



The Board of Pensions
of the Presbyterian Church (U.S.A.)

Medicare

Supplement

A summary of the Medicare Supplement provided by
the Benefits Plan of the Presbyterian Church (U.S.A.)

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The **Medicare Supplement booklet** is a publication of The Board of Pensions of the Presbyterian Church (U.S.A.).

The Board of Pensions tries to ensure the accuracy of its publications. If any discrepancy exists between this booklet and the official Benefits Plan document, the official Plan document governs. Copies of the official Plan document are available from the Board of Pensions.

For information, assistance, or to request a publication or form, please call the Board of Pensions at 800-773-7752 (800-PRESPLAN) or visit www.pensions.org.

Introduction

If you meet eligibility requirements, you may subscribe for Benefits Plan Medicare Supplement Coverage.

This coverage supplements your Medicare Part A and Part B benefits and provides prescription drug benefits. **If you choose to subscribe for this Supplement, you should not enroll in a separate Medicare Part D drug program. See page 8 for a description of the Supplement drug benefits. Medicare is your primary coverage for hospital and non-drug services.**

The cost of the Medicare Supplement is subsidized by vacancy and post-retirement service dues. To be covered under the Medicare Supplement, you must enroll and pay your share of the cost each month to the Board of Pensions through a deduction from your pension benefit or as a direct payment.

The complete terms of the Medicare Supplement are set forth in the *Benefits Plan of the Presbyterian Church (U.S.A.)*. Copies are available at Pensions.org or from the Board of Pensions on request.

If you are eligible and wish to subscribe to the Medicare Supplement, please complete the Medicare Supplement Subscription, Waiver, or Withdrawal form, and send it to:

The Board of Pensions of the Presbyterian Church (U.S.A.)
Pension Specialist
2000 Market Street
Philadelphia, PA 19103-3298

If you have questions, need additional information, or want to request forms, please call 800-773-7752 (800-PRESPLAN).

You may also access information and download forms at Pensions.org.

Medicare Supplement

Eligibility

If you do not subscribe for Medicare Supplement coverage when it is first offered to you, you may not be eligible to subscribe later. (Some members may be eligible to waive coverage while preserving their rights to enroll later; see page 2.) You must continue full Medicare coverage (Medicare Part A and Part B) to remain eligible for the Medicare Supplement.

You may be eligible for Medicare Supplement coverage if you:

- are a retired Plan member, spouse, surviving spouse, or ex-spouse
- have participated in the Benefits Plan for at least five years
- are enrolled for Medical Plan coverage under the Benefits Plan or in the Medical Continuation program, as a retiree continuously up to the date you become eligible for Medicare, or have an approved waiver on file, and
- are enrolled in Part A and Part B of Medicare on the proposed effective date of your Medicare Supplement coverage

You are eligible for Medicare benefits as of your 65th birthday. However, a member or spouse born after 1937 will not be eligible to receive 100% of Social Security retirement benefits at age 65; that eligibility date is extended with the length of the extension increasing for every year of birth beyond 1937.

If you retire but defer receipt of your Social Security retirement income until you are eligible for a 100% benefit, your cost to participate in Medicare Part B in the interim cannot be deducted from your monthly Social Security payment, and must be sent to Social Security.

How to Enroll

To transfer your coverage from the Medical Plan or Medical Continuation program to the Medicare Supplement, complete the Medicare Supplement Subscription, Waiver, or Withdrawal form and return it to the Board of Pensions.

You also should contact your local Social Security office (800-772-1213 or www.ssa.gov) to request a copy of the current *Medicare & You* handbook. It provides detailed information about how traditional fee-for-service Medicare (Part A and Part B) works, as well as the rules for electing a Medicare managed care option under Medicare Advantage. A retired member or spouse who has not yet reached age 65 may enroll in the Medical Continuation program and be eligible to be covered by the Preferred Provider Organization (PPO) provisions of the Medical Plan. (The Anthem Blue Preferred® HMO option remains available to members residing within the geographic boundaries of the Presbytery of Mid-Kentucky. Members in Puerto Rico not yet eligible for Medicare continue to receive their benefits through Triple-S.)

Subscription

If you receive a pension benefit, the Board of Pensions will deduct the Medicare Supplement monthly per-person subscription charge from it. If your benefit does not cover the full subscription cost, the Board will invoice you. You, together with your spouse and your dependent children, can purchase family coverage at the cost of a maximum of two subscription charges. The two subscriptions may combine the Medical Continuation program and the Medicare Supplement.

- If you and your spouse are both eligible for Medicare, your monthly subscription (dues) will be two Medicare Supplement subscription charges
- If you and your spouse are both eligible for Medicare but still have dependent children covered for medical benefits, the dues will be two subscriptions, one for the Medicare Supplement and one for Medical Continuation.
- If you are eligible for Medicare but your spouse is not Medicare-eligible, the dues will be for two subscriptions: one for the Medicare Supplement and one for Medical Continuation, regardless of whether or not eligible dependent children also are enrolled for coverage.

If you are invoiced directly, you are billed for subscription dues in advance with payment being due within 30 days of the invoice date. For example, the January bill would be for February coverage. If you do not include an initial payment with the subscription form, the first bill will be for two months.

Payment activates eligibility; the Board cannot reimburse members for medical expenses incurred or verify eligibility for coverage for any period for which the Board has not yet received payment.

When we receive your full monthly subscription dues, we extend eligibility for the period for which you paid. If we do not receive your payment by the due date, your coverage will be temporarily suspended. Members whose claims are denied during a period of non-payment may resubmit their claims when coverage is reinstated. Paying the full account balance within 30 days of the due date reinstates coverage. If we do not receive your payment by that time, the coverage is terminated with no option for reinstatement.

Visit Pensions.org or call call 800-773-7752 (800-PRESPLAN) for information on current subscription rates.

Waiver of Continuous Coverage Requirement

In general, to participate in the Medicare Supplement, you must participate in either the Medical Plan or the Medical Continuation program continuously until the date of retirement. The continuous coverage requirement may be waived for an otherwise eligible member. (See Eligibility, page 1, for other eligibility requirements.)

To qualify for the waiver provision of the Medicare Supplement, the member must be a retired or terminated vested member who satisfies the “Rule of 70” eligibility requirements and is protected by other employer-sponsored group medical coverage (active or retired). The waiver is available to the member and/or the member’s spouse.

To satisfy the “Rule of 70,” a member must be at least 55 years of age at termination of service and have a minimum of five years of Plan participation.

The sum of the years of Plan participation and age must equal 70 or more at the time active coverage ends.

If the member wants to waive the continuous coverage requirement at age 65, the member must complete and return the subscription form, completing the waiver section in which he or she certifies that group medical coverage is available through another employer, including through the Benefits Plan of the Presbyterian Church (U.S.A.) if covered as the spouse of a member.

If a member files for a waiver of the continuous coverage requirement when eligible for the Medical Continuation program, that waiver remains in force when becoming eligible for the Medicare Supplement, provided the employer-sponsored group coverage is still in place.

If you lose that employer-sponsored medical coverage because:

- your spouse dies or retires,
- an employer discontinues active or retired coverage, or
- your employment or your spouse’s employment terminates,

you and/or your spouse must notify the Board within 90 days of the qualifying event to be able to enroll in the Medicare Supplement. The Board will not require a health statement and places no limits on pre-existing conditions but you must participate in Medicare Part A and Part B to be eligible for the Medicare Supplement.

Continuing Your Medicare Supplement Participation

Your benefits continue as long as this coverage is available and you make timely payments for the subscription charges.

You may cancel your coverage. Once you have done so, you cannot reinstate it unless the cancellation and reinstatement are under the terms of the Medicare Advantage option (see page 16). The Board must receive a written request from you at least one month in advance of the date you want your coverage to cease to allow time to terminate the deductions from your pension benefit payment.

Should you die while covered under the Medicare Supplement, your surviving spouse and/or dependent children may continue coverage by paying the monthly subscription charges for the Medicare Supplement or Medical Continuation, as appropriate. If not yet eligible for Medicare, your surviving spouse can subscribe to receive coverage under the Medical Continuation program until he or she becomes eligible for Medicare. Then he or she may subscribe to the Medicare Supplement if he or she has maintained continuous coverage under Medical Continuation or has an approved waiver on file, and is participating in Medicare Part A and Part B. Visit Pensions.org or call 800-773-7752 (800-PRESPLAN) to request information on the Medical Continuation program.

Should you divorce while covered under the Medicare Supplement, your ex-spouse and eligible dependents may continue coverage by paying the monthly subscription charges for the Medicare Supplement or Medical Continuation as appropriate. Enrollment must take place within 90 days of the divorce and the subscription charge starts the day after the effective date of the divorce. There is no free coverage available to ex-spouses or eligible dependents since the member received 30 days of free coverage upon retirement or termination from service. The Board must receive a copy of the divorce decree.

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

Benefits Overview

Your Medicare Supplement benefits cover a wide range of medical services and supplies. After Medicare pays its share, you receive reimbursement from the Medicare Supplement based on Medicare's allowance for any balance remaining; the reimbursement rate depends on the type of medical expense.

The Medicare Supplement reimburses you only after Medicare has paid its portion of medical charges and you have incurred sufficient covered medical expenses to satisfy your deductible. This also applies to a Medicare-eligible spouse or permanently disabled child who has Medicare coverage.

All medical treatment, services, and supplies must be medically necessary. Medically necessary services and supplies are:

- provided or prescribed by a licensed hospital or physician
- appropriate to the symptom and diagnosis or treatment plan
- not custodial or for the convenience of the patient or provider
- not educational, experimental, or investigative in nature
- of demonstrated medical value
- the most appropriate standard or level of services

Benefits are not paid for charges above the amounts Medicare approves. Most insurance companies and third-party claims payers use these allowances, and physicians generally accept them as payment in full. Charges above these amounts are not credited toward your maximum copayment limit. The Board of Pensions may pay as primary if eligible Medicare benefits have been denied or exhausted; for example, for intravenous therapy at home, or services received while traveling (not residing) outside the U.S. For any expense to be paid, a Medicare Explanation of Benefits (EOB), even if it is only a denial, must be submitted with the claim.

Covered Expenses

100% without deductible for:

- annual physical, up to \$125 annually. You must first present your bills to Medicare and submit a Medicare EOB before your claim will be paid because Medicare now covers certain preventive services.
- second surgical opinions. You must submit a Medicare EOB.

After you have satisfied the deductible and Medicare has paid, the Medicare Supplement covers 100% of pre-admission testing and 80% of covered charges for:

- hospital/surgical expenses, semi-private accommodations, intensive care, and additional medically necessary services and supplies
- Medicare Part A and Part B deductibles
- physicians' fees, inpatient and outpatient surgery (see Services and Supplies Not Covered, page 7)
- inpatient and outpatient psychiatric treatment, subject to maximum reimbursement limits described on page 7
- home healthcare for up to 100 visits in a calendar year by a Medicare-certified agency, including nursing care and physical, occupational, or speech therapy, home health aide services (for non-custodial services), necessary medical equipment, and other prescribed supplies
- Extended Care Facility or a Skilled Nursing Facility for 180-day lifetime limit. Admission must be within 14 days of discharge following at least a three-day hospital confinement. Reimbursement for medical costs will not exceed 50% of the hospital daily room rate for the prior stay
- hospice for 180-day lifetime limit. Reimbursement for medical costs will not exceed 50% of the hospital daily room rate for the prior stay
- 90-day lifetime limit for inpatient substance abuse treatment
- mammograms and pap smear screenings
- private nursing charges up to \$100 a day except in a facility offering intensive care services
- diagnostic expenses, including x-rays and lab tests, and physicians' fees for interpretation
- durable medical equipment rental or purchase (at the Board's discretion)

- services provided by a licensed podiatrist for diagnosis, treatment, and surgery
- foot orthotics prescribed for treatment of metabolic peripheral vascular disease or other medical conditions
- complete eye examination by an ophthalmologist or other M.D. for diagnosis or treatment of a medical condition
- drugs and medications (prescription drug costs are covered under the Express Scripts® program, see page 8)
- X-ray, radium, and isotope therapy
- anesthetics and their administration
- medical and surgical equipment rental
- casts, splints, trusses, braces, crutches, and surgical dressings
- blood and blood plasma
- artificial limbs and eyes
- ambulance services

Annual Deductibles

For Medicare Supplement coverage, each subscriber’s deductible is \$254 (0.5% of the annual churchwide median salary for pastors serving churches). Each subscriber pays a separate \$100 prescription drug deductible **that is not credited against the medical deductible**. If you enroll for coverage for your spouse and/or dependent children, you have one additional annual medical deductible and one additional prescription drug deductible for your family.

If your spouse is under age 65 and/or you have dependent children, and you subscribe for Medical Continuation coverage for either your spouse and/or dependent children, their deductible and copayment maximum for medical coverage will be based on the annual churchwide median salary. If both your spouse and children are enrolled, they share one deductible and one copayment maximum. The covered services under the Medical Continuation program remain the same as those for members enrolled under the PPO (Preferred Provider Organization) provisions of the Medical Plan. (See the current *Healthcare Coverage* booklet.)

In the calendar year that you and/or your spouse transfer from the active Medical Plan or the Medical Continuation program to Medicare Supplement coverage, the amounts you’ve paid toward your **deductibles and copayment maximums are credited to your Medicare Supplement requirements.**

The prescription drug benefit is subject to different deductibles, copayments, and copayment maximums. (See page 8 for further information.)

A child who loses dependent status while covered under the active plan and is eligible for continued coverage has his or her own subscription charge and separate deductible and copayment maximum limits. The medical claims and cost-sharing amounts for this child are not counted toward the family limits.

Annual Maximum Cost-Share by Individual

An individual has reached the maximum non-drug limit when the total of the deductible and the required 20% copayments exceeds 4% of the annual churchwide median effective salary for pastors serving churches. (The maximum annual copayment per person for the prescription drug program is \$2,000, including the \$100 deductible; the maximum annual copayment maximum for Medicare Supplement in 2009 is \$2,032. After you reach your maximums, the Plan pays 100% of eligible drug or medical expenses, as appropriate, for the remainder of the calendar year.)

While Traveling Outside the United States

When members participating in the Medicare Supplement are traveling outside the U.S. and need services, the Board provides primary coverage since Medicare does not.

The Board of Pensions contracts with International SOS to provide assistance to Medicare Supplement subscribers traveling overseas.

Please see our Web site at Pensions.org or contact Member Services at 800-773-7752 (800-PRESPLAN) for more information.

The Medicare Supplement does not cover services for retired persons choosing to reside outside the U.S.

How to File a Claim

All your claims other than for prescription drugs should be submitted first to Medicare because it is your primary coverage.

Medicare will process your claim and then file your claim electronically with the Board's claim administrator (Highmark Blue Cross Blue Shield) for secondary processing under the Medicare Supplement.

Do not mail medical bills directly to either Highmark or the Board for processing before they have been submitted to Medicare.

For any Medicare Supplement claim that is not electronically filed, send the claim with its Medicare EOB (Explanation of Benefits) to:

Highmark Blue Cross Blue Shield
Fifth Avenue Place, 120 Fifth Avenue
Suite 1336
Pittsburgh, PA 15222-3099

You will still experience out-of-pocket costs because the Medicare Supplement pays for some, but not all, of your cost-share with Medicare. Also, if you or a covered dependent receives reimbursement from another source for medical expenses for which the Medicare Supplement already has paid, you must reimburse the claim administrator (Highmark BCBS).

If your spouse and/or other dependent is in the Medical Continuation Program, refer to the instructions outlined in the current *Healthcare Coverage* booklet.

Claim Year

The claim year is based on a calendar year from January 1 through December 31.

Filing Deadline

Subscribers must submit all claims within 12 months of the date they are incurred (as shown on their Medicare EOB), unless the subscribers are able to show that an earlier filing was not possible.

Direct Assignment

Under Medicare, a beneficiary usually assigns to the provider the right to receive reimbursement for medical expenses. In accepting the assignment, the provider agrees to accept the amount Medicare allows for a service as payment in full, and the beneficiary will not be charged for any difference other than the required cost-share. That cost-share will be based on the Medicare allowance. As long as you have satisfied your deductible and assigned your benefits, the hospital, doctor, or other health-care provider will be paid directly by both Medicare and Highmark.

Identification (ID) Cards

Each individual covered under the Medicare Supplement, whether member or spouse, will receive an ID card from Highmark with his or her name and a unique member ID. The prefix PPN will appear in front of this number.

Please note that when the member is covered under the Medicare Supplement and the spouse has Medical Continuation coverage, each will receive an ID card with the member's name and a unique member ID. The member will receive the Medicare Supplement ID card with the prefix PPN, and the spouse will receive a Medical Plan ID card with the prefix PBM.

In cases where the member is retired and is covered under the Medical Continuation program and the spouse is covered under the Medicare Supplement, each will receive a card with his and her own name and a unique member ID. The member's card will have the prefix PBM, and the spouse's card will have the prefix PPN.

Services and Supplies Not Covered

Even if provided or ordered by a physician, charges for these services and related supplies are not covered:

- medical services provided by United States government facilities or received elsewhere, for which the member is not legally obligated to pay
- services of a provider that has elected not to participate in Medicare Program
- dentures, dental X-rays, or dental services (including orthodontic services related to a covered medical cost) except for services related to the removal of bony, impacted wisdom teeth, injury to sound natural teeth, and treatment for TMJ. (Benefits for TMJ-related services are limited to a \$500 lifetime maximum.)
- eyeglasses or vision care, except for temporary and initial permanent corrective lenses needed following a cataract operation or for diagnosis or treatment of a medical condition. (A discount program is available.)
- hearing aids and hearing aid fittings. (A discount program is available.)
- cosmetic surgery or treatment (except reconstructive surgery following a mastectomy, after an accident, or to correct a congenital anomaly)
- services payable under any Workers' Compensation Law or similar legislation
- services for which payment is not actually required
- experimental or investigative medical treatment
- custodial care
- reversal of a previous sterilization procedure for either sex, unless the initial sterilization was required by accident or disease
- radial keratotomy (and similar laser surgeries)
- services or supplies for personal hygiene, comfort, or convenience
- medical reports or telephone consultation charges
- charges for services rendered by a person who ordinarily resides in a member's home or who is related to the patient, including parents or children, siblings, or spouses, whether the relationship is by blood or exists by law
- orthopedic and podiatric foot care charges for treatment or supplies for weak, strained, flat, unstable, or unbalanced feet, metatarsalgia or bunions, removal of corns, calluses, or toenails. Charges for orthopedic shoes or orthopedic prescription devices to be attached to or placed in shoes, unless prescribed for treatment of metabolic, peripheral-vascular disease, or other medical conditions
- non-emergency hospital admissions on a Friday or a Saturday, unless surgery is performed within 24 hours of admission
- acupuncture services unless performed by a licensed physician
- marital counseling services
- private duty nursing in a facility offering intensive care services or in excess of \$100 per day
- expenses for maintenance of durable medical equipment. The Plan provides coverage for the rental and purchase of durable medical equipment, but does not reimburse expenses for its routine maintenance and repair
- treatment of a pre-existing condition for first 12 months of coverage unless credit is available from prior continuous coverage

Maximum Reimbursement Limitations

Expenses that the Plan does not cover or for which you are responsible are not credited to the annual maximum limit.

The maximum amount of benefits payable during the lifetime of each covered individual is \$3,000,000. Annually on January 1, the Plan reinstates the lesser of \$5,000 or the amount of benefits paid the prior year toward the lifetime maximum. Benefits received while active or while covered by Medical Continuation count toward the lifetime and other maximum limits.

Maximum reimbursement limitations include:

- \$50,000 annually, \$200,000 lifetime for inpatient mental health/substance abuse treatment
- \$2,000 annually for outpatient mental health/substance abuse treatment. Office visits to a physician solely for medication management with no counseling are not counted toward the \$2,000 limit.
- \$2,000 annually for adjustment and manipulation of the spinal column and associated nervous system

- \$500 lifetime benefit per person for temporomandibular joint dysfunction (TMJ) treatment
- 180 days per lifetime for extended care facilities
- 180 days per lifetime for hospice care (in a facility or at home)
- 100 visits, of up to 8 hours each, annually, for home healthcare
- 90 days per lifetime for substance abuse treatment facility. Hospitalization for medically necessary detoxification treatment is not counted toward the lifetime substance abuse limit.

Prescription Drug Program through Medicare Supplement

Express Scripts,[®] the Medical Plan's pharmacy benefits manager, also administers the Prescription Drug Program for Medicare Supplement participants. It offers a network of participating providers (including a mail service pharmacy), maintains a formulary of preferred prescription medications, and processes claims.

To maximize your benefits under this program:

- use your Express Scripts ID card
- fill your prescriptions at pharmacies participating in the Express Scripts network or through the mail order service
- advise your physicians of the Plan's drug formulary
- ask for and take generic medications where appropriate and available

Each subscriber for Medicare Supplement must meet a \$100 annual deductible in 2009; your copays will be based on the schedule (found on the next page). If your spouse and/or children are covered under the Medical Continuation Program, a separate family deductible and copayment maximum apply.

Once you meet your individual \$2,000 Prescription Drug Program annual copayment maximum, including the deductible, the Plan pays your eligible prescription charges at 100% for the remainder of the calendar year, provided that the prescriptions are filled by Express Scripts pharmacies, they are formulary medications, and you use the Express Scripts card each time. Copays for brand name non-formulary drugs do not count toward the \$2,000 maximum and are still required even if the maximum is satisfied by the copays for generic and brand name formulary medications.

You may call Express Scripts for information about participating pharmacies at 800-344-3896 or visit www.express-scripts.com. Reimbursement for prescriptions filled by **non-participating** pharmacies is limited to participating pharmacy rates, and you may be responsible for out-of-pocket costs in addition to your applicable copay. For reimbursement of expenses incurred at non-participating pharmacies, call Express Scripts for claim forms and file your claims directly with Express Scripts.

Prescription Drug Program

Through Express Scripts, Plan members can obtain the medications they require to treat an illness or ongoing condition. Express Scripts offers a network of participating providers (including a mail service pharmacy), maintains a formulary of preferred prescription medications, and processes claims.

When a generic equivalent is available, the prescription drug program covers only the cost of the generic drug. If a Plan member purchases a brand name drug when a generic is available, he or she will pay the brand name, non-formulary copay plus the full cost difference between the brand name drug and the generic drug. The additional cost does not count toward the copayment limit.

Maintenance Prescription Medications

Maintenance medications are prescription drugs that a patient takes regularly. These medications are often used to treat ongoing conditions, such as diabetes, high cholesterol, and high blood pressure.

Under the maintenance medication program, Plan members can fill a 30-day prescription at a local pharmacy up to two times before additional copayments — \$5 for generic drugs, \$10 for brand name formulary drugs, and \$15 for brand name non-formulary drugs — are incurred. Ordering maintenance medications through Express Scripts Home Delivery not only allows members to avoid these additional charges, but provides them a 90-day supply of maintenance drugs usually for a lower copay than would be charged at retail pharmacies for the same quantity.

2009 Prescription Drug Benefits (after deductible¹ is satisfied)

| Type of Drug | Retail, a month ^{2,3} | | | Mail, 90-day | | |
|---|--------------------------------|---------------|---------------|----------------------|---------------|---------------|
| | Copay % ⁴ | Minimum copay | Maximum copay | Copay % ⁴ | Minimum copay | Maximum copay |
| Generic | 20% | \$10 | \$100 | 20% | \$25 | \$300 |
| Brand Name Formulary | 30% | \$20 | \$100 | 30% | \$50 | \$300 |
| Brand Name Non-Formulary⁵ | 40% | \$40 | \$100 | 40% | \$100 | \$300 |

1 Deductibles—\$100 for member and \$100 for family (applies to all other family members combined); \$100 for each subscriber to Medicare Supplement
 2 Lesser of 34 days or 100 units
 3 Plus surcharge for designated maintenance drugs, which does not count toward copayment maximum
 4 The percentage member pays of pharmacy or mail order allowed charge; subject to minimum and maximum amounts
 5 These do not count toward copayment maximum of \$2,000 for member or member and family, excluding deductibles; \$2,000 for each subscriber to Medicare Supplement, including deductible

Step Therapy

Step therapy is a program that can make prescription drugs more affordable for most Plan members and their families. In step therapy, the covered prescription drugs are organized in a series of steps, beginning with proven, cost-effective drugs, usually generics. These drugs have been approved by the FDA and have a history of successfully treating many medical conditions. More expensive drugs are then used only in the few situations where the generics fail to deliver the desired outcomes.

Prior Authorization

When prior authorization is required, it means that more clinical information is needed about a patient's particular medical condition before Express Scripts can confirm the medical necessity for the recommended prescription. A doctor, someone from the doctor's office, or nurse can provide that information and request a prior authorization. The goal is to ensure patients receive appropriate medications for their diagnoses.

Specialty Medications

Specialty medications — typically used to treat complex conditions — often have product handling and distribution requirements, and now need to be filled by Curascript, the Plan's exclusive specialty pharmacy. High-cost injectable or oral medications are considered specialty medications. Call Express Scripts at 800-344-3896 for information.

Additional Information

For more information, members can call Express Scripts at 800-344-3896 or visit www.express-scripts.com, where they can:

- make payments
- get statements
- order and track refills
- view a personal prescription history
- estimate out-of-pocket prescription drug costs
- review benefit details, including the formulary
- read health and drug information
- find a participating pharmacy
- learn about mail order pharmacy services for maintenance drugs

Members may also learn more about their prescription drug benefit by visiting the Board of Pensions Web site at Pensions.org. There, they can view the full formulary or learn about:

- Step therapy
- Prior authorization
- Rx updates
- Plan limitations

The Prescription Drug Program has a three-tier copay design with differing copays for generics, brand name formulary drugs, and brand name non-formulary drugs. By paying a higher copay for a non-formulary drug (see chart on page 9), you can obtain that drug without having to submit medical necessity documentation for prior approval (unless the drug has specific prior authorization requirements). With this approach, you can purchase a non-formulary drug if you believe it is worth the additional out-of-pocket expense. A copay for a non-formulary drug does not go toward satisfying the copayment maximum. When use of a non-formulary drug is demonstrated to be medically necessary, the Board grants approval for its use, and the copay will be at the formulary rate and count toward the copayment maximum.

Upon the advice of Express Scripts, the Board also may set rules about the use of prescription drugs. For example, it may set drug-specific quantity limits or require pre-authorizations for certain medications, including a requirement that other therapies are tried first. Call Express Scripts to find out if particular limitations apply to the medication you are prescribed.

Specialty medications that are typically used to treat complex conditions and often have product handling and distribution requirements now need to be filled at a specialty pharmacy. These medications include high-cost injectable or oral medications. Curascript (800-278-0980) is the Plan's exclusive pharmacy for these specialty medications. Call Express Scripts at 800-344-3896 for information.

Express Scripts administers the prescription drug benefit by processing claims and maintaining a drug formulary of preferred medications to help reduce costs. The complete drug formulary contains 95% of FDA-approved drugs, including all generics.

The formulary helps your physician prescribe cost-effective, quality medications and is updated regularly to add newly approved brand name and generic drugs. If your physician or pharmacist has questions, he or she may call Express Scripts at 800-344-3896. The Prescription Drug Program covers most prescription drugs, including injectables, approved for use by the FDA and prescribed by a licensed provider, dispensed by a licensed pharmacy, and deemed medically necessary by the Plan.

The Plan does not cover drugs/medications that:

- have no approved FDA indications
- have over-the-counter equivalents
- are appetite suppressants, smoking cessation products, or drugs prescribed for cosmetic purposes only (Note: smoking cessation products may be covered if you are enrolled in The Mayo Clinic Tobacco Quitline.)

Durable medical equipment is not covered under the prescription drug plan, but may be covered under the medical benefits. To confirm coverage, call 800-773-7752 (800-PRESPLAN).

FAQ

How can I make sure my prescription is covered?

If your physician is going to give you a prescription, ask him or her to write it according to the drug formulary so you can be reimbursed. Remember to have it filled at a participating pharmacy in the Express Scripts network and show your Express Scripts card when you purchase the prescription.

How can I find out about participating pharmacies or what drugs are on the drug formulary?

You can call Express Scripts at 800-344-3896 or visit Pensions.org.

What does my physician do if the drug he or she wants to prescribe is not on the formulary?

You may purchase the drug and pay the brand name non-formulary cost, or you may ask your physician to provide information about the medical necessity for use of the brand name non-formulary drug by calling Express Scripts at 800-344-3896.

If medical necessity is approved, you need only pay the brand name formulary copay. Check to make sure the drug is not subject to step therapy and/or preauthorization requirements.

What if my physician wants me to take a brand name drug instead of a generic one?

If your physician believes that this is medically necessary, he or she should contact Express Scripts at 800-344-3896 and speak to the Prior Authorization Unit. The physician will receive an FDA form that asks for detailed information about the negative results experienced with use of the generic medication. You also have the option to obtain the brand name by paying the full difference in cost, plus the generic copay.

What if my physician's request is denied?

Under the three-tier design, a member can pay a higher copay for a non-formulary drug (provided it is not subject to prior approval and/or step therapy limitations) without submitting medical necessity documentation for prior approval. With this approach, a member can purchase a non-formulary drug if he or she believes it is worth the additional out-of-pocket expense. As a Plan member, you have the right to file an appeal through the Board's Appeals Process.

Prescription Drug Coverage and Medicare

The Board of Pensions is encouraging Medicare Supplement subscribers to continue to use the prescription drug benefit that is part of the program rather than paying extra to subscribe to a separate Medicare-approved prescription drug plan.

If a Medicare Supplement subscriber joins a separate Medicare drug plan (Medicare Part D), that subscriber cannot take advantage of the prescription drug benefits under the Medicare Supplement, but the required subscription dues will remain the same.

For 2009, the monthly Medicare Supplement subscription dues will be \$194 for each subscriber.

Prescription drug benefits available through the Medicare Supplement program for the member and/or spouse can only be reinstated in the event

of involuntary loss of medical coverage (i.e., the Medicare Part D prescription drug plan or Medicare Advantage plan stops offering drug coverage).

Members must provide appropriate documentation from the Part D plan sponsor if it ceases offering prescription drug coverage.

Save the Notice

Benefits Plan members who are Medicare-eligible will receive an annual letter from the Board with an enclosure: the "Important Notice from the Board of Pensions About Your Prescription Drug Coverage and Medicare." Members need do nothing with this notice, other than keep it with their other medical papers. If you are Medicare-eligible and did not receive this federally required notice, please call the Board of Pensions.

The Medicare Supplement prescription drug coverage qualifies as "creditable coverage." That means it is, on average, at least as good as, and is, in fact, better than, standard Medicare prescription drug coverage.

Limited Income and Resources

The Federal government has designated some Medicare beneficiaries as having limited income and resources and thus eligible for extra help with drug costs under the Medicare prescription drug plan. If the government determines you are eligible, these special prescription drug plan provisions approved by Medicare will benefit you. The Board of Pensions encourages you to take advantage of them if you are notified of your eligibility.

If you are eligible for the extra help, you will not be eligible in 2009 for prescription drug coverage under the Medicare Supplement because you will be participating in the government program. For these members only, the Board is offering a different version of our Medicare Supplement that will supplement Medicare Parts A and B but exclude any prescription drug coverage. Please call the Board if you have been notified that you are to receive extra help to find out about this alternate benefit and the associated lower subscription dues.

Beware of Fraudulent Prescription Drug Plans

All Medicare beneficiaries, including members enrolled in the Benefits Plan Medicare Supplement coverage, may expect to receive many marketing and promotional communications from various Medicare prescription drug plans that have been authorized to offer services in their geographic areas.

The officials at CMS (Centers for Medicare and Medicaid Services) are concerned that there will be fraudulent activity associated with these marketing efforts.

Please be cautious and remember, never divulge personal information to anyone who calls or emails you, including your Social Security number, bank account information, or date of birth.

Medicare also does not permit its authorized programs to market door-to-door, selling the new prescription drug plans.

Federal authorities encourage you to report anything suspicious to them or police authorities.

Transition-Year Deductible and Copayment Requirements

The Medicare Supplement deductible is 0.5% of the churchwide median, and the copayment maximum is 4% of the same median. All examples exclude prescription drugs.

Example 1

Member medical deductible effective January 1, 2009, is \$310 with a separate deductible of \$310 for spouse (no eligible dependent children). Both the member and spouse transition to Medicare Supplement coverage on April 1, 2009, and neither had eligible expenses under the active Medical Plan. Effective April 1, 2009, the member and the spouse each have to meet a separate medical deductible of \$254. Then each has a copayment maximum of \$2,032, including the deductible, to satisfy before qualifying for 100% reimbursement of eligible expenses.

Example 1: Member and spouse transition to Medicare Supplement

| Out-of-Pocket Cost | Member | Spouse |
|---|---|---|
| Deductible–Active Medical Plan | No credited expenses under active Medical Plan. | No credited expenses under active Medical Plan. |
| Deductible–Medicare Supplement | Member must meet a deductible of \$254. | Spouse must meet a deductible of \$254. |
| Family Copayment Maximum–Active Medical Plan | No credited expenses while covered under active Medical Plan. | No credited expenses while covered under active Medical Plan. |
| Medicare Supplement Copayment Maximum | Member has a copayment maximum of \$2,032 to meet. The deductible counts toward this limit. | Spouse has a copayment maximum of \$2,032 to meet. The deductible counts toward this limit. |

Example 2

A member's medical deductible is \$350 effective January 1, 2009, with a separate deductible of \$350 for spouse (no eligible dependent children). Both the member and spouse transition to Medicare Supplement coverage on May 1, 2009. The member met \$100 of this deductible under the active Medical Plan; the spouse met the deductible of \$340.

The \$100 met toward the member's deductible under the active Medical Plan would be applied to the Medicare Supplement deductible and the member would have an additional \$145 to meet before the Medicare Supplement deductible would be satisfied; the spouse would have no additional deductible to meet under the Medicare Supplement benefit. Each of them must satisfy the copayment maximum of \$2,032, including the deductible, before qualifying for 100% reimbursement of eligible expenses.

Example 2: Member and spouse transition to Medicare Supplement

| Out-of-Pocket Cost | Member | Spouse |
|---|--|---|
| Deductible–Active Medical Plan | Member met \$100 of the active Medical Plan deductible of \$350. | Spouse met deductible of \$350 under active Medical Plan. |
| Deductible–Medicare Supplement | The \$100 accrued under the active Medical Plan will be subtracted from the \$254 Medicare Supplement deductible. The member will need to meet an additional \$154 in medical costs to satisfy the Medicare Supplement deductible. | Spouse does not have to meet the Medicare Supplement deductible of \$254. Deductible met under active Medical Plan. |
| Family Copayment Maximum–Active Medical Plan | Not met while covered under active Medical Plan. | Not met while covered under active Medical Plan. |
| Medicare Supplement Copayment Maximum | Member has a copayment maximum of \$2,032 to meet. The deductible counts toward this limit. | Spouse has a copayment maximum of \$2,032 to meet. The \$254 deductible counts toward this limit. |

Example 3

A member's medical deductible is \$555 effective January 1, 2009; there is a family deductible of \$555 for the spouse and one dependent child. The member transitions to Medicare Supplement, and the spouse and child will be covered under the Medical Continuation program. (The spouse is not yet age 65.) The member deductible has been met; \$300 has been met toward the family deductible under the active Medical Plan.

The member has no deductible to meet toward the Medicare Supplement deductible; the \$300 met toward the family deductible under the active Medical Plan will be applied to the Medical Continuation deductible of \$500, and an additional \$200 needs to be met for the Medical Continuation family deductible to be satisfied.

Example 3: Member transitions to Medicare Supplement and the spouse and dependent child transition to Medical Continuation

| | Member | Spouse and Children Family Deductible |
|--|---|---|
| Deductible–Active Medical Plan | Met deductible under active Medical Plan. | Spouse and children met \$300 of the active Medical Plan annual deductible of \$555. |
| Deductible–Medicare Supplement | Not required – met while covered under active Medical Plan. | Not applicable – spouse and children covered under Medical Continuation Program. |
| Deductible–Medical Continuation Program | Not applicable – Member covered under Medicare Supplement. | The \$300 accrued under the active Medical Plan will be subtracted from the \$500 Medical Continuation family deductible. The spouse and/or children need to meet an additional \$200 in medical costs to satisfy the Medical Continuation deductible for in-network providers. |
| Family Copayment Maximum–Active Medical Plan | Did not meet while covered under active Medical Plan. | Did not meet while covered under active Medical Plan. |
| Member Copayment Maximum–Medicare Supplement | Member must meet a copayment maximum of \$2,032. The \$254 deductible counts toward this limit. | Not applicable – spouse and children covered under Medical Continuation Program. |
| Family Copayment Maximum–Medical Continuation Program | Not applicable – member covered under Medicare Supplement. | Spouse and/or children need to meet a combined family copayment maximum of \$2,015 for in-network provider. The deductible does not count toward this limit. |

Appeals Procedures

If your claim for a benefit is denied, you receive written notice. The content of the notice depends on the type of claim or service, whether the claim has been incurred or the service is pending, and whether the denial comes from the Board or from one of its service providers (Highmark Blue Cross Blue Shield or Express Scripts). The notice may contain:

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

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

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

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

- requesting a claim review in writing
- submitting pertinent documents for review
- presenting issues and comments in writing

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

Board of Pensions Appeals Review Process

The final level of appeal is a review by the Board of Pensions Appeals Board. The Appeals Board is comprised of senior officers of the Board who are not responsible for routine determinations or operations management for the Benefits Plan. The decision of the Appeals Board is final and binding.

The Board of Pensions reserves the right to accelerate the review process to a higher level of appeal in any situation where the facts and circumstances call for such higher level of review to be expedited.

Plan Amendment or Termination

Although The Board of Pensions of the Presbyterian Church (U.S.A.) expects and intends to continue the Medicare Supplement indefinitely, it reserves the right to modify, terminate, or suspend the Medicare Supplement at any time and report such action to the General Assembly.

Medicare Managed Care (Medicare Advantage)

Medicare now allows beneficiaries to enroll in local Medicare HMOs or other Medicare managed care (Medicare Advantage) options rather than continue traditional Medicare Part A and Part B. If you are considering electing one of these options, contact a managed care provider in your area directly; the Board does not offer Medicare managed care options. The Medicare Supplement coverage available through the Board also does not provide supplemental coverage for Medicare Advantage plans. If you do enroll for a Medicare Advantage program, it replaces both Medicare Part A and B and the Medicare Supplement coverage is not available.

If you enroll in a Medicare managed care option, the federal government gives that organization a fee to cover the cost of providing all your health-care services. That fee varies based on Medicare experience by county. In some areas the managed care organization may offer extras like prescription drug coverage, vision, hearing, and even some dental benefits, subject to applicable premium requirements. The prescription drug coverage is usually subject to a separate annual limit, unlike the Board's Medicare Supplement. You will continue to have to pay a Part B premium. If the Medicare Advantage plan you choose is an HMO, you must access all care through physicians and other providers who participate with the managed care option you choose, and you need a referral from your primary care physician before you can consult a specialist. The advantages are that you have little or no paperwork and may only have to make modest copayments for services received rather than having to meet a deductible and 20% copayment requirements.

Medicare Advantage Enrollment

To enroll in a Medicare Advantage option, send your completed enrollment form directly to the selected managed care plan and pay any required subscription cost.

To cancel Medicare Supplement coverage, you also should complete and return the Medicare Supplement Subscription, Waiver, or Withdrawal form to the Board of Pensions. The supplement will not provide benefits when a Medicare Advantage plan has replaced Medicare Parts A & B and the Medicare drug plan Part D. The Board must receive your notice of intent to withdraw from coverage by the 15th of the month before your Medicare Advantage enrollment begins so that we do not take a Medicare Supplement deduction from your pension benefit for the next month. At that time, your decision to participate in the Medicare Advantage program and the effective date of your managed care coverage are recorded.

Medicare Supplement Re-Enrollment

If you are not satisfied with the Medicare managed care options, you may be eligible to re-enroll for the Medicare Supplement. You must first re-establish fee-for-service coverage under Medicare Part A and Part B. Your local Social Security office has information on how to re-enroll.

You may re-enroll in the Medicare Supplement on the first day of any month in which traditional Medicare Part A and Part B are effective and one of these situations exists:

- You choose to re-enroll in the Medicare Supplement within 12 months after you withdraw from Benefits Plan coverage. You need to send proof of prior Medicare Advantage coverage.
- You move out of the Medicare Advantage service area. You must send proof of prior coverage and confirmation of your new address.
- The Medicare Advantage plan significantly modifies premiums and/or benefits or ceases to offer coverage to Medicare-eligible participants. You must include a copy of the notification you received from the plan.

When you apply to re-enroll for the Medicare Supplement, you must send written notification to the Board of Pensions and provide:

- the name of each person re-enrolling and his or her Social Security number
- the termination date for the other coverage with written notification from the local Medicare Advantage option
- the date you want to re-enroll
- a copy of your Medicare Part A and Part B identification card and that of your spouse, if applicable. (This can be provided within 30 days after notification, but traditional fee-for-service Medicare coverage must be restored before the effective date of the Medicare Supplement.)

Sources of Medicare Information

If you or your friends need information about Medicare prescription drug plan options, you may:

- refer to the *Medicare & You 2009* handbook
- call your state SHIP (State Health Insurance Assistance Program)
- visit the Medicare Web site at www.medicare.gov where you can find fact sheets and an online Medicare Prescription Drug Plan Finder tool
- call 800-MEDICARE (800-633-4227), available 24 hours a day, 7 days a week. TTY users should call 877-486-2048.



The Board of Pensions
of the Presbyterian Church (U.S.A.)

2000 Market Street, Philadelphia, PA 19103-3298
800-773-7752 • 800-PRESPLAN • www.pensions.org

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