HealthFlex

Summary Plan Description

General Board of Pension and Health Benefits
of The United Methodist Church

Caring For Those Who Serve

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WELCOME

The General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois (General Board) has prepared this Summary Plan Description (SPD) to help you understand your group health plan and cafeteria plan coverage. Please read it carefully.

ABOUT THE PLAN

The General Conference of The United Methodist Church established a welfare benefit plan for clergy and lay employees effective January 1, 1961. The General Board maintains the Hospitalization and Medical Expense Program, more commonly known as HealthFlex (Plan), for the benefit of clergy and lay Employees (and their Dependents) of The United Methodist Church.

The Plan is a "Church Plan" as defined in §414(e) of the Internal Revenue Code (Code), as amended, and §3(33) of the Employee Retirement Income Security Act of 1974 (ERISA). The Plan's status as a Church Plan has a significant legal meaning; you can read more about it in the section titled *Miscellaneous Important Provisions*.

SERVING THE UNITED METHODIST CHURCH

The General Conference established the General Board to supervise and administer the employee benefit plans of The United Methodist Church. The General Board, in accordance with the provisions of *The Book of Discipline*, administers the Plan for the benefit of its Participants and Plan Sponsors to better enable them to serve the Church. You can help the General Board be a good steward by ensuring that the information you provide your Plan Sponsor and the General Board is timely and accurate.

EXPLANATION OF TERMS

You will find terms starting with capital letters throughout this SPD. Most of these terms are explained in the Definitions section of this SPD; others may be defined in the text.

PLAN SPONSOR

Your Plan Sponsor is the employer or Conference through which you have coverage under the Plan. Your Plan Sponsor has elected to participate in the Plan through an Adoption Agreement with the General Board. If you have questions about your benefits under the Plan, you may contact your Plan Sponsor in addition to the General Board.

YOUR RESPONSIBILITY TO PROVIDE ACCURATE INFORMATION

The Plan Administrator and its Claims Administrators rely on information provided by you when evaluating coverage and benefits under the Plan. All information you provide, therefore, must be accurate, truthful and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation or incorrect information may result in the denial of a Claim, cancellation or rescission of coverage or any other legal remedy available to the Plan.

QUESTIONS

If you have questions about the benefit plans administered by the General Board, please do not hesitate to contact us. For more information, please visit our website at **www.gbophb.org**. Or you may call the General Board Health Team at **800.851.2201**.

IMPORTANT NOTICES

Right to Amend the Plan

The General Board reserves the right to amend or modify the Plan in any manner, for any reason permitted by law, at any time and without prior notification.

Coverage Not Vested or Guaranteed

Coverage through HealthFlex as an Employee, Participant, Dependent or retired Participant is not a vested benefit—i.e., it is not guaranteed to continue. The General Board unequivocally reserves the right to amend or terminate HealthFlex at any time. In addition, your Plan Sponsor has reserved the right to terminate its participation in the active participant and retiree portions of HealthFlex, and may have reserved the authority to amend its cost-sharing policies or terminate its health plan for Employees and retired Participants.

HIPAA

The privacy of your health records is protected by specific security and privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, General Board personnel and Plan representatives and agents (such as Claims Administrators) may not release Protected Health Information (PHI) to your Plan Sponsor or Spouse (or any other third party) unless required by law or you authorize the release. The General Board's *Notice of Privacy Practices* describes the Plan's privacy practices and your rights to access your records. The notice is available on the General Board's website at **www.gbophb.org/TheWell/Root/HFLX/3157.pdf.**

Claims Administrators

The Claims Administrators for the Plan that the General Board has engaged through administrative service agreements, contracts and insurance policies (Contracts), provide the Plan's access to networks of health care providers, certain communications, identification cards, Claims processing, Claims payment, Claims determination and Claims appeals. The General Board has assigned many of its administrative duties with respect to the Plan to the Claims Administrators. In addition, pursuant to the terms of the Plan Document that governs HealthFlex, the General Board has delegated certain fiduciary responsibilities and duties to the Claims Administrators. The General Board has delegated the administrative authority to review, approve and deny Claims for medical, prescription drug, mental health and vision benefits to the Claims Administrators. The Claims Administrators make all determinations of medical necessity or medical appropriateness; they have the duty and authority to determine whether a particular benefit, procedure or service is covered by the Plan. The Claims Administrators also hold the authority to hear and decide appeals of denied claims for benefits under the Plan. The General Board does not have the authority to hear or overturn the determinations of the Claims Administrators related to benefits or medical necessity or appropriateness. Please contact the General Board if you have questions regarding the manner in which the Claims Administrators and General Board share duties under the Plan.

Moreover, certain Contracts with the Claims Administrators are insurance contracts and policies. As such, the terms of those Contracts with respect to the Participants covered under them will supersede the terms of this SPD where there is a conflict between the documents.

The Plan Is Not a Contract of Employment

Nothing contained in this SPD or the Plan will be construed as a contract or condition of employment between the General Board, any Plan Sponsor or any other employer and any Employee. All Employees are subject to discharge to the same extent as if their employer had never adopted the Plan.

ELIGIBILITY

If you are appointed to or work for a Plan Sponsor of HealthFlex, you may be eligible for coverage under the Plan. Your eligibility depends on the rules of the Plan and the choices of your Plan Sponsor. Contact your Plan Sponsor or the General Board if you have questions about your eligibility under the Plan. The descriptions below explain some general rules that govern the Plan.

Adoption Agreements

A Conference or Affiliated Organization that wishes to adopt HealthFlex must execute an Adoption Agreement with the General Board to become a Plan Sponsor. An Adoption Agreement is a contract through which a Plan Sponsor agrees to cover its Employees in the Plan and promises to abide by the terms of the Plan and assumes certain duties and obligations.

HealthFlex sets forth basic (i.e., required) and optional (i.e., discretionary) categories of coverage for clergy Employees (including deacons) and lay Employees. A Plan Sponsor must specify in its Adoption Agreement the optional categories of individuals that it wishes to make eligible under the Plan. The Adoption Agreement also defines eligibility as it pertains to a Plan Sponsor's Employees' Spouses, Dependents, surviving Spouses, surviving Dependents and retired Participants, as well as Employees on Continuation Coverage and leaves of absence under certain paragraphs of *The Book of Discipline*.

Some Plan Sponsors have age and service requirements that Employees must satisfy before they can participate in the Plan. A Plan Sponsor must offer HealthFlex participation in a nondiscriminatory manner to all persons described in the categories indicated on its Adoption Agreement.

Additionally, your Plan Sponsor's Adoption Agreement determines the medical, prescription drug, dental and vision Benefit Options available to you.

Basic Participation

If you are an Employee in one of the classes described below and your Plan Sponsor has adopted the Plan, you are eligible to participate in the Plan. However, the employee benefits policies and personnel rules of your Plan Sponsor also may affect your eligibility.

- An active bishop of The United Methodist Church;
- A clergy Employee of a Conference, including a full, provisional or associate member who is appointed:
- to full-time service in a local church in accordance with ¶338.1 or ¶346.1 of *The Book of Discipline*; or
- full-time to an extension ministry in accordance with ¶344.1 of *The Book of Discipline*;
- A full-time local pastor;
- A lay Employee of a General Agency that has adopted the Plan who is normally scheduled to work 30 or more hours per week (excluding persons employed by General Agencies as missionaries);
- A clergy Employee of a General Agency;
- A lay Employee of a Plan Sponsor other than a Conference or General Agency who is normally scheduled to work 30 or more hours per week.

Optional Participation

If your Plan Sponsor has elected, pursuant to its Adoption Agreement, to cover the class of Employee below that describes you, generally you will be eligible to participate in the Plan.

- A Bishop who has retired in accordance with ¶408.1, ¶408.2 or ¶408.3 of *The Book of Discipline*;
- A clergy Employee of a Conference who:
  - is appointed to less than full-time service under ¶338.2 of *The Book of Discipline*, but who is appointed to at least half-time service;
  - is appointed beyond the local United Methodist Church under ¶344.1a of *The Book of Discipline*, including full-time local pastors so appointed under ¶316 of *The Book of Discipline*;
  - is appointed beyond the local United Methodist Church under ¶344.1b of *The Book of Discipline*;
  - is appointed beyond the local United Methodist Church under ¶344.1d of *The Book of Discipline*;
  - is granted a Leave of Absence;

  - is appointed to attend school under ¶416.6 of *The Book of Discipline*;
  - is on sabbatical leave under ¶352 of *The Book of Discipline*;
  - has retired under ¶358.1 (mandatory retirement), ¶358.2b (with 35 years of service at age 62) or ¶358.2c (with 40 years of service at age 65) of *The Book of Discipline*;
  - has retired with 20 years of service under ¶358.2a of *The Book of Discipline*; or
  - has involuntarily retired under ¶358.3 of *The Book of Discipline*;
- A "part-time local pastor" as defined in ¶318.2 of *The Book of Discipline* who is appointed to at least a three-quarter time appointment;
- A student appointed as a local pastor under ¶318.3 of *The Book of Discipline*;
- A full-time local pastor who was eligible to participate in the Plan and who has been recognized as a retired local pastor under ¶320.5 of *The Book of Discipline*;
- A lay Employee of a Conference or Salary-Paying Unit within a Conference who:
  - is normally scheduled to work 30 or more hours per week; or
  - has retired under the retirement policy of his or her Salary-Paying Unit; or
- A lay Employee of a General Agency or other Plan Sponsor who has retired under the retirement policy of his or her General Agency or Plan Sponsor.

You should contact your Plan Sponsor for information about which of these categories is covered under your Plan Sponsor's Adoption Agreement.

Other Categories

A Plan Sponsor, with the written agreement of the General Board, may enroll other individuals in a category not specifically described above, provided that the Employees are individuals who may participate in a cafeteria plan (under §125 of the Code) and a Church Plan. Such individuals will be subject to all other terms of the Plan.

Exclusions

A clergy Employee of a Plan Sponsor shall be excluded from the Plan when:

- He or she has a quarter-time or less appointment;
- He or she is granted honorable location as that term is defined in ¶359 of *The Book of Discipline*;
- He or she is placed on administrative location as that term is defined in ¶362 of *The Book of Discipline*;
- His or her Conference relationship has been severed in any manner, e.g., by withdrawal, surrender of ministerial credentials or a penalty assessed by a trial court within the meaning of ¶360, ¶2719 or ¶2711.3 of *The Book of Discipline*, or surrender of the local pastor license as described in ¶320 of *The Book of Discipline*.

A Lay Employee shall be excluded from the Plan when:

- He or she normally is scheduled by his or her Plan Sponsor or Salary-Paying Unit to work fewer than 30 hours per week;
- He or she is a temporary or seasonal Employee, meaning he or she normally is scheduled by his or her Plan Sponsor or Salary-Paying Unit to work fewer than six continuous months during a Plan Year; or
- He or she normally is scheduled by his or her Salary-Paying Unit to work more than 30 hours per week during a period of time that is fewer than six continuous months, even if such Employee is normally scheduled by the Plan Sponsor or Salary-Paying Unit to work fewer than 30 hours per week beyond six months.

Any Employee who is residing outside of the United States for more than six continuous months at a time is excluded from the Plan.

In addition, you will be excluded from the Plan for failure to make Required Contributions on a timely basis. This means that your coverage will terminate and you will be excluded from coverage if you, your Plan Sponsor or the Salary-Paying Unit that is responsible for making Required Contributions on your behalf fails to make the Required Contributions. The General Board will notify you and your Plan Sponsor of the failure to make Required Contributions and will request payment of delinquent contributions. If you do not make payment in full within 15 calendar days of this notice, you will cease to be a Participant. Termination of coverage does not excuse you or your Plan Sponsor from making payment in full of all Required Contributions.

Your Spouse and Dependents

Your Spouse and Dependents may be eligible for coverage under the Plan depending upon:

- the choices elected by your Plan Sponsor on its Adoption Agreement, and
- the terms of applicable Benefit Options (such as limiting ages, etc.).

In certain circumstances, civil union partners and domestic partners of lay Employees may be covered, depending (1) upon the law of the State in which the lay Employee resides and Plan Sponsor is located, (2) the elections of the Plan Sponsor. For more about this coverage see the section of this SPD entitled Domestic Partner Coverage.

Special Rules

There are certain circumstances where you or your Dependent might be eligible for coverage where you otherwise would not.

Family Leave

If you are a clergy Employee placed on family leave or maternity or paternity leave pursuant to ¶354.2b) or ¶356 of *The Book of Discipline*, you may continue to participate in the Plan for a period up to 12 weeks.

FMLA

If you are a lay Employee of a Plan Sponsor that is subject to the terms of the Family and Medical Leave Act (FMLA) and you take an FMLA covered leave, or you are a clergy Participant and you are placed on incapacity leave, a family leave or a maternity/paternity leave as defined in *The Book of Discipline*, subject to the requirements of §125 of the Code (the cafeteria plan rules) and any other applicable laws and regulations and the personnel policies of your Plan Sponsor, the following rules generally will apply:

- You may maintain your medical, pharmacy, dental and vision benefits and flexible spending accounts for three months from the end of the month in which you began the FMLA leave. You can pay the premium Required Contributions for that period (i) in full, on a pre-tax basis, either before the medical leave or upon return from leave (if you return within the three-month period), or (ii) on an after-tax basis during the leave.
- If you continue to receive a salary pursuant to a short-term disability salary continuation plan or payroll practice maintained by your Plan Sponsor or employer, you may continue to have Required Contributions deducted from your pay on a pre-tax basis during the leave.
- At the end of the three-month period described above, if you do not return to work, the General Board will terminate any flexible spending accounts you might have.

Medical Child Support Orders

The General Board may determine that the Plan will provide benefits in accordance with the applicable requirements of any qualified medical child support order (QMCSO), as defined in §609 of ERISA or other medical support order, including a National Medical Support Notice issued pursuant to the Child Support Performance and Incentive Act of 1998, that the General Board reasonably determines applies to the Plan, relating to the child of a Participant. The General Board or its agent shall pay benefits covered by a QMCSO directly to the child or to the child's parent or legal guardian, as the General Board deems appropriate.

What is a Qualified Medical Child Support Order?

A QMCSO is a judgment, decree or order (including approval of a settlement agreement) or administrative notice that is issued pursuant to a state domestic relations law (including a community property law) or to an administrative process, which provides for child support health benefit coverage and relates to benefits under the Plan and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which you, as a Participant, are eligible;
- the order specifies your name and last known address and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice, it meets the requirements above.

The QMCSO may not require the Plan to provide any type or form of benefit or option not otherwise provided under the Plan.

Plan Sponsor Rules

Your Plan Sponsor may have rules and personnel policies that will affect your eligibility under the Plan. Ask your Plan Sponsor for additional information about the rules and regulations for coverage under this Plan and all the employee benefit plans that your Plan Sponsor offers.

Coverage in Retirement

Your Plan Sponsor will decide whether or not to offer coverage in retirement and how to share the cost of coverage with you.

Waiting Periods

Your Plan Sponsor may determine the length of time you are required to be employed before you can participate in the Plan.

Cost Sharing

Your Plan Sponsor determines the manner in which it shares the cost of coverage, the Required Contribution, with you. Your Plan Sponsor might split the Required Contribution with you or it might pay a certain percentage (for example, 75% of the cost) and pass on 25% to you. Your Plan Sponsor might pay the entire Required Contribution or it might assign the entire Required Contribution to you.

Benefit Options

Your Plan Sponsor has the authority to choose the Benefit Options under the Plan that it wishes to offer its Employees. As a result, not all of the Benefit Options in the Plan may be available to you. Please contact your Plan Sponsor or the General Board if you have questions about which Benefit Options are available to you.

Right to Terminate

Your Plan Sponsor has reserved the right to terminate its sponsorship of HealthFlex, subject to the conditions of its Adoption Agreement with the General Board. If your Plan Sponsor terminates its HealthFlex participation, your coverage under the Plan terminates. In addition, your Plan Sponsor may have reserved the right to terminate its sponsorship of a group health plan.

Coverage in Retirement

The following rules govern HealthFlex coverage for retired Participants.

General Eligibility

You must meet certain criteria to enroll in HealthFlex as a retired Participant. You must meet the Plan's criteria and the eligibility rules of your Plan Sponsor. Generally, you must be covered in HealthFlex as an active Participant for at least five consecutive years immediately preceding your retirement. However, if your Plan Sponsor adopted HealthFlex fewer than five years before you retire, you may be eligible to enroll if you were covered under your Plan Sponsor's previous group health care plan and you otherwise meet the eligibility criteria of the Plan and your Plan Sponsor.

Plan Sponsor Eligibility Requirements

Your Plan Sponsor may establish additional eligibility requirements for retired Participants. For example, your Plan Sponsor may require that you be covered by its group health plan, or have served or been employed longer than the five-year continuous coverage requirement under the Plan. Many Plan Sponsors require more than five years of service for eligibility in retirement. Your Plan Sponsor might exclude early retirees. Your Plan Sponsor's additional eligibility requirements can be more restrictive than the Plan's general rules, but they cannot be more generous.

Exceptions

At some point, you may be appointed outside your membership Conference under ¶346.1 of *The Book of Discipline* to a Conference that does not sponsor HealthFlex. You can still satisfy HealthFlex's five-year rule by maintaining continuous coverage under the group health plan of the Conference to which you are appointed.

However, simply satisfying the Plan's five-year rule does not necessarily entitle you to any Conference subsidy or cost sharing for the cost of coverage from your Plan Sponsor. A Plan Sponsor may choose not to credit the service under a ¶346.1 appointment

toward its cost-sharing policy. Moreover, if your Conference's years of service requirements for coverage as a retired Participant are more restrictive than the HealthFlex rule, your service in another Conference may not satisfy your Plan Sponsor's criteria.

A similar, though more restrictive, exception applies to clergy appointed to serve a general agency under ¶344.1(2) of *The Book of Discipline*. If you are appointed under ¶344.1(2), you will be treated as not having incurred a "break" in the continuous coverage required for HealthFlex retiree eligibility, so long as you maintain continuous coverage under the general agency's group health plan, and your Plan Sponsor approves the crediting of such coverage. You must still have been covered in HealthFlex for at least five years and must retire from a HealthFlex Plan Sponsor. A Plan Sponsor has the discretion to credit service under ¶344.1(2) toward its cost-sharing policy or to exclude ¶344.1(2) service from credit under its requirements for retired Participant coverage.

Electing Coverage or Postponing Your Election

You must enroll in the Plan as a retired Participant within 30 days of your retirement. Retirement in this context means early or normal retirement, as soon as you first become eligible for coverage as a retiree under the Plan and your Plan Sponsor's rules, regardless of whether you are eligible yet for Medicare. Your Plan Sponsor is obligated to provide you with the necessary forms and information prior to that date. If you do not enroll within this time limit, you will forfeit forever your eligibility to become a retired Participant.

Once you enroll as a retired Participant, if you terminate your coverage for any reason, at any time, you will permanently lose your eligibility to participate in the Plan. In other words, once you leave the Plan, you cannot come back.

Exception

There is one exception to this rule. If you work beyond age 65 (the retirement age for Medicare) and you have "current employment status" [1] as defined in Medicare's secondary payer (MSP) rules, you will remain enrolled in the Plan but be treated as an active Employee, unless you are in an employee class not otherwise eligible to participate in the Plan (e.g., a part-time Employee). You are considered a "working-aged employee" in this circumstance.

If you are a working-aged employee, but your employer has exemption from the MSP rules, you will remain covered in the Plan as a retired Participant. Please contact your Plan Sponsor or the General Board to determine whether your employer is exempt from the MSP rules as a small employer.

Postponement

Immediately upon retiring, if you have access to Other Employer-Sponsored Group Health Coverage, you may postpone your one-time retiree HealthFlex election. You must inform the General Board and your Plan Sponsor that you have Other Employer-Sponsored Group Health Coverage. And you must enroll in HealthFlex immediately upon losing your Other Employer-Sponsored Group Health Coverage. You must submit evidence of this other coverage when you are finally ready to enroll in HealthFlex. This coverage can only be through an employer group health plan; it cannot be through Medicare alone, other governmental coverage or an individual insurance policy.

Cost Sharing

The amount you will pay for coverage as a retired Participant can vary. Your Plan Sponsor determines how to share the cost of coverage with you and it can require that you pay the entire cost of coverage. Your Plan Sponsor should have a written policy that describes how it shares the cost of coverage with you. Be sure to obtain cost-sharing information from your Plan Sponsor annually.

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[1] An individual has current employment status if the individual is: (i) actively working as an employee; (ii) not actively working, and receiving disability benefits from an employer for the first six months of such disability benefits; or (iii) an individual that: (a) retains employment rights in the industry, i.e., through a union contract; (b) has not had his or her employment terminated by the employer; (c) is not receiving disability benefits from an employer for more than six months; (d) is not receiving Social Security disability benefits; and (e) has ongoing group health plan coverage that is not COBRA (continuation) coverage. Special Rule for Clergy: Because clergy are considered self-employed for many purposes, a member of the clergy is considered to have "current employment status" if the individual is receiving cash remuneration from the church or other religious order for services rendered.

Pre-Tax Premium Contributions and Flexible Spending Accounts
Generally, retired Participants are not eligible for the cafeteria plan to (i) pay for coverage on a pre-tax basis or (ii) defer money to flexible spending accounts. A limited exception applies to retired Participants who are actively at work and enrolled in the Plan for active Employees. The portion of the Required Contribution paid by your Plan Sponsor may be a tax-free benefit to you as a result of your "former employment relationship".

Early Retirement
These rules for coverage as a retired Participant apply to you whether or not you are eligible for Medicare (i.e., are age 65 or older) at the time you retire. If you retire early, you must remain covered in HealthFlex continuously, unless you have Other Employer-Sponsored Group Health Coverage, or you will forfeit your eligibility under the Plan. Generally, you will bear more of the cost of coverage if you retire before you are eligible for Medicare. Once you become Medicare-eligible, you should advise the General Board and your Plan Sponsor to change your coverage to HealthFlex's Medicare companion plan Benefit Option.

Medicare
Once you reach age 65, you will be entitled to coverage under Medicare Part A[2]. At that time, you also should enroll in Medicare Part B, because the Plan automatically assumes *you are enrolled in* Medicare Part B when it calculates benefit payments. Once you are Medicare-eligible, you will be covered through one of the Plan's Medicare companion Benefit Options, which pay after Medicare pays (i.e., the Plan is the secondary payer). If you are eligible for Medicare Part B and are not currently at work, but you do not enroll in Medicare Part B, you will incur additional out-of-pocket expenses that the Plan will not pay.

Medicare Part D
Also, once you reach age 65, you will be eligible for Medicare Part D, the Medicare prescription drug benefit. Generally, you should not enroll in Medicare Part D. You cannot be covered in HealthFlex and enrolled in Medicare Part D. If you are covered by HealthFlex as a retired Participant, your prescription drug coverage benefit is better on average than the Medicare Part D benefit. You should enroll in Medicare Part D only if you are also enrolled in Medicaid or are otherwise eligible for Medicare Part D low-income assistance, and you should enroll only after consulting with the General Board and your Plan Sponsor.

Medicare-Eligible Participants
A series of federal laws, collectively referred to as the Medicare Secondary Payer (MSP) laws, regulate the manner in which the Plan may offer group health care coverage to Medicare-eligible Employees, Spouses and, in some cases, Dependents.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan (GHP) coverage (HealthFlex coverage), as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

- A GHP that covers individuals with end-stage renal disease (ESRD) during the first 30 months of Medicare eligibility. This is the case regardless of the number of employees employed by the employer or whether the individual has "current employment status."
- In the case of individuals age 65 or older, a GHP of an employer that employs 20 or more people, if that individual or the individual's Spouse (of any age) has "current employment status." If the GHP is a multiemployer or multiple employer plan that has at least one participating employer that employs 20 or more people, the MSP rules apply, even with respect to employers of fewer than 20 people (unless the Plan elects the small employer exception under the statute, which HealthFlex has done for some Plan Sponsors).
- In the case of disabled individuals younger than age 65, a GHP of an employer that employs 100 or more people, if the individual or a member of the individual's family has "current employment status" with the employer. If the GHP is a multiemployer or multiple employer plan that has at least one participating employer that employs 100 or more people, the MSP rules apply, even with respect to employers of fewer than 100 employees.

Please note: Contact the General Board or your Claims Administrator if you have questions regarding the ESRD period or other provisions of the MSP laws and their application to you.

[2] Unless you are a clergyperson who has opted out of Social Security.

Coverage Not Guaranteed
Coverage through HealthFlex as a retired Participant is not a vested benefit; it is not guaranteed to continue. The General Board reserves the right to amend or terminate HealthFlex at any time. In addition, your Plan Sponsor has reserved the right to terminate its participation in the retiree portion of HealthFlex, and may have reserved the authority to amend its cost-sharing policies or terminate its health plan for retired Employees.

Spouses and Dependents
Your Spouse at the time you retire is eligible to become a retired Participant if you had been covered in the Plan for at least five years preceding your retirement and has met any additional requirements of your Plan Sponsor, such as a longer period of coverage. Your Spouse will immediately lose eligibility if you lose eligibility, other than if you die. Your Spouse is subject to the Plan's one-time election rule and other rules for coverage in retirement, as well as the eligibility rules of your Plan Sponsor.

Generally, a new Dependent acquired by a retired Participant after his or her retirement date is not eligible for HealthFlex.

Surviving Spouses and Dependents
Plan sponsors can elect to cover surviving Spouses and surviving Dependents of active and retired Participants. The same general rules apply to surviving Spouses and Dependents as apply to retired Participants. If a surviving Spouse remarries, he or she may retain HealthFlex coverage as a surviving Spouse. However, he or she may not enroll new Dependents acquired after the primary Participant's death; those Dependents are ineligible for coverage under HealthFlex. A surviving Dependent who is the child of a deceased Participant may continue coverage as a surviving Dependent under the Plan until he or she no longer meets the Plan's definition of a Dependent child (e.g., by reaching a limiting age).

Medicaid and Government Aid
If a Plan Sponsor has elected to cover surviving Spouses and Dependents, the one-time election and postponement rules of the Plan apply to such individuals. However, surviving Spouses of limited means may be better served covering their minor children through a State Child Health Insurance Plan (S-CHIP) or minor and adult dependent children through Medicaid. For such persons, the General Board makes a limited exception to the one-time election rule. Surviving Spouses may opt to (1) cover their minor children or adult dependent children in a government plan[3], (2) decline HealthFlex coverage for the Dependents so covered and (3) retain the eligibility to re-enroll these Dependents should they lose coverage under the government plan on account of (i) bankruptcy or termination of the government plan, (ii) loss of eligibility under the government plan due to income changes or (iii) other loss of eligibility for the government plan, not including reaching a limiting age. Dependents must satisfy all other eligibility criteria of the Plan in order to re-enroll, including, but not limited to, limiting ages and payment of Required Contributions.

Divorced Spouses

If you are the former Spouse (Divorced Spouse) of a Participant, i.e., you are divorced or legally separated from the Participant, you may be eligible to participate in the Plan if the Participant is made responsible through a court order for:

- the majority of your financial support; or
- your medical or other health care expenses.

You or the Participant must notify the General Board or your Plan Sponsor of a divorce in a timely manner.

In the event that the Participant is not required to cover you by court order, you may be eligible for up to 24 months of Continuation Coverage. See the section entitled *Continuation Coverage* for additional information.

Medical Reimbursement and Dependent Care accounts are not available to you as a Divorced Spouse. If you remarry, you remain eligible under the Plan, unless the court order provides otherwise. New Dependents acquired after the divorce are not eligible for coverage through a Divorced Spouse under the Plan. If a former Spouse is covered through Continuation Coverage (see below), then Dependents acquired after the divorce may be eligible for coverage for the remainder of the Spouse's Continuation

[3] A government plan for the purposes of this policy shall be (i) an S-CHIP as defined under federal law, such as PeachCare, TennCare, Illinois AllKids, among others, (ii) Medicaid, (iii) the Indian Health Services Program or (iv) another governmental health plan or program that is intended to aid low-income minor children and is, in the view of the General Board, substantially similar to the programs in i, ii and iii.

Coverage. Divorced Spouses are subject to the same one-time election and continuous coverage rules that apply to retired Participants (see above). As a Divorced Spouse, you, or the Participant on your behalf, must pay the Required Contribution for coverage.

Domestic Partner Coverage

A Plan Sponsor may elect, through its Adoption Agreement, with respect to lay Employees only, to offer coverage for the same sex partner (Civil Partner) of a lay Employee who has entered a civil union or domestic partnership, which, under the law of the state in which the lay Employee resides, provides the same substantive and procedural rights, privileges, and immunities as marriage. Such coverage shall be subject to the limitations of federal law, i.e., with respect to the Code, and the conditions described in Judicial Council Decision No. 1075 and *The Book of Discipline*, as explained below.

As of 2011 the following states have such laws: California, Delaware (effective January 1, 2012), Hawaii (effective January 1, 2012), Illinois, New Jersey, Nevada, Oregon, and Washington. Connecticut, the District of Columbia, Iowa, Massachusetts, New Hampshire and Vermont permit same sex couples to enter marriages, which the Plan recognizes.

The federal Defense of Marriage Act (DOMA) prohibits other federal laws, such as the Code and the ERISA, from recognizing state-sanctioned same sex marriages, civil unions and domestic partnerships. Civil Partners do not benefit from federal rights and responsibilities, including social security survivors' and spousal benefits; filing joint federal income tax returns; exemption from income tax on Civil Partner health insurance; spousal protections in bankruptcy; federal veterans' spousal benefits; and the ability to sponsor a spouse to immigrate. Therefore, federal law treats health insurance benefits for Civil Partners as taxable income to the employee. If a Plan Sponsor were to pay for the coverage of Civil Partners in HealthFlex, i.e., pay the same share of the premium as it does for Spouses, then the fair market value of that additional coverage is treated as imputed income to the lay Employee subject to federal income and employment taxes. However, for state income tax purposes, this coverage usually is treated as tax-exempt, so the lay Employee would not be subject to state income tax on the value of the added coverage.

In addition, unless his or her Civil Partner is a tax dependent under Code §152, a lay Employee may not make pre-tax contributions to a cafeteria plan on behalf of a Civil Partner, i.e., the employee responsibility portion of the premium that is attributable to the Civil Partner coverage generally must be paid on an after-tax basis. A lay Employee also may not receive reimbursement for expenses of the Civil Partner from flexible spending accounts (FSAs) or health reimbursement accounts (HRAs) under HealthFlex.

The Judicial Council of The United Methodist Church has ruled, in Decision No. 1075, that an annual conference health plan providing health benefits to domestic partners of lay employees did not violate *The Book of Discipline*. The plan in that case required the employee to pay the full additional premium cost for the coverage of his or her partner. The Judicial Council held that the plan did not violate ¶806.9 or ¶612.19 of *The Book of Discipline*, because the annual conference council on finance and administration had determined that the plan did not inappropriately use church funds to promote the acceptance of homosexuality. Plan Sponsors considering providing this coverage should review Decision No. 1075.

Coverage During Disability

If you are a clergy Participant and you become disabled under the terms of the Comprehensive Protection Plan (CPP), then you may be eligible to continue to participate in HealthFlex as long as you remain disabled, provided that your Plan Sponsor continues to cover you under its policies and rules, and subject to certain limitations set forth below. Generally, HealthFlex covers disabled participants as the primary payer for 24 months of disability, after which, due to the disability, the participant becomes eligible for Medicare coverage. Medicare then becomes the primary coverage and HealthFlex pays secondary. As long as you remain disabled, the Plan will allow you to be covered by your Plan Sponsor. However, whether you remain covered as a disabled Employee depends on the policies and practices of your Plan Sponsor. If your Conference relationship terminates, for example, your Plan Sponsor may not necessarily continue to cover you under the Plan. If you reach retirement age and your Plan Sponsor does not provide coverage in retirement, your coverage may terminate.

If you are a clergy Employee and you were not covered under CPP through an appointment or leave status at the time you become disabled, but nonetheless you are disabled in the view of the General Board (pursuant to a definition similar to that in CPP), you remain eligible for coverage under HealthFlex, but actual coverage would depend on the polices of your Plan Sponsor. Disability

under CPP is distinct from being appointed to incapacity leave. Incapacity leave is an appointment status and a Conference membership relationship, and does not necessarily prove disability.

A Plan Sponsor's personnel policies (and for Conferences, *The Book of Discipline*) have significant impact on coverage in disability. The Plan Sponsor can establish its own rules about cost sharing for disabled Employees, as long as they aren't discriminatory to other similarly situated Employees, as long as the disabled individual remains an Employee. For clergy Employees, if the Participant terminates Conference relationship, then the Plan Sponsor's policies regarding continued membership, coverage and cost sharing of premiums will apply. That may require the terminated, disabled Participant to pay the entire Required Contribution or terminate coverage entirely. If a Plan Sponsor's personnel policy indicates a termination of employment for lay Employees who become disabled (e.g., after 24 months of disability), then that policy will govern continued coverage and cost sharing. The Plan will allow the disabled Participant to continue coverage if the Plan Sponsor's rules allow it, but it does not require such coverage. When Plan coverage ceases, Continuation Coverage may be available if the affected individual is not eligible for Medicare.

One Type of Coverage

You may not participate in this Plan as an Employee and as a Dependent, and your Dependent may not participate in this Plan as a Dependent of more than one Employee.

Waiting Periods

Contact your Plan Sponsor for details regarding your waiting period, if any.

Effective Date of Your Coverage

You will become a covered Participant on the date you elect coverage by signing an approved *HealthFlex Enrollment/Change Form (Enrollment Form)*. You will not be denied enrollment for coverage due to your health status. Your coverage will be subject to any applicable Pre-existing Condition Waiting Period. It is your Plan Sponsor's responsibility to provide all completed enrollment materials, including your *Enrollment Form*, to the General Board within 30 days of your eligibility date. Failure by your Plan Sponsor to perform this duty may subject you to adverse consequences.

Coverage for your Dependents, if they are eligible, will be effective on the date you elect such coverage on an approved *Enrollment Form*. Your Dependents will be covered only if you are covered under the Plan.

Newborns

Any Dependent child born while you are covered under the Plan will become covered on the date of his or her birth if you elect Dependent coverage no later than 30 days after the birth. If you do not elect to cover your newborn child within 30 days, coverage for that child will end on the 30th day.

Adopted Children

Pursuant to the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), any child under the age of 18 whom you adopt, including a child who is placed with you for adoption, will be eligible for Dependent coverage upon the date of placement with you. The Plan will consider a child placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption. If a child placed for adoption is not adopted, all health coverage ceases when the placement ends and will not be continued.

Termination of Coverage

Termination of Coverage—Employees

Your coverage will cease on the earliest of the following dates:

- the date you cease to be in a class of eligible Employees as described above;
- the last day for which you have made any Required Contributions for coverage;
- the date the General Board terminates the Plan;
- the date Your Plan Sponsor terminates its participation in the Plan; or
- the last day of the calendar month in which your employment ends.

Leave of Absence

If your employment ceases due to a leave of absence, your coverage will be continued according to the terms set by your Plan Sponsor. However, the coverage will not continue beyond the date your Plan Sponsor ceases paying Required Contributions for you.

Other Events Ending Your Coverage

When any of the following happen, the General Board may terminate your coverage and it or the Claims Administrator will provide you written notice that your coverage has ended.

- Fraud, Misrepresentation or False Information—You commit fraud or misrepresentation, or you knowingly give the General Board or the Claims Administrator false material information. Examples include false information relating to another person's eligibility or status as a Dependent.
- Material Violation—You materially violate the terms of the Plan.
- Improper Use of ID Card—You permit an unauthorized person to use your ID Card, or you use another person's card.
- Threatening Behavior—You commit an act of physical or verbal abuse that poses a threat to the General Board's staff, the Claims Administrator's staff, a provider or other Participants.

Termination of Coverage—Dependents

Coverage for your Dependents will cease on the earliest of the following dates:

- the date your coverage ends;
- the last day for which you have made any Required Contributions for coverage; or
- the last day of the month in which your Dependent ceases to be a Dependent as defined in the Plan.

Generally, when your coverage terminates, you will have the opportunity to elect Continuation Coverage for you and your Dependents.

Continuation Coverage

The Plan does not offer Continuation Coverage under the terms of COBRA[4]. COBRA is the federal Continuation Coverage law that applies to most employer group health plans. Because HealthFlex is a Church Plan, the Plan is exempt from COBRA requirements by federal law[5].

Nonetheless, if you lose coverage[6] under the Plan, you may elect Continuation Coverage. Medical, mental health and prescription drug coverage are included in the Plan's Continuation Coverage. Continuation Coverage does not include dental, vision or health care flexible spending account coverage, because they are limited scope benefits. A dependent care flexible spending account is not considered a health plan and therefore is not part of Continuation Coverage. Generally, the Plan offers Continuation Coverage for twelve months from the date you lose coverage[7]. If you elect Continuation Coverage, you will remain in your then currently elected Benefit Options for the balance of the Plan Year in which you lose coverage or as long as you are eligible for Continuation Coverage, whichever is shorter.

Continuation Coverage for a Spouse who loses coverage in the case of a divorce from a Participant is 24 months. Generally, HealthFlex will consider your newly acquired Dependents during a period of Continuation Coverage to be eligible for coverage for the remaining period of your Continuation Coverage (you must pay an additional Required Contribution for such coverage, however). You must notify your Plan Sponsor and the General Board of events that may cause a loss of coverage under the Plan, such as a divorce or a child reaching a limiting age. When you become eligible for Medicare, you are no longer eligible for Continuation Coverage.

Generally, when you or your covered Dependents lose coverage under the Plan, coverage terminates at midnight on the last day of the month in which the event ending eligibility occurs. The General Board or its agent will inform you of the termination of coverage and opportunity to elect Continuation Coverage within 10 business days of the termination.

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4 The Consolidated Omnibus Budget Reconciliation Act of 1985.

5 Under §4980B(d) of the Code and Treasury Regulation §54.4980 B-2, Q. and A. No. 4.

6 Loss of coverage may be, for example, by reason of termination of employment, attainment of a limiting age, divorce or death.

7 The Plan may offer longer periods of coverage in certain circumstances.

Continuation Coverage will cease on the earliest of the following:

- the last day for which you have paid the Required Contribution;
- the date you become eligible for coverage under another group health care plan, policy or under Medicare;
- the last day of the month of such Continuation Coverage in accordance with the terms of the Plan; or
- the date the Plan terminates.

You have 60 calendar days from the date you lose coverage to elect Continuation Coverage. If you do not elect Continuation Coverage within this time limit, you forfeit coverage. If you elect Continuation Coverage, you must pay the entire cost of coverage, in other words, the Employee and employer portions of the Required Contribution, on an after-tax basis.

The Plan is only required to provide Continuation Coverage to you if you have been covered under the Plan for at least ninety (90) days.

You should contact your Plan Sponsor or the General Board if you have questions about Continuation Coverage.

THE CAFETERIA PLAN

The Plan is made up of two primary parts: the group health plan and the cafeteria plan. The group health plan contains several Benefit Options that cover your (i) medical and hospitalization expenses, (ii) prescription drug expenses and (iii) mental and behavioral health expenses. In addition, the Plan provides certain ancillary or *limited scope* benefits that cover your (iv) dental expenses and (v) vision expenses. These Benefit Options are described in the section called *Your HealthFlex Benefits*. You can find more information about these Benefit Options in the applicable benefit summary or *HealthFlex Benefit Booklet*.

The other part of the Plan is the cafeteria plan. The cafeteria plan has three parts: (i) a premium conversion plan, (ii) a flexible spending account for health care expenses and (iii) a flexible spending account for dependent day care expenses.

What Is a Cafeteria Plan?

A cafeteria plan is a type of employee benefit plan that employers provide pursuant to §125 of the Code. The name derives from the design of allowing employees to choose among different types of benefits, similar to food choices in a cafeteria. Employees may choose between cash, in the form of their full compensation, and non-taxable benefits such as group health coverage and flexible spending accounts. A cafeteria plan thereby provides a funding mechanism by which employees may pay for the benefits they choose on a pre-tax basis. The General Board administers the entire Plan as a cafeteria plan under Code §125.

Generally, only current common-law employees may be Participants in the cafeteria plan. Though self-employed individuals typically are not permitted to be Participants in a cafeteria plan, United Methodist clergy can participate in the HealthFlex cafeteria plan. The Benefit Options under the group health plan and the rules of the cafeteria plan are explained below.

Your Plan Sponsor

Your Plan Sponsor or employer may maintain its own cafeteria plan. You should ask your Plan Sponsor if it has a cafeteria plan for Employees. If so, you should consult your Plan Sponsor for information about its cafeteria plan and its features and options.

Premium Conversion Plan

Pre-Tax Contributions

Through the cafeteria plan, you can pay the Required Contributions, often called premiums, for coverage under the Plan and its Benefit Options on a pre-tax basis. This is known as a premium conversion plan. You may do so if you are actively at work (i.e., not on a leave or assigned any non-salaried status). Your Required Contributions are deducted from your gross income each payroll period. Your new gross (taxable) income is your salary less the pre-tax contributions to the cafeteria plan. Alternatively, you can forego the benefits of the premium conversion plan, paying all Required Contributions on an after-tax basis. By choosing the latter, you are choosing cash, in the form of your full salary, over qualified benefits.

Whether or not you opt to participate in premium conversion, the General Board administers the Plan as a cafeteria plan under §125 of the Code. As such, you can only change your Benefit Options during Annual Election Periods and on account of certain Life Status Events. Please refer to the section of this SPD entitled *Life Status Events* for more information.

After-Tax Contributions

If you are not actively employed, but remain covered (e.g., you are on a covered, unpaid leave of absence), you must pay the Required Contributions for your Benefit Option coverage on an after-tax basis.

Retired Participants and disabled Participants generally cannot participate in the cafeteria plan. In certain cases, you can request that the General Board deduct Required Contributions directly from your pension or welfare plan benefit payments on an after-tax basis, if they are administered by the General Board. In other cases, your Plan Sponsor will collect Required Contributions directly from you. Certain retired Participants who continue to work beyond retirement age or who return to work after retirement can continue to participate in the premium conversion plan and flexible spending accounts.

Elections

Generally, you are allowed to elect or change coverage (i.e., your Benefit Options and your flexible spending account contributions), only during each Annual Election Period, typically each November. You may revoke or change your elections at other times of the year only as permitted by the Plan.

Because the Plan is designed to provide tax-advantaged benefits under §125 of the Code as a cafeteria plan, once you make your benefit elections for a Plan Year, you cannot change them, except in limited circumstances. The circumstances under which you may change your benefit elections are called Life Status Events, and they include rights stemming from Special Enrollment Events, as defined in HIPAA. Life Status Events and Special Enrollment Events are described below. Life Status Events are sometimes called "change of status events."

The rules that govern changing elections apply to Employees as well as Spouses and Dependents, surviving Dependents, retired Participants, Divorced Spouses, individuals on Continuation Coverage and all other Participants.

Changing Your Elections (the Cafeteria Plan Rules)

You may change your Benefit Option elections only under the following circumstances:

- during the Annual Election Period;
- if you experience a Life Status Event (as described below); or
- if you experience a Special Enrollment Event (as described below).

It is very important that you inform your Plan Sponsor of any Life Status Event within 31 days of the event. If you or your Plan Sponsor fails to inform the General Board of such an event in a timely manner, it may jeopardize your ability to make election changes and it can have adverse tax consequences or cause you to lose coverage.

Life Status Events

If you experience certain changes in your family's status, you may be permitted to make limited changes to your HealthFlex elections. These Life Status Events include:

- marital status changes (e.g., marriage or divorce);
- changes in the number of Dependents (e.g., an increase through birth or adoption or a decrease through death);
- a Dependent becoming ineligible or regaining eligibility (e.g., reaching a limiting age);
- change in employment status[8] of you or your Dependent that affects eligibility for the Plan (e.g., changing from full-time to part-time employment, commencement of or return from an unpaid leave of absence);
- HIPAA Special Enrollment Events (see below); and
- change in residence[9] that affects eligibility (e.g., moving out of the coverage area for a managed care option, such as an HMO).

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[8] Appointment changes within a Conference and compensation changes alone are not considered Change of Status Events.

[9] Changes in residence that affect eligibility for certain Benefit Options do not qualify as Change of Status Events for flexible spending accounts.

For example, if you previously resided in an area in which only the PPO Benefit Option was available and you move to an area where both the EPO (or an HMO) Benefit Option and the PPO Benefit Option are available, and as a result, you gain access to the EPO (or HMO) Benefit Option, you may change your election for medical Benefit Option. Note, though, that in this circumstance, you will not have incurred a Change of Status for flexible spending account purposes. In such a circumstance you could change your election from the PPO Benefit Option to the EPO Benefit Option, but you could not change your medical reimbursement account election.

Conversely, if you move out of the EPO (or HMO) Benefit Option service area, and you are therefore no longer eligible for the EPO (or HMO) Benefit Option, you will have incurred a Change of Status for purposes of your medical Benefit Option.

Any election changes you make based upon a Life Status Event must be on account of and consistent with such a Life Status Event. For example, when you acquire a new Dependent, the election change you would make for that Life Status Event would be to add coverage for that Dependent, not to drop coverage for other Dependents[10].

In certain other limited circumstances you may make changes to your elections. These additional Life Status Events are:

- judgment, decree or order (i.e., a Qualified Medical Child Support Order);
- Medicare Entitlement (or loss of such entitlement);
- mid-year Plan changes (e.g., significant changes in the cost of coverage or significant curtailment of coverage during a Plan Year); and
- certain required circumstances under the Family and Medical Leave Act where applicable to your employer.

HIPAA Special Enrollment Events

If you decline coverage under the Plan, in certain situations you may be able to enroll in the Plan at the time you lose Other Health Coverage. This rule would also apply if you were assigned "No Coverage" by the Plan due to noncompliance with the 31-day Plan Sponsor signature requirement for enrollment.

The situations in which you may enroll in HealthFlex upon the loss of Other Health Coverage or in which you may make changes to certain elections are called Special Enrollment Events and are as follows:

- you decline HealthFlex coverage because you (or your Spouse or Dependent) have Other Health Coverage or COBRA or other continuation coverage, then you (or your Spouse or Dependent) lose the Other Health Coverage because you are no longer eligible (e.g., through an employment status change, divorce, change of residence, loss of student status, limiting age, etc.) or because the employer failed to pay the required premium or you or your Dependent exhausts the COBRA or other continuation coverage;
- you decline coverage under HealthFlex for your Spouse or Dependent because your Spouse or Dependent has Other Health Coverage or has COBRA or other continuation coverage, then your Spouse or Dependent loses the Other Health Coverage because he or she is no longer eligible (e.g., through an employment status change, divorce, etc.) or because the employer failed to pay the required premium or your Spouse or Dependent exhausts the COBRA or other continuation coverage period;
- you gain a new Dependent due to marriage, birth, adoption or placement for adoption or legal guardianship; and
- the Plan (or the plan of your Spouse or Dependent) no longer offers a Benefit Option to an entire class of similarly situated individuals that includes you; and
- you or your dependent become eligible for a premium subsidy for coverage under HealthFlex through Medicaid or a state Children's Health Insurance Program.

In order to enroll in the Plan as a result of a Special Enrollment Event, you, your Spouse or Dependent must be otherwise eligible for coverage under the Plan, e.g., under your Plan Sponsor's Adoption Agreement.

If you do not experience a Life Status Event, you cannot change your elections at any time during the Plan Year.

[10] In accordance with IRS guidance, however, you can add other Dependents in addition to the newly acquired Dependent under what is known as the "tag-along" rule.

Effective Dates of Coverage Changes Due to a Special Enrollment Event or Life Status Event
When you elect HealthFlex coverage due to a Special Enrollment Event or make an election change due to a Life Status Event, the effective date of the change will be as follows:

- **Special Enrollment Event—loss of Other Health Coverage**: HealthFlex coverage will be effective as of the first day you are without Other Health Coverage.
- **Special Enrollment Event—exhaustion of COBRA coverage or other continuation coverage**: HealthFlex coverage will be effective as of the first day you are without the COBRA coverage or other continuation coverage.
- **Special Enrollment Event or Life Status Event wherein you add a new Dependent to your family**: HealthFlex coverage will be effective as of the date of the marriage, birth, adoption, placement for adoption or legal guardianship, which is the basis for acquiring the Dependent.
- **Life Status Event wherein a Dependent regains eligibility**: HealthFlex coverage will be effective as of the date the Dependent first meets the eligibility requirements.

Though coverage may be effective retroactively on account of these events, pre-tax cafeteria plan elections cannot be retroactive. Required Contributions for retroactive coverage must be paid on an after-tax basis. If you make a change to your Medical Reimbursement Account or Dependent Care Account on account of a Life Status Event, when permitted under the Plan, the effective date of that change will be the first day of the month following the election change. When you lose or decline HealthFlex coverage due to a Change of Status Event, termination is effective on the last day of the month in which the Change of Status Event occurred.

Example 1:
John has declined HealthFlex coverage because he has coverage through his spouse's employer. John's spouse subsequently loses the Other Health Coverage because her employment is terminated. The last day of coverage under the Other Health Coverage plan is March 31. John notifies his Plan Sponsor and receives an *Enrollment Form*. He completes and returns the Enrollment Form to his Plan Sponsor's office. All of this must be done so that the Plan Sponsor can sign the *Enrollment Form* by the end of the business day on April 30. Coverage is effective April 1.

Example 2:
Susan is covered under HealthFlex. She also covers her husband and son. On May 12, Susan gives birth to her daughter, Alicia. Susan notifies her Plan Sponsor of the birth and receives an *Enrollment Form*. She completes the *Enrollment Form*, adding Alicia as a covered Dependent and returns it to her Plan Sponsor's office. All of this must be done so that the Plan Sponsor can sign the *Enrollment Form* by the end of the business day on June 11. Coverage is effective May 12.

If you fail to meet the timeliness requirement, you cannot make coverage or election changes due to the Life Status Event (Special Enrollment Event or otherwise), and you will have to wait until the next Annual Election Period to make the change.

Other Life Events
In addition to the events described above, certain other events can change your coverage and elections:

- **Disability Medicare Entitlement**: When you become eligible for Medicare due to disability, you may elect to change coverage to the Medicare Companion Benefit Option (or Medicare HMO where available). When you become eligible for Medicare because of age, you will change Benefit Options to a Medicare Companion Benefit Option or a Medicare HMO.
- **Medicare Secondary Payer Small Employer Exception (MSP)**: If you are a Medicare-entitled Participant actively working for a small employer in the MSP program, you will be covered under the Medicare Companion Benefit Option (or Medicare HMO where available).

Flexible Spending Accounts (FSAs)

If you are a Participant who is actively at work, you can choose to contribute a portion of your compensation to flexible spending accounts on a pre-tax basis[11] through the cafeteria plan. The flexible spending account for health care expenses is called the Medical Reimbursement Account (MRA), and the flexible spending account for dependent day care expenses is called the Dependent Care Account (DCA). Together they are called reimbursement accounts or FSAs. You can elect to reduce your salary for a Plan Year (or the remainder of the Plan Year if you are a newly hired eligible Employee), through a salary-reduction agreement. Your employer deducts the contribution amounts pro rata each month or payroll period from your compensation.

Reimbursement accounts are subject to strict rules and requirements of the Code, under §105, §106, §125 and §129. FSAs can only reimburse you for health care expenses or dependent day care expenses. The Plan maintains FSAs as bookkeeping entries, with the "account balance" representing the amount of your salary reduction contributions that are available to reimburse your eligible expenses.

To participate in the FSAs, you must be enrolled in the Plan and covered in a medical Benefit Option. For each year in which you want to have FSAs, you must make an election to contribute a portion of your salary. If you do not elect an amount for the FSAs in any Plan Year, you are presumed to have made an election to contribute zero dollars. FSA elections do not carry over from one year to the next; they are not "evergreen." **Amounts remaining in your FSAs at the end of a Plan Year do not carry over to the following year**, other than in the limited manner permitted by the Grace Period (see below) for the MRA; you forfeit them to the Plan.

FSAs can help you save significantly on the cost of health care and dependent care by allowing you to pay for qualified expenses on a tax-advantaged basis. However, the funds you contribute are subject to certain restrictions in their use, as explained below, and are subject to the *"use-it-or-lose-it"* rule.

When you elect to contribute to the MRA or DCA, you are choosing to contribute that amount over the applicable Plan Year, which is a Calendar Year, not a Conference or appointment year or season. If you enroll in the Plan mid-year and elect to contribute to an MRA or DCA, your election will apply to the remaining portion of the Calendar Year.

Medical Reimbursement Accounts

The MRA allows reimbursement only for eligible medical expenses. To be an eligible expense, you cannot otherwise be reimbursed for the expense by the Plan or through other insurance or similar group health coverage; you cannot claim the expense as an itemized deduction on an individual income tax return. In other words, the expense must be out-of-pocket to you and you cannot "double dip." Many out-of-pocket health care expenses, such as Co-payments, Coinsurance amounts, Deductibles and out-of-network charges are reimbursable. In addition, only with a physician's prescription order, the costs of some over-the-counter medications may be reimbursable. Importantly, you cannot use an MRA to pay for long-term care expenses, HealthFlex Required Contributions or any premiums for health insurance. Contact the General Board or the Claims Administrator for a list of permissible and impermissible MRA expenses.

Under the MRA, the amount you elect for the entire Plan Year is available to you beginning with the first day of the Plan Year. This requirement is called the *uniform coverage rule*.

To be an eligible expense, you must incur the expense during the applicable Plan Year. You incur an expense when the service or care is provided, not necessarily when you are billed or pay for the service. HealthFlex has incorporated a grace period (Grace Period) for the MRA, as allowed by the Internal Revenue Service (IRS), so you can submit eligible health care expenses incurred from January 1 through March 15 after the end of a Plan Year. You may be reimbursed through your MRA for out-of-pocket health care expenses incurred by your Spouse or Dependents (even for qualified expenses for dependents not covered under a HealthFlex medical Benefit Option).

If you elect to contribute to an MRA, you must contribute at least $300, but you may not contribute more than $5,000 in any Plan Year.

[11] Salary reduction contributions should not be subject to federal income or FICA tax withholdings. In some cases, salary reduction contributions also may be exempt from state and local tax withholdings. Consult your tax advisor and Plan Sponsor.

Dependent Care Accounts

If you contribute to a DCA, you set aside part of your compensation on a before-tax basis to reimburse yourself for certain eligible dependent day care expenses (even for qualified expenses for dependents not covered under a HealthFlex medical Benefit Option). You may be reimbursed for expenses incurred for care of your dependents that enable you and your Spouse to work. Dependent day care expenses may include expenses for summer day camp, babysitting services while you work or a day care center for children or dependent adults. Eligible expenses include dependent care expenses for your dependent children (age 12 and younger[12]) or your Spouse or other tax dependents who are physically or mentally incapable of self-care.

Unclaimed amounts in your DCA at the end of the Plan Year cannot be used to pay for benefits in future years or returned to you. You forfeit these unused amounts. The DCA is also subject to the *use-it-or-lose-it rule*. The General Board uses forfeited amounts to offset the Plan's administrative expenses.

You must be able to provide substantiation of your dependent day care expenses and the provider's name, address and tax identification number (Social Security number if it is a home provider). In addition to submitting this information to the Claims Administrator to request your reimbursement, you may want to save a copy of this information for reference when you prepare your income tax return. Qualifying dependent care providers include, but are not limited to:

- Dependent care centers. If the center provides care for more than six non-resident individuals, it must meet all applicable state and local regulations;
- An individual who provides care inside or outside your home. However, your own child younger than age 19 or any other individual for whom you can claim a personal income tax exemption does not qualify as a care provider;
- Facilities for pre-school children; and
- A housekeeper whose services include, in part, providing care for a qualifying dependent.

It is relatively easy to estimate your expenses for a DCA, since you most likely know the cost of the services in advance. Generally, if you contribute to a DCA, you must contribute at least $300, but you may not contribute more than $5,000 in any Plan Year. However, your DCA contributions are subject to the following additional limits. In a Plan Year, the amount you may contribute to the DCA is limited to the smallest of the following:

- $5,000 (or $2,500 if you are married, but filing separately);
- your earned income; or
- if you are married at the end of the taxable year, your Spouse's earned income.

If you are married, but your Spouse has no earned income, your Spouse is deemed to have an earned income of $250 per month ($500 per month if there are two or more qualifying individuals) in each month that he or she is either a full-time student or incapable of self care.

To be eligible to use the DCA, you must be at work during the time your eligible dependent receives care. You also must meet one of the following eligibility guidelines:

- you are a single parent;
- you have a working Spouse;
- your Spouse is a full-time student at least five months during the year while you are working;
- your Spouse is physically or mentally unable to provide for his or her own care; or
- you are divorced or legally separated and have custody of your child most of the time even though your former Spouse may claim the child for income tax purposes.

An eligible dependent for DCA purposes is an individual who spends at least eight hours per day in your home and is one of the following:

- a child younger than age 13 for whom you have custody most of the time even though your former Spouse may claim the child for income tax purposes;
- any other dependent who is physically or mentally unable to care for himself or herself; or
- your Spouse, if he or she is physically or mentally incapable of self-care.

[12] Your child will cease to be an eligible dependent for DCA purposes the day that he or she reaches age 13.

Certain types of expenses are not eligible for reimbursement under the DCA. Examples of ineligible expenses include:

- services that are primarily educational or medical in nature (pre-school is generally regarded as primarily for the child's well-being and protection and not primarily educational);
- educational expenses at kindergarten level or higher;
- services provided on behalf of a qualified dependent while you or your Spouse is not working;
- household services provided by individuals who are not responsible for providing care to the dependent; and
- overnight camp costs.

Unlike the MRA, the amount of DCA reimbursement available to you at any time during the Plan Year is limited to the amount already credited to your DCA at the time of the request, i.e., the amounts your employer has withheld from your compensation, reduced by the amounts you have already been reimbursed in that Plan Year. In other words, the DCA is not subject to the *uniform coverage rule*.

Which Is Better for You—the DCA or Dependent Care Tax Credit?

Any reimbursements received through the DCA are not eligible for the Dependent Care Tax Credit on your personal income tax return and DCA reimbursements can reduce the amount of eligible expenses that you can claim under the Dependent Care Tax Credit. You should speak to a tax advisor to determine if a DCA or the Dependent Care Tax Credit is more advantageous to you.

Tax Reporting

Although you will not have to pay federal, Social Security (FICA) or state (except in a few states) taxes on amounts you contribute to the DCA, the amount you are reimbursed should be recorded in a separate box on your Form *W-2*. When preparing your personal income tax return, you should complete and file an IRS *Form 2441* or *Schedule 2*; depending on the type of income tax return you file (*Form 1040 or 1040A*). *Form 2441* or *Schedule 2* requires that you report the name, address and taxpayer ID number of your dependent care providers. These forms allow the IRS to identify dependent care reimbursements received through the DCA and to calculate any expense which may remain eligible for the Dependent Care Tax Credit. For more information about income tax filing requirements related to the DCA, you should review *IRS Publication 503*.

"Use-It-or-Lose-It" Rule

Amounts you contribute to the MRA and DCA cannot carry over from one year to the next. This prohibition is known as the *use-it-or-lose-it rule*. You will forfeit unused MRA funds if you do not incur enough expenses during the Plan Year and the Grace Period to exhaust your MRA. You will forfeit unused DCA funds if you do not incur enough expenses during the Plan Year to exhaust your DCA.

You do have a run-out period (Run-Out Period) during which you may continue to submit Claims for reimbursement from FSA accounts for eligible expenses that you incurred during the Plan Year. Generally, you have until the April 30 that immediately follows the end of a Plan Year to submit all Claims for that just-ended Plan Year. You will not be reimbursed for any Claims submitted after the Run-Out Period deadline. You forfeit all amounts remaining in MRA and DCA accounts after the end of the applicable Run-Out Period. The General Board uses such forfeited amounts to offset the administrative expenses of the Plan.

Grace Period

HealthFlex has established a Grace Period for the MRA as permitted by the Internal Revenue Service. The Grace Period is the 2½-month period immediately following the end of a Plan Year. MRA expenses incurred during this Grace Period (i.e., expenses for health care services received from January 1 to March 15 of the year that immediately follows the end of a Plan Year) may be reimbursed from the just-ended Plan Year's MRA balance, if any, or from the then current year's balance. Prior to this rule change, you could only request reimbursement for expenses that were incurred during the 365-day Plan Year. Now, you the 2½ months after the end of a Plan Year to incur claims and seek reimbursement, thus helping you "use" your MRA balance rather than "lose" it.

For example, expenses (e.g., a Co-payment for an office visit) you incur during the Grace Period from January 1, 2012until March 15, 2012 may be reimbursed from your 2011 MRA if it has a positive balance. Otherwise, they will be reimbursed from your 2012 MRA balance, if any.

Moreover, the Grace Period will run concurrently with the Run-Out Period described above. That means that after the end of the Grace Period on March 15, you will have only until April 30, to submit any and all Claims incurred through March 15, for reimbursement from the MRA balance remaining from the preceding Plan Year and its just-ended Grace Period. Any Claims submitted after April 30 that you incurred during the previous Plan Year or the just-ended Grace Period will not be reimbursed. Eligible Claims incurred during the Grace Period but submitted after April 30 (after the end of the Run-Out Period) may be reimbursed from the then current Plan Year MRA funds, if any.

You must be a Participant with an MRA as of the last day of the Plan Year in order to take advantage of the Grace Period for that Plan Year. It is important to remember that you can still forfeit MRA funds if you do not incur enough expenses during the Plan Year and the Grace Period to exhaust your MRA contribution.

Important: The Grace Period *does not apply* to the DCA. All claims under your DCA must be incurred during the applicable Plan Year, by December 31, and you must submit them before the end of the Run-Out Period.

Termination of Employment

If you terminate employment, you will no longer be eligible to participate in the premium conversion plan. Typically, your pre-tax contributions (and Plan coverage) will continue through your last regular payroll period. Contact your Plan Sponsor for more information regarding pre-tax contributions if your employment terminates. If you terminate employment, your participation in the MRA and DCA will automatically terminate. You may receive reimbursement for eligible expenses incurred prior to termination if you submit your Claims within 90 days of termination.

If you terminate employment and are rehired in less than 30 days, you will re-enter the Plan with the same election you had before you terminated. In this case, you do not have to pay the missed contributions, but expenses incurred during the time not employed are not eligible for reimbursement. If you are rehired more than 30 days but less than 90 days after your termination, the Plan will allow you to continue with the same election as before your termination, but you must make up missed contributions. If you are rehired more than 90 days after your termination, you must make a new election or wait until the next Plan Year to participate.

Key Provisions of the MRA and DCA

- To use an MRA or DCA each year, you must elect to contribute part of your compensation to the MRA or DCA during the Annual Election Period or upon enrollment. If you make no election, you will not have an MRA or DCA for that year; your contributions will be zero. MRA and DCA elections do not carry over from year to year.
- For the MRA, the total annual amount that you elected to contribute for the Plan Year is available at any time during the Plan Year (reduced by the amount of prior MRA reimbursements already paid to you). For the DCA, only the amounts your employer has withheld from your pay, less expenses already reimbursed, are available to you at any time during the Plan Year.
- You must incur the eligible expenses during the Plan Year (or during the Grace Period for MRA Claims). Expenses are incurred when services are performed, not necessarily when payment is made (subject to certain exceptions for orthodontia and eyeglasses).
- The amount you elect to contribute is for a Plan Year (calendar year), not a conference or appointment year or season. If you enroll in the program mid-year and elect to contribute to an MRA or DCA, your election will apply to the remaining portion of the Plan Year.
- If you terminate from HealthFlex, you have 90 days from the date of termination to submit all Claims you incurred before your termination date.
- Eligible MRA expenses must be allowed as deductions for medical expenses as described in §213(d) of the Code, other than premiums for health insurance or coverage (Required Contributions). Eligible MRA expenses may include Deductibles, Co-payments and amounts over the maximum the Plan pays for reasonable and customary care. Other health care charges that may be reimbursed include routine physicals, vision care, hearing care, dental care and orthodontic care. In addition, if prescribed by a doctor, expenses for many over-the-counter medications may be reimbursable.

- Examples of expenses specifically non-reimbursable under the MRA include cosmetic surgery that does not treat an illness or disease, gym membership fees, costs of weight loss programs done for your general health, long-term care expenses and premiums you pay for insurance coverage.
- Expenses that are reimbursed through the MRA cannot also be used as deductible expenses when filing your personal income tax return. However, the MRA allows you to reduce taxes on many health-related expenses, even if the expenses do not exceed the 7.5% of your gross income required to claim them as a deduction on your personal income tax return.
- You cannot change the amount that you elected to set aside in your FSAs during the Plan Year. Generally, you may contribute between $300 and $5,000 to each type of FSA, to be deducted from your salary in equal amounts through the year. However, certain Life Status Events may allow you to make election changes during the Plan Year.
- The Claims Administrator will reimburse your DCA Claim up to the available balance in your DCA at the time you submit the Claim. If there are insufficient funds in your DCA to reimburse the entire Claim, the remaining amount of the Claim will be paid as soon as there have been enough payroll deductions credited to your DCA. You will not have to re-submit the Claim.
- You have tax reporting requirements related to the DCA that you should make sure you understand.
- The General Board may amend or terminate the cafeteria plan at any time. Your consent is not required to terminate the Plan.

Tax Consequences for You

There are important tax implications associated with electing to pay your Required Contributions through the cafeteria plan and with contributing to an MRA or DCA. You may want to speak with your tax advisor before electing to participate in the MRA or DCA if you have questions about the tax savings and implications. Salary reduction contributions will reduce your gross taxable income for Social Security purposes. This means that your future Social Security benefits could be impacted by the decreased amount of taxable income considered for Social Security purposes.

Nondiscrimination

FSAs are subject to certain nondiscrimination requirements in the Code. This means that in terms of eligibility and contributions, FSAs cannot improperly favor highly compensated Employees (HCEs). The General Board tests the FSAs periodically to ensure the Plan meets these requirements. And the General Board may reject any Participant's election and reduce the amount of any Participant's contributions or nontaxable benefits to the extent necessary to assure that the Plan does not discriminate in violation of Code §125. If it must take these actions, the General Board will do so on a reasonable and nondiscriminatory basis. Contributions that the Plan is unable to return to Participants will be forfeited.

YOUR HEALTHFLEX BENEFITS

Benefit Options

HealthFlex gives Plan Sponsors a choice of medical, prescription drug, dental and vision Benefit Options to offer their Employees. Some Plan Sponsors may offer only medical Benefit Options, while other Plan Sponsors may offer a combination of medical, dental and vision Benefit Options.

The General Board can add new Benefit Options and can eliminate or discontinue any existing Benefit Options at any time. However, the General Board will provide you and your Plan Sponsor reasonable notice in such cases, barring extraordinary circumstances.

For more information about the Plan's Benefit Options and the specific terms and conditions of the benefits offered under each, please review the benefit summaries available online and the *HealthFlex Benefit Booklet* or certificate of insurance applicable to each Benefit Option.

Medical Benefit Options for Active Participants and Retired Participants Younger Than Age 65

There are four medical Benefit Options administered by the Plan's Claims Administrators (BlueCross BlueShield of Illinois and UnitedHealthcare, depending on your geographic location and Plan Sponsor) available to Plan Sponsors. Depending on your Plan Sponsor's choices, one or more of the following medical Benefit Options are available to you:

- Preferred Provider Organization (PPO),
- Out-of-Area (OOA),
- Exclusive Provider Organization (EPO); and
- Consumer-Driven Health Plan (CDHP).

Within each of the Benefit Options, several plan designs are available. Differences among these Benefit Options and the various designs within each option are primarily the Deductibles, Co-payments, Coinsurance amounts, network restrictions, out-of-network coverage and charges and out-of-pocket maximums.

Coverage and Benefits

You can find detailed descriptions of your Benefit Options and the rules governing each, including coverage, exclusions, network restrictions, covered procedures and specific costs, in the *HealthFlex Benefits Booklets* applicable to your Benefit Options. In addition, you can find summary information in the benefit summary applicable to your Benefit Option online at the General Board's website. You can also call your Claims Administrator for information about your coverage and benefits.

Consumer-Driven Health Plan (CDHP)

A CDHP is a type of health insurance plan that allows you as a Participant to use a health reimbursement arrangement called a Health Reimbursement Account (HRA) to pay certain eligible health care expenses directly, while a high-deductible health coverage plan, i.e., a PPO-type plan with a higher Deductible, protects you from catastrophic medical expenses.

An HRA is used to offset eligible unreimbursed expenses incurred by you or your covered Dependents on a nontaxable basis (the contributions to the HRA from the Plan and your Plan Sponsor generally are not taxable). If you do not use all HRA funds during a Plan Year, the remaining amount will roll over to the following Plan Year, with no maximum on accumulated rolled-over funds as long as you continue participation in the CDHP. You are only eligible to participate in the HRA if you have elected and are enrolled in a CDHP under the Plan.

HRA balances remaining when you retire may be used to the extent allowed under the law for eligible health care-related expenses, including health coverage in retirement through Medicare, the Medicare Companion Plan Benefit Option under the Plan, and Medicare supplement plans outside of HealthFlex. To be eligible, you must satisfy the retiree eligibility rules of both HealthFlex and your Plan Sponsor (see the section of this SPD titled Coverage in Retirement). Your HRA balance will be available for your use even if your Plan Sponsor does not sponsor health coverage for retired Participants through the Plan.

HRA Funding

An HRA will be established for each eligible Participant and used for the sole purpose for reimbursement of eligible medical expenses. Each year the General Board will determine the amount that will be contributed to your account for the Plan Year. In addition, your Plan Sponsor may contribute to your HRA. Contributions will be funded and available at the beginning of each Plan Year.

HRA Reimbursements

The HRA allows reimbursement only for eligible medical expenses. To be an eligible expense, you cannot otherwise be reimbursed for the expense by the Plan or through other insurance or similar group health coverage; and you cannot claim the expense as an itemized deduction on an individual income tax return. In other words, the expense must be out-of-pocket to you and you cannot "double dip." Many out-of-pocket health care expenses, such as Co-payments, Coinsurance amounts, Deductibles and out-of-network charges are reimbursable. In addition, medical expenses described in §213(d) of the Code are eligible for reimbursement from the HRA. And, only with a physician's prescription order, the costs of some over-the-counter medications are reimbursable.

In addition, if you have a Retiree HRA as described below, you may request reimbursements for long-term care insurance, or any premiums for health and dental insurance or Medicare Part B.

Expenses not Eligible

Importantly, you cannot use an HRA to pay for HealthFlex Required Contributions, while you are an actively employed Employee.

Expenses incurred by a Spouse or Dependent who are not covered in the CDHP under the Plan are not eligible for reimbursement. You may contact the General Board or the Claims Administrator, Ceridian for the HRA, for a list of permissible and impermissible HRA expenses.

Carryover of Accounts

If any balance remains in your HRA for a Plan Year after all reimbursements have been made for the Plan Year, such balance shall carried over to reimburse you for eligible medical expenses incurred during a subsequent Plan Year, if you maintain participation in the CDHP.

Termination of HRA Participation

If you are no longer eligible to participate in a CDHP, as described below, and a balance remains in your HRA Account, the funds will be handled in the subsequent Plan Year in the following way:

- If you have a positive HRA account balance, and retire in accordance with all the retirement eligibility rules of the Plan and those of your Plan Sponsor, i.e., become a Retired Participant in the Plan and a Retired HRA Participant, your HRA Account balance shall be transferred to a Retiree HRA, as described below.
- If you elect to discontinue participation in a CDHP under the Plan although it is offered by your Plan Sponsor, or the Plan Sponsor no longer offers a CDHP Benefit Option, you shall have 365 days to spend-down (i.e., both incur and be reimbursed for eligible medical expenses) the HRA account balance (but will not be eligible for any additional contributions). After the 365-day spend-down period any remaining balances shall be forfeited.
- If you become a terminated Participant, through a termination of employment or termination of conference relationship, any remaining balance shall be available for reimbursement for eligible expenses incurred prior to termination if you submit your Claims within 90 days of such termination. However, if you are on Continuation Coverage, any remaining balance shall be available for reimbursement for the duration of the Continuation Coverage period. Any remaining balances after this period shall be forfeited.
- If you are a clergyperson who is appointed to a Plan Sponsor that does not offer a CDHP as a Benefit Option, any remaining balance shall be frozen until you return to a Plan Sponsor offering a CDHP Benefit Option or become a terminated participant. If you return to a Plan Sponsor offering a CDHP Benefit Option, the balance again becomes available for reimbursement. If you become a terminated Participant, any remaining balance shall be available for reimbursement for eligible expenses incurred prior to termination if you submit your Claims within 90 days of termination.

If you become a terminated Participant for any reason and then are rehired, you will be considered a new HRA Participant. However, if you go on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, the General Board will continue to maintain your benefits on the same terms and conditions as if you were still an active Employee. If you go on a leave of absence that is not subject to the FMLA or USERRA, you will be treated as having terminated participation.

Retiree HRA

If you retire pursuant to the retirement eligibility rules of the Plan and your Plan Sponsor, any remaining balance in your HRA Account will be converted and transferred to a Retiree HRA Account. You may be reimbursed from your Retiree HRA Account for eligible medical expenses until your account is exhausted. Amounts are carried over from Plan Year to Plan Year as long as you remain retired and have not died. If your Spouse or other Dependents are covered under a CDHP after you retire, they will continue participation in the non-Retiree HRA while covered under the CDHP.

Upon your death, if you have an eligible surviving Spouse or eligible surviving Dependents, the eligible survivors may be reimbursed from your Retiree HRA Account for eligible medical expenses until the account is exhausted or until such survivors

die. Expenses incurred by a Spouse or Dependent who are not covered in the CDHP under the Plan are not eligible for reimbursement. If you die with a balance in your account and have no eligible surviving Spouse or Dependents, the balance of such account is forfeited to the Plan.

Medical Benefit Options for Medicare-Eligible Participants

If you are age 65 or older (i.e., eligible for Medicare) or younger than age 65 but eligible for Medicare (e.g., through disability), there are up to two medical Benefit Options available to you, depending on the choices of your Plan Sponsor:

- Medicare Companion Benefit Option (an indemnity type plan that pays secondary to Medicare as permitted in the Medicare Secondary Payer Rules); and
- Medicare HMO Benefit Option (this Benefit Option is available only for those who live within the Medicare HMO services areas). If your Plan Sponsor offers a Medicare HMO Benefit Option, it also must also offer you a Medicare Companion Benefit Option if you live outside the Medicare HMO service area.

You and your Dependents generally must be covered under the same Benefit Option, even if you live in different geographic areas. In certain circumstances, you and your Dependent can be covered under different Benefit Options due to factors such as age and Medicare eligibility. For example, a retired Participant who is older than age 65 will be covered in a Medicare Companion Benefit Option while his or her Spouse or Dependent who is younger than age 65 will remain enrolled in a medical Benefit Option for active Participants, like the EPO Benefit Option. Retired Participants who are eligible for Medicare but are actively employed, i.e., "working aged," will be covered in a Benefit Option for active Participants pursuant to the MSP rules, unless they work for small employers that have elected to be exempt from the MSP rules.

Coverage and Benefits

You can find detailed descriptions of your Benefit Option and the rules governing it, including coverage, exclusions, network restrictions, covered procedures and specific costs, in the *HealthFlex Benefit Booklet* applicable to your Benefit Option. In addition, you can find summary information in the benefit summary applicable to your Benefit Option online at the General Board's website. You can also call your Claims Administrator for information about your coverage and benefits.

Prescription Drug Coverage

Medco is the Claims Administrator for all prescription drug Claims under the Plan. Do not send Claims for prescription drug benefits to your medical benefits Claims Administrator. Please contact your Plan Sponsor or the General Board if you have any questions about to whom you should submit a Claim for your prescription drug or medical benefits.

Coverage and Benefits

Your Plan Sponsor can choose among four prescription drug Benefit Options. Your Benefit Option for prescription drugs will depend on the medical Benefit Options you elect or are assigned.

You can find a detailed description of your prescription drug Benefit Option and the rules governing it, including covered drugs, exclusions, limitations and specific costs, in the *HealthFlex Benefit Booklet* applicable to your *medical* Benefit Option. In addition, you can find summary information in the benefit summary applicable to your prescription drug Benefit Option online at the General Board's website.

Obtaining Your Prescription Drugs

There are two ways to fill your prescriptions. You can use (i) one of the 55,000 participating retail pharmacies nationwide or (ii) the Medco Pharmacy program (for long-term needs). You can find additional information about your prescription drug benefits, including the location of participating retail pharmacies in your area, through the Medco website at **www.medco.com** or by telephone at **800.841.2806**. You must present your ID Card when receiving prescription drugs and services from a participating retail pharmacy. You must pay any applicable Deductibles and Co-payments at the time you fill the prescription.

Plan Rules for Prescription Drugs

Generic First Requirement

Generic medications may have unfamiliar names, but they are safe and effective. Generic medications and their brand-name counterparts have the same active ingredients and are manufactured according to the same strict federal regulations. Generic drugs may differ in color, size or shape, but the FDA requires that the active ingredients have the same strength, purity and quality as their brand-name counterparts. For this reason, the Plan will cover only the cost of the generic drug equivalent if you purchase a brand-name drug when there is an equivalent generic drug available; you will pay the remainder of the cost.

Medco Mail Pharmacy

You should use the Medco Pharmacy, also sometimes called "mail-order" for maintenance (long-term) medications. You can receive up to a 90-day supply of medication for a Co-payment that is equal to two retail pharmacy Co-payments.

Retail Refill Allowance

The Plan maintains a retail refill allowance policy. This policy requires that you use the Medco Pharmacy if you are prescribed a maintenance medication (long-term prescription drug), rather than refilling multiple prescriptions at a retail pharmacy. If you have a prescription for maintenance medication and you do not use the Medco Pharmacy, your prescription may not be covered. You are allowed to obtain three fills (the initial fill plus two refills) of maintenance drugs at a retail pharmacy. For all subsequent fills, you must use the Medco Pharmacy. Otherwise, you will be responsible for paying 100% of the cost of the drug. Certain medications are uniquely appropriate for multiple refills at a retail pharmacy, and are therefore exempt from the mandatory Medco Pharmacy provision.

Prescription Drug Formulary

Medco utilizes a formulary management program designed to control costs for you and the Plan. The formulary includes all U.S. Food and Drug Administration (FDA)-approved prescription drugs that have been placed in tiers based on their clinical effectiveness, safety and cost. Generally, tier 1 includes primarily generic drugs; tier 2 includes formulary brand-name drugs; and Tier 3 includes non-formulary brand-name drugs and non-sedating antihistamines. Though all currently FDA-approved prescription drugs are included on the formulary list, the Plan may elect to exclude some drugs.

It is always up to you and your physician to decide which prescriptions are best for you. You are never required to use generic drugs or brand-name drugs that are on the Medco formulary list. If you prefer, you may use non-formulary brand-name drugs and simply pay a higher Co-payment. You can find the most up-to-date list of covered prescription drugs or formulary drugs on Medco's website at **www.medco.com**. It is important that you note that not all drugs listed on the formulary are covered due to Plan exclusions and limitations. You can find detailed descriptions of your prescription drug benefits and the drugs covered and excluded by the Plan in the *HealthFlex Benefits Booklet* applicable to your *medical* Benefit Option.

Dental Benefits

Your Plan Sponsor may choose to offer you dental Benefit Options. Plan Sponsors may choose to offer dental Benefit Options to active Participants without necessarily offering the same to retired Participants.

Plan Sponsors can choose from three dental Benefit Options:

- indemnity (i.e., traditional dental);
- PPO; and
- dental HMO.

You must be covered under a medical Benefit Option in order to be covered under a dental Benefit Option. Please contact your Plan Sponsor with questions regarding the availability of dental benefits for you. You may also contact the General Board regarding eligibility and other dental benefits questions. Connecticut General Life Insurance Company (CIGNA) is the Claims Administrator for dental benefits under the Plan. CIGNA administers utilization, review, benefit payment and case management of your dental benefits. You or your dentist must submit all dental Claims to CIGNA.

A detailed description of your dental benefits can be found in the *HealthFlex Dental Benefits Booklet*, available online at the General Board's website.

CIGNA customer service coordinators are available at **800.CIGNA.24** (**800.244.6224**) to answer questions about your dental benefits 7 days a week 24 hours a day (including holidays). If you are calling due to a dental emergency, follow the directions as instructed on the CIGNA voice response system. You can also find information about your dental benefits online at **www.cigna.com**.

Vision Benefits

The Plan provides basic vision benefits to every Participant covered through a medical Benefit Option. This coverage is called basic vision coverage. In addition to basic vision coverage, your Plan Sponsor may choose to offer you one of two vision Benefit Options. Plan Sponsors may choose to offer vision Benefit Options to active Participants without necessarily offering the same to retired Participants.

Plan Sponsors can choose from the following vision Benefit Options:

- an "incentive materials" Benefit Option, which provides vision eyewear coverage for Participants who meet certain incentive requirements, for example, completing a health risk assessment or a routine wellness exam; or
- a "full-service" Benefit Option that covers vision eyewear for all enrolled Participants.

You must be covered under a medical Benefit Option in order to be covered under a vision Benefit Option. The Plan provides your vision benefits through Vision Service Plan Insurance Company (VSP). VSP is the Claims Administrator for vision benefits. You or your provider must submit all Claims for vision benefits to VSP.

For more complete information regarding your vision coverage, you should consult the materials provided by VSP or the benefit summaries available online at the General Board's website. You can find a full explanation of your vision benefits in the *HealthFlex Benefits Booklet* that applies to your medical Benefit Option. To find out more about your vision benefits under the Plan or to find a participating provider of vision benefit services you may call VSP at **800.977.7195** or visit **www.vsp.com**.

Mental and Behavioral Health Benefits

The Plan provides mental and behavioral health benefits through United Behavioral Health (UBH). The Claims Administrator for your medical benefits does not administer Claims for mental and behavioral health benefits. UBH is responsible for all administration, utilization review and case management of your mental health and behavioral health benefits. You or your provider must submit all Claims for mental health benefits to UBH. UBH customer service coordinators are available to answer questions about your mental health benefits 24 hours a day, seven days a week.

Your mental health Benefit Option depends on your elected or assigned medical Benefit Option. If you are covered in a PPO or OOA medical Benefit Option, you will also be covered in a PPO mental health Benefit Option. And if you are covered in an EPO medical Benefit Option, you will be covered in the EPO mental health Benefit Option.

The terms and conditions of your mental health benefits are governed by the agreements between UBH and the General Board. You can find out more about your mental and behavioral health benefits at the UBH website at **www.liveandworkwell.com/member**. You may also review the benefit summaries for mental health benefits and the *HealthFlex Benefits Booklets* for Mental Health Benefits (EPO and PPO) available on the General Board's website at **www.gbophb.org** for more information.

Required Review Procedures

To ensure that you receive the maximum benefits available under the Plan, you should contact UBH at **800.788.5614** prior to receiving care. If the services are rendered as the result of an emergency, you or a family member should contact UBH within 48 hours. When you call, you should provide the following: the name of the covered Employee; the name of the patient; and the name, address and telephone number of the hospital and the scheduled date of admission. If you do not have a mental health or behavioral health provider and need assistance in selecting one, UBH can assist you with a referral. For emergency admissions (including evenings and weekends), you or your provider must contact UBH customer service at the time of the admission.

Reduced Benefits for Failure to Follow Required Review Procedures
The Plan provides significantly reduced benefits for any inpatient and other mental health services that have not been pre-authorized through UBH. Your benefits will be reduced and you may be penalized for expenses incurred for services that have not been pre-authorized by UBH. Pre-authorization, however, is not a guarantee of benefits.

Other Benefits Available

Regardless of your Benefits Options for medical and other benefits, the following additional benefits are available to you through the Plan. They are aimed at helping you maintain and improve your health and wellness.

Health Team (General Board)
The General Board's Health Team advocates for you and can help you manage your HealthFlex benefits. The Health Team is your resource for Plan information. Health Team representatives are available at **800.851.2201**, Monday through Friday from 8:00 a.m. to 6:00 p.m., Central time.

Employee Assistance Program (EAP)
The Plan maintains an Employee Assistance Program (EAP), through UBH, for your use in dealing with such matters as work-life balance, substance abuse, stress management, family counseling, financial advice, legal assistance and other concerns. You can find out more about the EAP at the UBH website at **www.liveandworkwell.com/member**.

Wellness
The Plan provides a wide array of wellness benefits. In addition to generous wellness benefits within the Plan's medical Benefit Options, you may have access to biometric screenings, an online health assessment, health coaching, disease management programs, WeightWatchers® memberships at reduced nationwide rates, online tools, and an extensive library of information at WebMD and through the Optum NurseLine. Most of these services are available to you at no additional cost, through HealthFlex.

You can find more information about these services on the HealthFlex/WebMD website. Start at **www.gbophb.org** and click on "**HealthFlex/WebMD**." After you log in, search under "**Get Started**" and "**HealthFlexVendor Links**."

Blueprint for Wellness
The Quest Diagnostics Blueprint for Wellness® is a biometric screening that evaluates more than 20 health indicators. With a blood draw followed by lab analysis, Blueprint for Wellness provides valuable information about heart disease risk, diabetes risk or management, kidney health, liver health and much more.

HealthQuotient
HealthQuotient (HQ) is WebMD's confidential health assessment tool (often called a health risk assessment), which allows you to take an active role in managing your health. Based on the data you enter, HQ evaluates your present health status, as well as your likelihood of developing certain serious health conditions, such as diabetes or heart disease. It provides personalized reports and recommendations by analyzing various risk factors that can affect your health. Based on your HQ results, you may be eligible for WebMD health coaching.

Health Coaching
Health coaching is offered through WebMD. Health coaching provides individualized support by telephone and is completely confidential. WebMD's coaches are trained health care professionals who help you address common risk factors by focusing on:

- weight loss and weight management;
- high blood sugar;
- exercise;
- high blood pressure;
- high cholesterol;
- nutrition and diet;
- emotional strain, such as depression or stress; and
- smoking.

Virgin HealthMiles

The Virgin HealthMiles program—part of the denomination-wide *Center for Health*—channels the health benefits of walking and other types of exercise, and rewards participants financially for their physical activity. Participants in Virgin HealthMiles:

- receive a free GoZone step-tracker to count steps taken;
- upload steps on the computer to earn "HealthMiles" (rewards points), and
- can convert HealthMiles into "HealthCash," which can be redeemed for retailer gift cards or directly deposited into a bank account.

Optimal Health Disease Management

The Optimal Health condition and disease management program is a collaborative effort between Medco and Healthways, Inc. Optimal Health provides telephone-based support from registered nurses. This confidential, voluntary program can help you address certain chronic health conditions, including:

- diabetes,
- coronary artery disease,
- heart failure,
- COPD; and
- asthma.

WeightWatchers®

This popular weight-loss program is available to HealthFlex participants at prices up to 50% lower than typical national corporate rates. You can choose among four program designs—online, at home, in your community or at work. WeightWatchers offers a healthy way to incorporate diet, exercise and lifestyle changes into your life.

NurseLine

Optum® NurseLine's registered nurses are available to answer your questions about symptoms and self-care for many health conditions. This is a helpful resource when your doctor is unavailable. You can call **800.475.7923** to reach the NurseLine any time, any day, at no cost to you. A wide range of health and well-being articles and tools also are accessible online through Optum NurseLine. You can also pose questions to medical professionals during online chats. To access Optum NurseLine online:

- If you are in a medical plan administered by UnitedHealthcare, go to **www.myuhc.com**.
- If you are in a medical plan administered by Blue Cross and Blue Shield of Illinois, go to **www.healthforums.com**.

WebMD

More information about HealthFlex services can be accessed online through WebMD. To reach the HealthFlex/WebMD website, start at the General Board website (**www.gbophb.org**) and click on "**HealthFlex/WebMD**." You will need to enter a username and password to reach the WebMD Personal Health Manager™—the entry point for your HealthFlex benefit information.

WebMD has much to offer. You can access information on all HealthFlex services, calculate your out-of-pocket costs for certain services, compare coverage, and learn how to manage a variety of health conditions. WebMD can personalize the information you receive by e-mail, based on your health interests and concerns. The HealthFlex/WebMD site hosts information about health conditions, tools to help you make prudent health care choices, and programs to help you on your path to better health. It also allows you to connect directly to other websites to access your medical, pharmacy, behavioral health and wellness benefits.

CLAIMS

How to File a Claim

In order to obtain your medical benefits under the Plan, you must submit your Claim to the proper Claims Administrator. To file a Claim, usually all you will have to do is show your ID Card to your hospital, physician or other provider. Typically, the provider will file your Claim for you. Remember, however, it is up to you to ensure the Claims Administrator has all necessary information to process your Claim. Once the Claims Administrator receives your Claim, the Claims Administrator will send benefit payment directly to the provider. You should receive an Explanation of Benefits (EOB) statement telling you how much was paid.

In certain situations, you will have to submit a Claim yourself, primarily when you are receiving services from providers other than a hospital or physician. An example would be when you have had ambulance expenses.

To file a Claim on your own, follow these instructions:

- Complete a Claim form. Claim forms are available from the General Board or from the Claims Administrator's office or website.
- Attach copies of all bills to be considered for benefits. These bills must include the provider's name and address, the
- patient's name, the diagnosis, the date of service, a description of the service and the Claim charge.
- Mail the completed Claim form with attachments to the proper Claims Administrator, whose address you can find in
- the appropriate *HealthFlex Benefits Booklet* or on the General Board's or Claims Administrator's website.

You should keep copies of any documents you submit with a Claim.

In any case, you must submit your Claims no more than 12 months from the date of service. Claims filed after 12 months may not be eligible for payment or will be subject to reduced payment.

Should you have any questions about filing Claims, contact the General Board or call the Claims Administrator's office or review the *HealthFlex Benefits Booklet* applicable to your Benefit Option and Claim.

Claims Procedures

Usually, the Claims Administrator will pay Claims within 30 days of receipt of all information required to process your Claim. If the Claims Administrator denies your Claim, in whole or in part, you will receive a response with:

- the reasons for denial,
- a reference to the Plan provisions on which the denial is based,
- a description of additional information that may be necessary to process the Claim, and
- an explanation of how you may have the Claim reviewed by the Claims Administrator if you do not agree with the denial.

Claim Review Procedures

If your Claim has been denied in whole or in part, you may have your Claim reviewed. The Claims Administrator will review its decision in accordance with the procedures it has established that are described in the *HealthFlex Benefits Booklet* applicable to your Claim and on your Claim denial notice.

The Claim review procedures of the Plan's Claims Administrators will comply with the requirements of the Patient Protection and Affordable Care Act (PPACA), Section 2719 of the Public Health Service Act (PHSA), and, as made applicable by the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act; Interim Final Rule issued by the Department of Health and Human Services (45 CFR Part 147) the Department of Labor's claims procedure regulations under 29 CFR 2560.503-1.

You cannot sue or pursue a cause of action in law or equity in state or federal court against the Plan, the General Board, any of the Claims Administrators or insurers, or your Plan Sponsor, with respect to any Claim of any kind until you have exhausted the Claims, Claims review and appeals procedures applicable to your Claim.

APPEALS

The terms of the appeals processes for Claims under HealthFlex are outlined in this section.

Delegated Appeals Procedures—Medical, Prescription Drug and Mental Health Claims

The General Board has a fiduciary duty to hear appeals of Claims under the Plan. The Plan Document grants the General Board the power to delegate fiduciary and non-fiduciary duties and obligations to its agents. The General Board has delegated, through the terms of administrative services agreements and contracts and policies of insurance, the fiduciary duties of:

- adjudicating Claims for benefits, and
- hearing and adjudicating appeals of denied Claims

to its Claims Administrators for medical, prescription drug, mental and behavioral health, and vision Benefit Options. You or your provider must submit all Claims for medical, prescription drug, mental health and vision benefits to these Claims Administrators. Claimants must submit ***all appeals*** of denied Claims for medical, prescription drug, mental and behavioral health and vision benefits to these Claims Administrators.

The appeals procedures of the Plan's Claims Administrators will comply with the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act; Interim Final Rule issued by the Department of Health and Human Services (45 CFR Part 147) implementing Section 2719 PHSA.

The final determination—***the final and binding appeal***—with respect to (i) medical, (ii) prescription drug, (iii) mental and behavioral health; and (iv) vision benefits rests with these Claims Administrators. **The General Board has delegated these administrative and fiduciary duties to the Claims Administrators and does not have the authority to review the determinations.**

Other Claims and Appeals Procedures

The following appeals procedures apply when you wish to appeal a Claim regarding your elections, eligibility, enrollment, reimbursement from a flexible spending account, or dental benefits.

HealthFlex Election, Eligibility and Enrollment Appeals

As the Plan's administrator, the General Board is charged with determining:

- your eligibility for coverage under the group health plan and flexible spending account components of the Plan in
- accordance with the Plan and your Plan Sponsor's Adoption Agreement;
- premium conversion plan benefits;
- your ability to make elections and the validity thereof; and
- your proper enrollment.

If you have a Claim under the Plan related to eligibility, enrollment or elections, you must submit the Claim in writing to the General Board at the following address:

General Board of Pension and Health Benefits of The United Methodist Church
Attention: Health Team
1901 Chestnut Avenue
Glenview, Illinois 60025

The General Board will treat Claims submitted in writing as initial Claims. In addition, the General Board, in its discretion, can treat a Claim raised by telephone with the Health Team as an initial Claim. Moreover, in its discretion, the General Board can treat an inquiry raised by your Plan Sponsor or other representative as an initial Claim.

The General Board will promptly consider your Claim and notify you in writing of the Plan's decision within 30 days of receipt of the Claim. This period may be extended one time by the Plan for up to 15 days, provided that the General Board both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects

to render a decision. If the General Board denies any Claim under the Plan, in whole or in part, the General Board will provide you written notice setting forth:

- the specific reason or reasons for the denial;
- reference to pertinent provisions of the Plan on which the denial is based;
- a description of any additional material or information necessary for adjudicating the Claim and an explanation of
- why such material or information is necessary; and
- an explanation of the Plan's appeals procedures.

First Appeal

You or your representative then have 180 days from the date of the notice of denial from the General Board in which to submit an initial appeal (Initial Appeal). The Claim denial from the General Board should contain a *Notice of Initial Appeal*. You must carefully read the *Notice of Initial Appeal* and follow the time frames set out therein.

On appeal, you may submit documentation that supports your Claim, such as additional facts, information, documentation or arguments, to the Initial Appeal Committee. The Initial Appeal Committee will only consider those issues and supporting documents that are submitted with the Notice of Initial Appeal, except by its leave or discretion. The Initial Appeal Committee will be guided by an assigned Compliance Analyst. The Compliance Analyst, at her or his discretion, may speak with you to gather more facts and allow you to explain your Claim and argument. The Initial Appeal Committee will review and consider (i) the facts and circumstances; (ii) your argument; (iii) the applicable provisions from the Plan Document, Summary Plan Description, Benefit Booklets and other pertinent documents; and (iv) any mitigating circumstances, and then make its determination.

The Initial Appeal Committee will grant or deny your Claim and notify you of the decision within 45 days of receiving your *Notice of Initial Appeal*, unless the Initial Appeal Committee requires additional time. In cases requiring additional time, the Initial Review Committee will notify you of its need for additional time, up to an additional 30 days, within 45 days of receiving the *Notice of Initial Appeal*. If the Initial Appeal Committee denies your appeal, you will receive a letter of denial that sets forth the specific reason for the denial and includes a *Notice of Final Appeal*.

Final Appeal

You may appeal the Initial Appeal Committee's denial of your Claim by submitting, within 90 days of the notice of denial from the first appeal, a *Notice of Final Appeal* and documentation that supports your Claim, such as additional facts or information tending to dispute the General Board's interpretation of the Plan or the facts upon which the General Board based its Claim denial decision. The Final Appeals Committee will only consider those issues and supporting documents that are submitted with the *Notice of Final Appeal*, except by its leave or discretion. You must file your appeal on the forms required by the General Board.

The Final Appeals Committee will hold a hearing of the intermediate appeal within 60 days of the date that the General Board receives both the *Notice of Final Appeal* and all supporting documentation. Upon receipt of your completed Notice of Final Appeal, the General Board will send you a letter 1) confirming receipt of the *Notice of Final Appeal* and supporting documentation, if any, and 2) informing you of a scheduled hearing date. You may request a delay of the scheduled hearing for up to 45 days. The Final Appeals Committee will respond to you in writing with a decision within 30 calendar days after you requested a delay. If the Final Appeals Committee requires more time or information to make its determination, the Final Appeals Committee will notify you in writing within the initial 30 days to request an extension of up to 45 calendar days, if, at the discretion of the Final Appeals Committee, such extension is necessary, and to specify any additional information the Final Appeals Committee requires to complete the review.

You or your duly authorized representative may present your appeal to the Final Appeals Committee in person or by conference call. If you or your representative choose to appear at the hearing in person, you will be wholly responsible for all costs associated with such appearance.

Dental and FSA Claims

You must submit Claims for dental benefits under the Plan and claims for reimbursement from the FSAs (the MRA and DCA) to the applicable Claims Administrator for those Benefit Options, CIGNA and Ceridian, respectively. Through contracts with these

two Claims Administrators, the General Board has delegated administrative duties to process and review only initial Claims. If the Claims Administrator denies your Claim for dental benefits or FSA reimbursement and you wish to appeal the denial, you must follow the appeals process outlined above for eligibility, enrollment and election Claims.

ERISA and DOL Regulations Inapplicable

The Plan is a Church Plan. As a Church Plan, the Plan is exempt under §4(b)(2) of ERISA from all the requirements of Title I of ERISA. The Plan is not subject to most of the regulations promulgated by the U.S. Department of Labor.

Grievances

If you have a concern regarding a person, a service, the quality of care or benefits under the Plan, you can write the General Board to explain your concerns. If you are unhappy with the General Board's customer service or with the design of the Plan (i.e., specific exclusions under the Plan), or if you have other complaints or concerns, you should explain your grievance in writing and send it to the General Board at the following address:

General Board of Pension and Health Benefits of The United Methodist Church
Attention: Legal Services Department
1901 Chestnut Avenue
Glenview, Illinois 60025

You may also submit grievances to your Plan Sponsor.

Legal Action Against the Plan

No Participant or other Claimant may sue or pursue a cause of action in law or equity in state or federal court against the Plan, the General Board, any of the Claims Administrators or insurers, or Plan Sponsors, with respect to any Claim of any kind until the Participant or Claimant has exhausted these Claims and appeals procedures. The Participant or Claimant must sue within three years of the time the Claim arose, unless the law in the area where the Participant or Claimant lives allows for a longer period of time.

LIMITATIONS AND EXCLUSIONS

The Plan excludes payment of certain expenses. The following list describes the Plan's general exclusions and limitations, but other limitations and exclusions may apply under each Benefit Option. It is important that you review the *HealthFlex Benefits Booklets* applicable to your Benefit Options to thoroughly understand your coverage. The Plan will not make any payment for expenses incurred by you as an Employee, Spouse or Dependent:

- for or in connection with an injury or illness arising out of any employment for wage or profit;
- for or in connection with an illness or injury for which you are entitled to benefits under any workers' compensation or similar law;
- for charges made by a hospital owned or operated by or which performs services for the United States Government, unless there is a legal obligation to pay such charges whether or not there is coverage; or if such charges are directly related to a military service-connected illness or injury;
- to the extent that payment is unlawful where you reside when you incur the expenses;
- for charges that would not have been made if you had no coverage;
- to the extent that they are more than the reasonable and customary charge or allowable amount as defined in the applicable Benefit Option as determined by the Claims Administrator;
- for charges or expenses that are not eligible expenses as determined by the Claims Administrator; that are not medically necessary or medically appropriate for treatment of an illness or injury as determined by the Claims Administrator;
- for or in connection with custodial services, education or training;
- to the extent that you are in any way paid or entitled to payment for those expenses by or through a public program of any federal, state or local governmental entity, including Medicare (except when Medicare is assuming the role of secondary payer to this Plan), but not including Medicaid;

- that are payable under any Other Health Coverage or insurance or program to the extent described under the section entitled *Coordination of Benefits*;
- for charges made by any provider who is a member of your family, or your Spouse's family or for charges made by any provider who shares a legal residence with you or your Dependent;
- for experimental, investigational or unproven services (or services that conflict with accepted medical standards) that are medical, surgical, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that the Claims Administrator determines are:
  - not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use or not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional journal;
  - the subject of review or approval by an Institutional Review Board for the proposed use;
  - the subject of an ongoing clinical trial that meets the definition of a phase I, II or III clinical trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or
  - not demonstrated through existing peer-reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed;
- for treatment that is outside the scope of or inconsistent with a provider's license;
- for cosmetic surgery or cosmetic dental work, unless such cosmetic surgery or dental work is for the treatment of an injury that occurred while you were covered under the Plan, and such cosmetic surgery or dental work qualifies as reconstructive surgery that is performed on you following a surgical procedure when both the surgical procedure and the reconstructive surgery are medically necessary or appropriate;
- for prescription medications used to prevent natural conditions such as baldness, including vitamins, Rogaine, etc.;
- that are designed to be your expenses under the Benefit Options of this Plan such as Co-payments, Coinsurance, Deductibles and other Out-of-Pocket expenses, except that such amounts can be reimbursed under a Medical Reimbursement Account;
- for or in connection with an injury or illness that is due to war, declared or undeclared, or acts of terrorism;
- outside the United States, unless you are a U.S. resident, and the charges are incurred while traveling;
- for non-medical ancillary services, including but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation;
- for medical treatment if you are age 65 or older and covered under this Plan as a working retiree but the Plan pays secondary under the Medicare Secondary Payer Rules, or your Dependent who is age 65 or older, when Medicare denies payment;
- for medical treatment when payment is denied by a primary plan under the terms of the section entitled Coordination of Benefits because treatment was received from a provider that is not a network or participating provider in the primary plan's network;
- for medical treatment when payment is denied by a primary plan (including Medicare; see the section entitled *Coordination of Benefits*) because treatment was not a covered service or covered expense under the primary plan, unless otherwise expressly covered by the Plan;
- for charges that you are not obligated to pay or for which you are not billed or for which you would not have been billed but for your coverage under this Plan;
- for charges you submit more than 12 months after you incur them;
- for medical and hospital care and costs for the infant child of your Dependent, unless that infant child is otherwise eligible under the Plan;
- for charges for services and supplies that the Plan Administrator or Claim Administrator otherwise determines are excluded under the Plan; and
- for any Benefit Option, charges that are excluded in accordance with the limitations and exclusions of that Benefit Option as described in the *HealthFlex Benefits Booklet* for that Benefit Option.

You should review the applicable *HealthFlex Benefits Booklet* for your Benefit Options for specific exclusions and limitations to your coverage. In addition, for any Benefit Option that is fully insured through an insurer, the limitations of that Benefit Option

according to the policy of insurance from the insurer shall apply at all times. Always consult the certificate of insurance or benefits booklet for your Benefit Options.

COORDINATION OF BENEFITS

Coordination of Benefits for Medical Claims

Coordination of Benefits (COB) applies when you have health care coverage through more than one policy or group plan. The purpose of COB is to ensure that there is not a duplication of benefit payments. In other words, the total payment from this Plan as a secondary payer (Secondary Plan) will not, when added to the benefit paid by the primary plan (Primary Plan), exceed what this Plan would have paid if it were the Primary Plan or only plan. You are obliged to notify the Claims Administrator or Plan Administrator if you are covered by Other Health Coverage or if you have other health insurance; failing to do so can be considered fraud.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit plan. The following rules apply:

- The coverage under which you are the Participant or Employee (rather than covered as a dependent) is the Primary Plan (meaning that benefits are paid first under that plan). The other coverage is the Secondary Plan and only pays any remaining eligible charges up to what the Secondary Plan would pay if it were the Primary Plan.
- When a Dependent child receives services, the birthdays of the child's parents are used to determine which coverage is the Primary Plan. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the Primary Plan. If both parents have the same birthday, then the coverage that has been in effect the longest is the Primary Plan. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either the Primary Plan or the Secondary Plan, then the provisions of the other coverage will determine which coverage is the Primary Plan.
    - However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan that covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan that covers the child as a dependent of the parent without custody.
    - When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan that covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan that covers that child as a dependent of the stepparent, and the benefits of a plan that covers that child as a dependent of the stepparent will be determined before the benefits of a plan that covers that child as a dependent of the parent without custody.

However, if there is a court decree that would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan that covers the child as a dependent of the parent with such court-ordered financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the Claims Administrator and upon its request to provide a copy of such court decree.

If neither of the above rules applies, then the coverage that has been in effect the longest is the Primary Plan. The only time these rules will not apply is if the other group plan does not include a COB provision. In that case, the other group plan is automatically the Primary Plan and HealthFlex will be the Secondary Plan.

The Claims Administrator has the right in administering these COB provisions to:

- pay any other organization an amount that it determines to be warranted if payments that should have been made by the Claims Administrator have been made by such other organization under any other plan; and
- recover any over payment that the Claims Administrator may have made to you, any plan, provider, insurance company, person or other organization.

Right to Receive and Release Information

The Claims Administrator, with or without your consent, may obtain information from and release information to any other health care plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide all information the

Claims Administrator requests in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted Claim; if so, you will be advised that the "other coverage" information (including an Explanation of Benefits paid under the Primary Plan) is required before the Claim will be processed. If no response is received within 90 days of the request, the Claim will be denied. If the requested information is subsequently received, the Claim may be processed, subject to certain time limits.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the MSP rules of the Social Security Act. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above will be used to determine how benefits will be coordinated.

Coordination of Benefits for Claims Other Than Medical Claims

Your mental health benefits are coordinated in a similar manner as those for medical claims, described above, but are coordinated pursuant to the terms of the policy of insurance with UBH described in the *HealthFlex Benefits Booklet* for Mental Health Benefits. Your dental benefits are subject to a coordination of benefits provision that is similar to that described above for medical claims and is explained in the *HealthFlex Benefits Booklet* for Dental Benefits. The Plan does not coordinate benefits for prescription drug claims, as explained in the *HealthFlex Benefits Booklet* for your medical Benefit Option. If the Plan is not the primary plan for prescription drug coverage, the Plan will not pay any amounts for prescription drug Claims.

Medicare-Eligible Persons

The Claims Administrator will pay on behalf of the Plan as the Secondary Plan only as permitted by the MSP rules for the following:

- a former Employee or Participant who is eligible for Medicare and whose coverage is continued for any reason as provided in this Plan;
- a former Employee's or Participant's Dependent or a former Dependent Spouse who is eligible for Medicare and whose coverage is continued for any reason as provided in this Plan;
- an Employee or Participant eligible for Medicare due to disability;
- the Dependent, eligible for Medicare due to disability, of an Employee or Participant whose employer and each other employer participating in the Plan having fewer than 100 employees;
- an Employee or Participant or a Dependent of an Employee or Participant of an employer who has fewer than 20 employees, if that person is eligible for Medicare due to age; and
- an Employee or Participant, retired Employee or Participant, Employee's or Participant's Dependent or retired Employee's or Participant's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

The Claims Administrator will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he or she would receive if he or she had applied; and
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he or she would receive if he or she were enrolled.

Your Medicare Secondary Payer Responsibilities

In order to assist your Plan Sponsor and the General Board in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Claims Administrator, your Plan Sponsor and the General Board regarding your Medicare eligibility or that of your Spouse and Dependents. In addition, if you, your Spouse or Dependents become eligible for Medicare, or have Medicare eligibility terminated or changed, please contact your Plan Sponsor or the General Board promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

REIMBURSEMENT

Recovery of Excess Benefits

If the General Board or Claims Administrator makes payments for benefits that should have been paid by a Primary Plan (under *Coordination of Benefits*, above), or if the General Board or Claims Administrator makes payments in excess of those for which the Plan is obligated to provide under its terms, the Claims Administrator and General Board will have the right to recover the actual payment made, pursuant to a claim in equity. The General Board and Claims Administrator will have the discretion to seek such recovery from any person to, or for whom, or with respect to whom, such payments were made by any insurance company, Other Health Coverage or other organizations. You are required to execute and deliver to the General Board or Claims Administrator the instruments and documents necessary to secure this right of recovery.

Expenses for Which a Third Party May Be Liable

The Plan does not cover expenses for which another party may be responsible as a result of having caused or contributed to the injury or illness. If you incur an expense for a covered service for which, in the reasonable opinion of the Claims Administrator, another party may be liable:

- The Claims Administrator shall, to the extent permitted by law, be subrogated (meaning it will stand in your place legally) to all rights, claims or interests that you may have against such party and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid under the Plan. You or your representative may be required to execute the documents necessary to secure the Claims Administrator's subrogation rights.
- Alternatively, the Claims Administrator may, at its sole discretion, pay the benefits otherwise payable under the Plan. However, you must first agree in writing to refund to the Claims Administrator the lesser of a) the amount actually paid for the covered services by the Claims Administrator or b) the amount you actually receive from the third party for the covered services at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration, award or otherwise.

CONFIDENTIALITY, PRIVACY AND HIPAA

The General Board and all HealthFlex Plan Sponsors have a duty under HIPAA to maintain adequate separation of Plan functions and employment matters. The General Board permits disclosures relating to payment under, health care operations of and other matters pertaining to the Plan in the ordinary course of business. Access to and use of PHI is limited to the minimum amount necessary to perform the Plan administrative functions. Anyone employed by the General Board who does not comply with HIPAA and the related provisions of the Plan is subject to disciplinary action and sanctions.

CREDITABLE COVERAGE AND WAITING PERIODS

Pre-existing Condition Waiting Period

Generally, your benefits are subject to a Pre-existing Condition Waiting Period of 365 days. The Pre-existing Condition Waiting Period will begin on the effective date of your coverage. For more information about the Pre-existing Condition Waiting Periods, you should review the *HealthFlex Benefit Booklets* for your Benefit Options.

A Pre-existing Condition is an injury or illness for which you receive or have been recommended treatment, incur expenses or receive a diagnosis from a physician during the 90 days before you become covered under the Plan.

Only Participants and Dependents who are age 19 and older are subject to the Pre-existing Condition Waiting Period, i.e., pre-existing condition exclusions.

Exceptions to Pre-existing Condition Waiting Period

Under the terms of the PPACA, pre-existing condition exclusions, including the Plan's Pre-existing Condition Waiting Period, are not applicable to Participants and Dependents who are under the age of 19. Pregnancy and genetic information with no related treatment are not Pre-existing Conditions subject to the Pre-existing Condition Waiting Period.

Credit for Coverage Under Prior Plan

If you were previously covered under a plan that qualifies as Creditable Coverage (as described below) and you notify the General Board or the Claims Administrator of your prior coverage, and fewer than 63 days have elapsed between coverage under the prior plan and coverage under this Plan, the Claims Administrator will reduce any Pre-existing Condition Waiting Period under the Plan by the number of days of prior Creditable Coverage you had under the prior plan. You must provide proof of your prior Creditable Coverage in order to reduce a Pre-existing Condition Waiting Period. You should submit proof of prior Creditable Coverage with your *Enrollment Form*. You should contact the General Board or the Claims Administrator if you need assistance to obtain proof of prior Creditable Coverage from your prior plan. You are entitled by federal law to a copy of your Certificate of Creditable Coverage from your prior plan or policy.

Creditable Coverage

Creditable Coverage will include coverage under a self-insured employer group health plan; individual or group health insurance indemnity or HMO plans; state or federal continuation coverage (e.g., COBRA coverage); individual or group health conversion plans; Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; the Indian Health Service; coverage through the Peace Corps Act; a state health benefits risk pool; a public health plan; health coverage for current and former members of the armed forces and their dependents; a State Children's Health Insurance Program (S-CHIP); health coverage provided under a plan established by a foreign country; and health insurance for federal employees and their dependents. Please contact a customer service representative at your prior plan, the Claims Administrator or the General Board if you have questions about prior Creditable Coverage.

PLAN SPONSOR DUTIES

Each Plan Sponsor has the following duties with respect to the Plan:

- to determine initial eligibility consistent with the terms of the Plan and to enroll clergy Employees and lay Employees within 30 days of each Employee becoming eligible;
- to maintain records of Employees' compensation, enrollment and elections;
- to remit Required Contributions to the General Board;
- to provide the General Board with notice of a Participant's termination of employment, termination of Conference relationship or Change of Status, where the Plan Sponsor is made aware of the Change of Status;
- to provide the General Board with statistical data and other information satisfactory in form and accuracy within a reasonable time after a request;
- to register with and report to government agencies, as appropriate;
- to comply with applicable federal and state laws and regulations, including, but not limited to, nondiscrimination requirements;
- to properly notify clergy Employees and lay Employees of their rights and obligations under the Plan, including giving notices required under the Plan, HIPAA or the Code;
- to comply with the terms of HIPAA; and
- to execute an Adoption Agreement indicating its elections of optional Plan provisions and providing any other information called for by the Adoption Agreement.

The Plan Sponsor may be deemed to satisfy its duties through actions by a Salary-Paying Unit or other entity, but the Plan Sponsor remains responsible for the duties if they are not carried out in an appropriate manner or timely fashion.

PLAN SPONSOR AMENDMENT AND TERMINATION

The General Board may amend prospectively or retroactively any and all provisions of this Plan or an Adoption Agreement at any time by written instrument. A Plan Sponsor may amend its Adoption Agreement from year to year with respect to eligibility and Benefit Options.

The General Board may terminate a Plan Sponsor's association with the Plan for any reason by providing the Plan Sponsor 90 days' written notice. In addition, the General Board may terminate a Plan Sponsor for breach of the Plan's provisions or the terms of the Adoption Agreement, or for non-payment of Required Contributions if the Plan Sponsor does not cure the breach or delinquency upon notice within 30 days. If a Plan Sponsor's participation in the Plan is terminated, the Plan Sponsor cannot re-adopt the Plan for a period of three years. The termination of a Plan Sponsor will not excuse the Plan Sponsor from making payment in full of all Required Contributions. The General Board will notify affected Participants in the case of a termination of a Plan Sponsor.

A Plan Sponsor may terminate its participation in the Plan by providing 180 days' notice to the General Board. Your Plan Sponsor must inform you of its termination from the Plan at least 60 days before the date of termination.

TERMINATION OF THE PLAN

The General Board has the right to terminate the Plan and the Trust at any time. The disposition of assets remaining in the Plan, if any, after all obligations of the Plan have been satisfied, will be at the discretion of the General Board.

MISCELLANEOUS IMPORTANT PROVISIONS

Not Insurance

Use of the terms Coinsurance, Co-payment, Deductible and premium in this SPD does not imply that the Claims Administrators insure the Plan. Similarly, use of such terms does not imply that the Plan or the General Board is in the business of insurance. The Plan is offered by the General Board as a self-funded Church Plan only for the benefit of eligible clergy and Employees and their families, of organizations affiliated with the General Board through The United Methodist Church.

Though Church Plans are considered employee welfare benefit plans under Section 3(1) of ERISA, as indicated by Section 4(b)(2) of ERISA, Title I of ERISA does not apply to Church Plans. Therefore, most regulations issued by the U.S. Department of Labor do not govern the administration of the Plan. In addition, Church Plans are exempt from most state laws regulating insurers, such as state insurance licensing, solvency and funding requirements, by the Church Plan Parity and Entanglement Protection Act of 2000 (Parity Act). Self-insured Church Plans generally are not subject to many other state laws and regulations that govern insurers because they are not in the "business of insurance," and the Parity Act, along with certain state laws with respect to Church Plans, may exempt such Plans from state regulatory reach.

Interpretation of the Plan and Benefits

The General Board has sole and exclusive discretion to do all of the following:

- interpret the provisions and terms of and benefits available under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD; and
- make factual determinations related to the Plan and the benefits provided under it.

The General Board has delegated some of that authority to the Claims Administrators. The General Board has delegated the authority to adjudicate Claims and appeals to the Claims Administrators. The General Board and the Claims Administrators (with the consent of the General Board) may delegate this discretionary authority to other persons or entities that provide services to the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the General Board and Claims Administrator may, in their discretion, offer benefits for services that would otherwise not be covered. The fact that the General Board or Claims Administrators do so in any particular case shall not in any way be deemed to require them to do so in other similar cases.

No Waiver

The failure of the General Board or the Claims Administrator to enforce strictly any term or provision of this SPD or the Plan will not be construed as a waiver of such term or provision. The General Board reserves the right to enforce strictly any term or provision of this SPD and the Plan at any time.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to benefits under the Plan. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverage or entitlements. Oral statements made by the General Board, the Claims Administrators or any other person will not serve to amend the Plan. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control.

Applicable Law

The Plan will be construed according to applicable federal law and the laws of the State of Illinois, other than its laws respecting choice of law, to the extent state laws are not preempted by federal law.

The Plan is intended to be:

- a cafeteria plan under Code §125(d) containing a medical expense reimbursement plan under Code §105 and a dependent care expense reimbursement plan under Code §129,
- an employee welfare benefit plan under ERISA §3(1), and
- a Church Plan under Code §414(e) and ERISA §3(33) exempt from Title I of ERISA by ERISA §4(b)(2), and will be construed accordingly.

In addition, state insurance laws and regulations will not apply to the Plan to the extent:

- they are preempted by federal law, including, but not limited to, ERISA, the Code, HIPAA, and the Parity Act; and
- they are made inapplicable by state laws, regulations or case law that exempt self-insured plans from the applicability of state insurance statutes and regulations.

Plan Document Controls

If there are any discrepancies between this SPD and the terms and conditions set forth in the official plan document of the Hospitalizations and Medical Expense Program (Plan Document), the terms of the Plan Document will govern.

Your Rights

If you have any questions about your rights under HIPAA or the PPACA, you should contact the appropriate department of the U.S. Department of Health and Human Services, primarily, for HIPAA concerns, the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, or, for PPACA concerns, the Center for Consumer Information and Oversight, , U.S. Department of Health and Human Services, 200 Independence Avenue, S.W. - Washington, D.C. 20201.

Legal Requirements

The Plan's Benefit Options comply with the following federal laws:

The Women's Health and Cancer Rights Act—Coverage for Reconstructive Surgery Following Mastectomy

When a Participant who has had a mastectomy decides to have breast reconstruction, based on consultation between the attending physician and the patient, the following benefits will be subject to the same Co-payments and Deductibles that apply to other Plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- treatment of physical complications in all stages of mastectomy, including lymphedema; and

- mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs.

The coverage described above is consistent with the requirements of the Women's Health and Cancer Rights Act of 1998 (Cancer Rights Act). Though the Cancer Rights Act is not directly applicable to the Plan because it is a Church Plan, the benefits described above are available to Participants. For more information about this coverage, review your HealthFlex Benefits Booklet.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans generally may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. The law does not prohibit an attending physician from discharging a mother or newborn earlier than 48 or 96 hours, where appropriate. Please review your *HealthFlex Benefits Booklet* for further details on the specific coverage terms.

Patient Protection and Affordable Care Act

Notice of Patient Protections

The Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Plan's network, i.e., is a participating primary care provider, and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider and for a list of the participating primary care providers, you can access Blue Cross and Blue Shield of Illinois at **www.bcbsil.com** or UnitedHealthcare at **www.myuhc.com**.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or following procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, you can access Blue Cross and Blue Shield of Illinois at **www.bcbsil.com** or UnitedHealthcare at **www.myuhc.com**.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

USERRA sets requirements for continuation of health coverage and reemployment with respect to military leaves of absence. These requirements may apply to medical coverage for you and your Dependents. They do not apply to any life, short-term or long-term disability or accidental death and dismemberment coverage.

Continuation of Coverage

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents by paying the Required Contribution to your Plan Sponsor until the earliest of the following:

- the end of a period of time determined by your Plan Sponsor in accordance with USERRA from your last day of employment,
- the day after you fail to return to work, or
- the date the Plan is terminated.

The Plan may charge you and your Dependents up to 102% of the total Required Contribution for coverage during the leave.

Reinstatement of Benefits

If your coverage ends during the leave because you do not elect USERRA continuation coverage and you are reemployed by your Plan Sponsor, you may reinstate coverage for you and your Dependents if you gave your Plan Sponsor advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your Plan Sponsor does not exceed five years.

Time Frames for Requesting Reemployment

When a leave ends, you must report your intent to return to work as follows:

- for leaves of less than 31 days or for a fitness exam, by reporting to your Plan Sponsor by the next regularly scheduled
- work day following eight hours of travel time;
- for leaves of 31 to 180 days, by submitting an application to your Plan Sponsor within 14 days; and
- for leaves of more than 180 days, by submitting an application to your Plan Sponsor within 90 days.

Consult your employer or Plan Sponsor for more details regarding your USERRA rights.

MEDICALLY NECESSARY DETERMINATIONS

The Claims Administrator of the Benefit Option under which you make your Claim will make the decision whether any health care services or supplies are medically necessary or medically appropriate. The Plan will not pay Claims that its Claims Administrators determine are not medically necessary or medically appropriate. Under the terms of its agreements with its Claims Administrators, and its authority under the Plan to delegate duties, **the General Board does not have the discretion or authority to make determinations of medical necessity.**

DEFINITIONS

Adoption Agreement

An Adoption Agreement is an agreement that is executed by each Plan Sponsor and becomes part of the Plan when it is accepted by the General Board. An Adoption Agreement is the means by which a Plan Sponsor adopts the Program and specifies any optional provisions, such as Benefit Options, that are a part of any Program as to that Plan Sponsor.

Affiliated Organization

The term Affiliated Organization means any of the organizations and corporations associated with the General Board through The United Methodist Church, as described in Section 414(e) of the Code.

Annual Election Period

The term Annual Election Period means a period of time during which Participants and eligible Employees may elect Benefit Options for the following Plan Year for themselves and Dependents, by completing an election worksheet or making elections online through the HealthFlex website. The General Board determines the period of time that is the Annual Election Period. Generally, the Annual Election Period for the Plan is a period of time each November. For newly eligible Employees, there is an open enrollment period and election period that works as an Annual Election Period for the remainder of the Plan Year and it is the 30 days immediately following the date of hire by or appointment to the Plan Sponsor.

Benefit Option

Benefit Option means a qualified benefit under §125(f) of the Code that is offered under a cafeteria plan or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option or a PPO option). In other words, under the Plan, generally, the HMO, PPO, EPO, OOA, Medicare HMO, Medicare Companion, Mental Health HMO and Mental Health PPO plans for medical benefits with their corresponding prescription drug plans are considered separate Benefit Options, as are the Indemnity, PPO and HMO dental plans and the incentive materials and full-service vision plans.

The Book of Discipline

The Book of Discipline means the body of church law established by the General Conference of The United Methodist Church, as amended from time to time.

Calendar Year

The term Calendar Year means a 12-month period beginning on January 1 and each 12-month period thereafter.

Life Status Events

Life Status Events are the events that allow a Participant to change his or her elections during a Plan Year, as described in the section of this SPD entitled *Life Status Events*.

Church Plan

A Church Plan is an employee benefit plan established and maintained for its employees by a church or by a convention or association of churches as established in §414(e) of the Code and §3(33) of ERISA.

Claim

A Claim is notification in a form acceptable to the Claims Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, gender, identification number, the name and address of the provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim charge and any other information that the Claims Administrator may request in connection with services rendered to you.

Claims Administrator

For medical and hospitalization services provided under the Plan's medical Benefit Options, the term Claims Administrator means BlueCross BlueShield of Illinois or UnitedHealthcare Insurance Company, depending on the geographic area in question. For administration of prescription drug benefits provided by the Plan, the Claims Administrator is Medco. For administration of dental benefits provided by the Plan, the Claims Administrator is Connecticut General Life Insurance Company (CIGNA). For administration of vision benefits provided by the Plan, the Claims Administrator is VSP, Inc. For administration of mental and

behavioral health benefits provided by the Plan, the Claims Administrator is United Behavioral Health. For administration of FSA Claims under the Plan, the Claims Administrator is Ceridian. The General Board has delegated certain administrative and fiduciary duties to the Claims Administrators pursuant to contractual arrangements, including, but not limited to, providing access to networks of providers, processing and paying Claims and hearing and deciding Claims appeals. The Plan's Claims Administrators may be changed at the discretion of the General Board.

Code

The term Code means the Internal Revenue Code of 1986, as amended.

Coinsurance

The term Coinsurance means the percentage of charges or expenses for covered services that a Participant is required to pay under the Plan after satisfaction of any applicable Deductible.

Conference

The term Conference means an Annual Conference, Provisional Conference or Missionary Conference of The United Methodist Church that is located in a Jurisdictional Conference in the U.S., as such entities are defined in *The Book of Discipline*.

Consumer-Driven Health Plan (CDHP)

A Benefit Option under the Plan that is a consumer-driven health plan (CDHP), also called high deductible health coverage (sometime referred to as a high deductible health plan though technically not a high deductible health plan under the Code). The CDHP is designed to drive your behavior toward informed medical decision-making and carries higher deductible and out-of-pocket limits than the PPO Benefit Options under the Plan. The CDHP is generally accompanied by an HRA, so you have Plan Sponsor- and Plan-provided financial assistance toward satisfying those higher deductibles.

Co-Payment

Co-payment, sometimes called a "co-pay," means the first-dollar amount you must pay for certain covered services under the Plan that is usually paid at the time the services are performed (e.g., physician office visits or emergency room visits). Co-payments do not apply to your annual Deductible. Co-payments do apply to your annual out-of-pocket maximum and continue to apply once you reach your Out-of-Pocket Maximum.

Deductible

The term Deductible means the amount of charges for covered services you must pay during each Plan Year before the Plan will begin considering paying expenses or making reimbursement.

Dependent

The term Dependent, for all Participants, regardless of a Participant's State of residence, means:

- your lawful Spouse; and
- any child of yours who is:
  - less than 26 years old; or
  - age 26 and older and:
    - an unmarried child who is mainly dependent on you for financial support and is currently a covered dependent as a result of Michelle's Law; or
    - an unmarried child who is not self-supporting due to a physical or mental impairment.

A child includes one who is in the custody of the Participant, pursuant to an interim court order of adoption or placement for adoption, whichever comes first, whether or not a final order granting adoption is ultimately issued. It also includes a stepchild who lives with you. It also includes a child living with you for whom you are the legal guardian. Benefits for a Dependent will continue until the last day of the calendar month in which age 26 is reached. No one may be considered as a Dependent of more than one Participant. Under the Medical Reimbursement and Dependent Care Accounts, the definition of "dependent" is determined by §§125, 152, 105 and 129 of the Code.

Employee

For purposes of this SPD, the term Employee means a person who is described as an employee of a church in Sections 414(e)(3) or 7701(a)(20) of the Code, who is a clergyperson serving The United Methodist Church or who is a common-law employee of the General Board or a Plan Sponsor, including a former Employee who has retired.

ERISA

The term ERISA means the Employee Retirement Income Security Act of 1974, as amended.

General Board

The term General Board means the General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois in its role as Plan Administrator.

Health Reimbursement Account (HRA)

The Health Reimbursement Accounts are health reimbursement arrangements as described in IRS Notice 2002-45. HRAs are employer (i.e., Plan Sponsor and Plan)-funded accounts that help Participants covered in the CDHP Benefit Option satisfy higher deductibles and out-of-pocket expenses by reimbursing certain eligible medical expenses. HRA Accounts do not include any Participant contributions.

HIPAA

The term HIPAA means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder by the Secretary of the Department of Health and Human Services.

ID Card

The term ID Card means the identification card that contains your Participant information issued to you by the Claims Administrator.

Medco Pharmacy

The term Medco Pharmacy means the program in which Participants may submit a maintenance (long-term) prescription along with the applicable Co-payment to Medco for dispensing via Medco Pharmacy, e.g., through the U.S. Postal Service or commercial delivery courier.

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965, as amended.

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965, as amended.

Medicare Secondary Payer (MSP)

The term Medicare Secondary Payer (MSP) means those provisions of the Social Security Act set forth in 42 U.S.C. w1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their Spouses and, in some cases, Dependent children.

Medically Necessary/Medically Appropriate

The term Medically Necessary/Medically Appropriate means health care services and supplies that are determined by the Claims Administrator to be:

- required to meet your essential health needs;
- consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research;
- required for purposes other than the convenience of the provider or the comfort and convenience of the patient; and
- rendered in the least intensive setting that is appropriate for the delivery of health care.

Other Employer-Sponsored Group Health Coverage

Under HealthFlex, Other Employer-Sponsored Group Health Coverage has a very specific definition and impacts eligibility in retirement, specifically, postponement of enrollment. It is defined as an employer-sponsored self-insured group health plan or insured group health or HMO plan; or employer-sponsored group health coverage provided under the Federal Employees Health Program. It *excludes* individual health insurance; Medicare Parts A and B; a Medicare Plus Choice plan not provided through HealthFlex; a plan for current and former members of the armed forces; a health plan provided through Indian Health Services; a state health benefit risk pool; a plan provided under the Peace Corps Act; a state, county, or municipal public health plan; an association health plan; and an individual or group health conversion plan.

Other Health Coverage

Under HealthFlex, Other Health Coverage includes a self-insured group health plan; an individual or group health insurance or HMO plan; Parts A and B of Medicare; Medicaid; a health plan for current and former members of the armed forces; a health plan provided through Indian Health Services; a state health benefit risk pool; the Federal Employees Health Program; a plan provided under the Peace Corps Act; a state, county or municipal public health plan; a State Children's Health Insurance Program (S-CHIP); health coverage provided under a plan established by a foreign country; coverage provided under state or federal health continuation mandates (e.g., COBRA); individual or group health insurance through an association; and an individual or group health conversion plan.

Out-of-Pocket

The term Out-of-Pocket applies to expenses that call for Participants to incur a cash liability, such as the Participant's share of Coinsurance, Co-payment or Deductible.

Out-of-Pocket Maximum

The term Out-of-Pocket Maximum means the maximum amount of charges for covered services you must pay during a Plan Year, including the Deductible, before the Coinsurance percentage of the Plan increases. The individual Out-of-Pocket Maximum applies separately to each Participant and Dependent. When an individual reaches the annual Out-of-Pocket Maximum, the Plan then will pay 100% of additional eligible charges for covered services for that individual during the remainder of that Plan Year. The family Out-of-Pocket Maximum applies collectively to all Participants and Dependents in the same family. When the annual family Out-of-Pocket Maximum is reached, the Plan then will pay 100% of eligible charges for covered services for any covered family member during the remainder of that Plan Year.

However, expenses for services that do not apply to the Out-of-Pocket Maximum will never be paid at 100%.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for services that are not covered services under the applicable Benefit Option.
- Charges in excess of the maximum allowance as defined by the applicable Benefit Option.

Co-payments for services available from HealthFlex vendors or administrators other than Medco and either BlueCross BlueShield of Illinois or UnitedHealthcare, as applicable.

In accordance with federal mental health parity regulations, eligible out-of-pocket expenses for both the behavioral health and medical Benefit Options count toward one, shared Out-of-Pocket Maximum that is determined by the medical Benefit Option in which you are enrolled.

Participant

The term Participant means either the Employee, i.e., the primary Participant, or an enrolled Dependent, but this term applies only while such person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Participant. The term also may include retired Employees of Plan Sponsors who are eligible to participate under the Plan's terms and the Plan Sponsor's Adoption Agreement.

Plan

The term Plan means the Hospitalization and Medical Expense Program maintained by the General Board on behalf of its Employees and the Employees and other Participants of the Plan Sponsors. The Plan is a Church Plan.

Plan Administrator

The Plan Administrator of the Plan is the General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois, or its designee.

Plan Sponsor

The term Plan Sponsor means the Conference if the Participant is an Employee of the Conference (or of a local church if the Conference so elects) or a clergy member, or the Affiliated Organization for other Employees, that has executed an Adoption Agreement.

Plan Year

The term Plan Year means the twelve month period ending on December 31 of each Calendar Year.

Required Contribution

Required Contributions include, but are not limited to, contributions or premiums due to the Plan for coverage under the Plan as calculated by the General Board in its discretion and any other amounts due as a condition of receiving coverage under the Plan.

Salary-Paying Unit

Salary-Paying Unit means any one of the following units associated with The United Methodist Church:

- the General Conference;
- a general agency;
- a Jurisdictional Conference;
- a Conference;
- a Conference board, agency or commission;
- a local church located in a Conference;
- any other entity to which a clergyperson under Episcopal appointment is appointed; and
- any other employer of lay Employees who are eligible to participate in a Church Plan.

Special Enrollment Events

Special Enrollment Events are certain events that, under HIPAA, allow a Participant to change his or her elections during a Plan Year, as described in the section of this SPD entitled *Special Enrollment Events*.

Spouse

The term Spouse, for purposes of the Plan, means a person who is married to a Participant (or to a surviving Spouse) in accordance with the law of the jurisdiction in which the Spouse resides, except that a person who is a “common-law” Spouse is not a Spouse for purposes of the Plan. A person who is a Spouse will still be a Spouse even if the person is geographically or legally separated (but not yet divorced) from the person to whom he or she is married.

GENERAL INFORMATION

Name and Address of the Plan Administrator

General Board of Pension and Health Benefits of
The United Methodist Church, Incorporated in Illinois
1901 Chestnut Avenue
Glenview, Illinois 60025
847.869.4550

Name and Address of the Designated Agent for Service of Legal Process

CT Corporation
208 South LaSalle Street
Chicago, Illinois 60604
800.475.1212

Name and Address of the Third-Party Claims Administrators for Medical Benefits

BlueCross and BlueShield of Illinois
300 East Randolph Street
Chicago, Illinois 60601
866.804.0976

United Healthcare Insurance Company
450 Columbus Boulevard
Hartford, Connecticut 06115-0450
800.901.1939

Name and Address of the Third-Party Administrator for Prescription Drug Benefits

Medco
100 Parsons Pond Drive
Franklin Lakes, New Jersey 07417
800.841.2806

Name and Address of the Third-Party Administrator for Mental Health Benefits

United Behavioral Health
425 Market Street, 27th Floor
San Francisco, California 94105

Name and Address of the Third-Party Administrator for Dental Benefits

Connecticut General Life Insurance Company (CIGNA)
1000 Corporate Center Drive, Suite 500
Franklin, Tennessee 37067
www.cigna.com
888.336.8258

Name and Address of the Third-Party Administrator for Vision Benefits

Vision Service Plan Insurance Company (VSP)
3333 Quality Drive
Rancho Cordova, California 95670

Name and Address of the Third-Party Administrator for Flexible Spending Accounts Benefits

Ceridian
3311 East Old Shakopee Road
Minneapolis, Minnesota 55425

Internal Revenue Service Identification Number

The corporate tax identification number assigned by the Internal Revenue Service to the General Board is 36-2166979.

Method of Funding Benefits

Health benefits are self-funded or self-insured from accumulated assets and are provided directly from the General Board. The General Board may purchase excess risk insurance coverage, often called stop-loss coverage, which is intended to reimburse the General Board for certain losses incurred and paid under the Plan by the General Board. Payments out of the Plan to health care Providers on behalf of Participants will be based on the provisions of the Plan.

GENERAL BOARD OF PENSION AND HEALTH BENEFITS
OF THE UNITED METHODIST CHURCH

Caring For Those Who Serve

1901 Chestnut Avenue
Glenview, IL 60025
800.851.2201
www.gbophb.org