare supplement plans does not vary based on any of these factors.

Administrative Information

Your Costs for the Dental Plans

The per person per month cost for the three dental plans is as follows:

- Dental & Orthodontia = \$63
- Basic Dental = \$49
- Preventive Dental = \$23

Again, we cannot tell you how much you will have to pay for a dental plan. Your former employer may pay for this coverage. In addition, if you do not need a Medicare supplement plan from the Medical Trust (e.g., you have TRICARE from the federal government) and you qualify for assistance from The Church Pension Fund, you may apply the assistance subsidy toward a dental plan.

Billing

You have several options for how to pay for your Plans.

If your former employer or the diocese from which you retired subsidizes any portion of your premium, the bill for your premium may be sent directly to them. In some cases, you may be billed and your diocese/former employer may reimburse you.

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

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

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

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

Pension Check Deduction Policy for 2009

If you are enrolling with the Medical Trust for the first time and if you choose to pay for your Plan via pension check deduction, you will be required to submit a personal check or money order for the first two months of coverage. This will ensure that your pension check deduction process is set up correctly beginning with the third month of coverage.

ID Cards for 2009

Coventry—You will only receive a new ID card if you are signing up for the first time. If you switch from one plan to another (e.g. from the Comprehensive Plan to the Premium Plan), you will not receive a new ID card.

Medco—You will only receive a new ID card if you are signing up for the first time. If you switch from one plan to another (e.g. from the Comprehensive Plan to the Premium Plan), you will not receive a new ID card.

EyeMed—You will only receive a new ID card if you are signing up for the first time.

HearPO—No ID card is provided or needed to access benefits.

CIGNA Dental—You will only receive a new ID card if you are signing up for the first time or if you switch from one plan to another (e.g. from the Comprehensive Plan to the Premium Plan).

Health Advocate—You will receive a brochure containing contact information with your Medicare Supplement handbook.

Employee Assistance Program—You will receive a brochure containing contact information with your Medicare Supplement handbook.

Administrative Information

Coordination of Medical Benefits

If you enroll in a Medicare supplement plan, Medicare is your primary plan. When you receive health care, Medicare is responsible for determining how much it will pay. The Medicare supplement plans are secondary, picking up some of the costs where Medicare leaves off.

If you are enrolled in Medicare but are still working and are eligible for health benefits from your employer, your active health benefits plan from your employer is your primary plan, and Medicare is your secondary plan. So, you may not need a Medicare supplement plan. Contact Customer Engagement at (866) 273-4545 if you have any questions.

Member Services

The Medical Trust has a dedicated Post-Retirement Health Benefits Customer Engagement Team to help you with any questions you may have about these health plans.

Customer Engagement can:

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

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

Glossary

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

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

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

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

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

Brand-Name Drug. A drug advertised and sold under its protected trademark.

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

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

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

Coordination of Benefits. An insurance provision regulating payments to eliminate duplicate coverage when a beneficiary is covered by multiple plans. The provision prevents double payment by making one insurer the primary payer and ensuring that not more

Glossary

than 100% of the cost is covered. Standard rules determine which of two or more plans pays its benefits first (primary payer) and which becomes the supplementary payer (secondary payer) on a claim.

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

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

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

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

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

Formulary. A list of prescription medications that are preferred by a pharmacy benefit manager or health plan. The medications are selected based on their clinical effectiveness and the opportunities to help contain a health plan's costs. Formulary lists are usually subject to periodic review and modification.

Generic Drug. A drug that by law must have the same active ingredients as the brand-name drug it replaces. Generics typically cost less than brand-name drugs and, according to the FDA, are just as safe and effective as brand-name drugs. The FDA regulates generic drugs to ensure that they meet rigid standards of quality.

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

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

Mail-Order Pharmacy. A pharmacy that fills prescriptions through the mail, often in greater quantities and at a lesser cost than retail pharmacies. Many mail-order pharmacies are affiliated with health plans.

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

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

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

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

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

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

Medicare Part D. See definition for Medicare Prescription Drug Plan.

Medicare Prescription Drug Plan. A stand-alone drug plan, offered by insurance and other private companies to add prescription drug coverage to the Original Medicare Plan, Medicare Private Fee-for-Service Plans that don't have prescription drug coverage, and other types of Medicare health plans. Also known as Medicare Part D.

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

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

Non-Formulary Brand-Name Drug. A medication not on a health plan's formulary.

Glossary

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

Original Medicare. *Also known as “Traditional Medicare.”* The federal health insurance program, created in 1965, under which the government pays providers directly for each service a person receives (on a fee-for-service basis). About 89 percent of the Medicare population is enrolled in Original Medicare, as opposed to a private Medicare plan (HMO, PPO).

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

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

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

Prescription Drug Plan. Part D prescription drug coverage that is offered to beneficiaries enrolled in Medicare fee-for-service by a plan sponsor under a contract with CMS. A PDP sponsor may offer more than one prescription drug plan.

Prescription Drug Plan Region. A geographic area in which a Part D drug plan provides access to covered Part D drugs. CMS has established 26 Medicare Advantage regions and 34 prescription drug plan regions.

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

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

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

Provider. An individual or facility offering health care services.

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

Secondary Payer. A health plan that pays costs not covered by the primary payer under coordination of benefits rules. The three main sources for secondary insurance are employers, privately purchased Medicare supplement plans, and Medicaid.

Significant Life Events. These include births, deaths of immediate family members, marriage, and divorce.

Skilled Care. Care that can be given only by, or under the supervision of, skilled or licensed medical personnel. Skilled care is medically necessary when it is provided to improve the quality of health care of patients and/or to maintain or slow the deterioration of a patient's condition.

Skilled Nursing Facility. A facility that provides skilled care that is usually not for acute (life-threatening) medical conditions.

Notes

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.

How to Contact Us

To enroll or ask questions about the benefit plans available to Episcopal Church retirees, contact your diocesan administrator or Customer Engagement at (866) 273-4545, Monday through Friday, from 8:30 a.m. to 5:30 p.m. EST.

Important Phone Numbers

Provider	Phone Number and Website
The Episcopal Church Medical Trust	(866) CPF-4545 ((866) 273-4545) www.cpg.org/healthcare Email: mtcustserv@cpg.org
Coventry HealthCare	(800) 398-5654 www.mycoventryhealth.com Access ID ECM
CIGNA Dental	(800) 244-6224 www.cigna.com
Medco	(800) 841-3361 www.medco.com
EyeMed Vision Care	(866) 723-0596 www.enrollwiththeyemed.com/access
HearPO	(888) 432-7464 www.hearpo.com
MEDEX Assistance Corporation	(800) 527-0218 (from U.S., Canada, Puerto Rico, Virgin Islands, and Bermuda) (410) 453-6330 (call collect) www.medexassist.com
Employee Assistance Program	(866) 395-7794 www.cignabehavioral.com
Health Advocate	(866) 695-8622 www.healthadvocate.com
Medicare	(800) 633-4227 www.medicare.gov
Social Security Administration	(800) 772-1213 www.ssa.gov

Please send payments to:

Episcopal Church Clergy & Employee
Benefits Trust (ECCEBT)
75 Remittance Drive, Suite #6109
Chicago, IL 60675-6109

Please send correspondence to:

The Episcopal Church Medical Trust
Post-Retirement Health Benefits
445 Fifth Avenue
New York, NY 10016



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New York, NY 10016