Wespath

BENEFITS | INVESTMENTS

Via Benefits

Summary Plan Description
Plan Sponsor: _____

a general agency of The United Methodist Church

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Via Benefits™ Summary Plan Description

Welcome

This Summary Plan Description (SPD) has been prepared to help you understand your health benefits through Via Benefits™, a Willis Towers Watson company (Via Benefits). Please read it carefully.

About The Health Reimbursement Account Plan

The HRA is considered a group health plan under the Code and the Affordable Care Act (ACA). It is intended to be an excepted benefits group health plan under the ACA and Code because it is a plan for retirees. The HRA is also 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*. The HRA plan is used to reimburse out-of-pocket expenses incurred by purchasing an individual Medicare Supplement or Medicare Advantage Policy.

Wespath Benefits and Investments (Wespath) has partnered with Via Benefits, a provider of health care solutions for Medicare-eligible individuals. Via Benefits provides an exchange or connector-type marketplace through which eligible retired participants, as described herein and in the Plan Sponsor's eligibility policies and rules, receive guidance to choose from an array of Medicare Advantage, Medicare Supplement and prescription drug Policies (referred to together, generally, as Medicare Supplemental Policies hereinafter).

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

The Plan Sponsor is the employer or Conference through which you have coverage under Via Benefits. The Plan Sponsor has elected to participate with Via Benefits through Wespath. If you have questions about your benefits under the Plan, you may contact your Plan Sponsor or Via Benefits.

Your Responsibility To Provide Accurate Information

Your Plan Sponsor, Via Benefits and the insurance companies or issuers (Issuers) that offer the plans in the Via Benefits marketplace rely on information provided by you when evaluating coverage and benefits through Via Benefits. 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 Plan Sponsor or the Issuers.

Questions

If you have questions about the benefit plans available through Via Benefits, please contact Via Benefits. For more information, please visit the Via Benefits website at **My.Via.Benefits.com/wespath**. You may also contact Via Benefits directly at **1-866-249-7785**.

IMPORTANT NOTICES

Right to Amend the Plan

Your Plan Sponsor reserves the right to amend or modify this Health Reimbursement Account Plan in any manner, for any reason permitted by law, at any time and without prior notification.

Right to Terminate

Your Plan Sponsor reserves the right to terminate its sponsorship of Via Benefits, subject to the conditions of its Adoption Agreement with Wespath and Via Benefits. If your Plan Sponsor terminates its Via Benefits participation, your coverage or any HRA funding may terminate. In addition, your Plan Sponsor may have reserved the right to terminate entirely its sponsorship of a retiree health plan.

Coverage Not Vested or Guaranteed

Coverage through Via Benefits, and Plan Sponsor contributions toward such coverage as an Employee, Participant, Dependent or retired Participant are not vested benefits—i.e., they are not guaranteed to continue. The Plan Sponsor unequivocally reserves the right to amend or terminate its relationship with Via Benefits at any time. In addition, the Plan Sponsor has 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, Wespath personnel, the Plan Sponsor and Via Benefits representatives and agents (such as Issuers) 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.

Coverage Offered Through Individual Medicare Supplemental Policies

You will work with Via Benefits to select medical coverage in the form of an individual Medicare Supplemental Policy. The Issuer of the Medicare Supplemental Policy you choose will provide access to networks of health care providers, certain communications, identification cards, Claims processing, Claims payment, Claims determination and Claims appeals. The Issuer will make all determinations of medical necessity or medical appropriateness. The Issuer also will have the duty and authority to determine whether a particular benefit, procedure or service is covered by the Plan. The Plan Sponsor does not have the authority to hear or overturn the determinations of the Issuer related to Medicare Supplemental Policy benefits or medical necessity or appropriateness.

The terms of the Medicare Supplemental Policies and related Contracts with respect to the Participants covered under them will supersede the terms of this SPD where there is a conflict between the documents.

ELIGIBILITY

You may be eligible for coverage through Via Benefits through your Plan Sponsor if any of the following apply:

- You are retired from service with or for your Plan Sponsor and are eligible for Medicare;
- You are long-term disabled and eligible for Medicare (and your Plan Sponsor rules and policies allow such coverage);
- You are appointed to or work for your Plan Sponsor or a covered employer or local church associated with your Plan Sponsor and you are eligible for Medicare and your Plan Sponsor rules and policies allow such coverage; or
- Such coverage is permitted under the Medicare Secondary Payer regulations.

Check with your Plan Sponsor for its Via Benefits eligibility requirements and rules about contributions to a health reimbursement arrangement, if any.

Your eligibility depends on the rules of the Medicare Supplemental Policies and Issuers provided through Via Benefits and the choices of the Plan Sponsor. For example, the Plan Sponsor may require that you be covered by its group health plan at the time of retirement, have been covered in its group health plan for a certain number of years, have served for a certain number of years or some combination of these requirements. Please contact your Plan Sponsor if you have questions about your eligibility through Via Benefits.

The descriptions below explain some general rules that govern the Plan.

Adoption Agreements
A Conference or Affiliated Organization that wishes to adopt and offer Via Benefits must execute an Adoption Agreement with Wespath to become a Plan Sponsor. An Adoption Agreement is a contract through which a Plan Sponsor agrees to cover its retirees and other eligible individuals (Participants) in the Plan and promises to abide by the terms of the Adoption Agreement and assumes certain duties and obligations.

Your Plan Sponsor's Adoption Agreement also determines any additional wellness benefits that may be available to you.

Medicare Coverage
In order to participate in Via Benefits, you must be entitled to and enrolled in coverage under Medicare Parts A and B[1]. Once you are Medicare-eligible, you can select an individual Medicare Supplemental Policy through Via Benefits, which pays after Medicare pays (i.e., the Plan is the secondary payer).

Medicare Secondary Payer Laws
A series of federal laws, collectively referred to as the Medicare Secondary Payer (MSP) laws, regulate the manner in which a 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 coverage (for example, HealthFlex coverage), as well as certain other factors, including the size of the employers sponsoring the group health plan. Via Benefits provides health coverage solutions in the event Medicare is the primary payer for your medical coverage.

In general, Medicare pays secondary to the following:

- A group health plan 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 group health plan 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 group health plan is a multiemployer or multiple employer plan with 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 Medicare Secondary Payer Small Employer Exception (MSPSEE) under the statute.
- In the case of disabled individuals younger than age 65, a group health plan 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 group health plan 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 Via Benefits, Wespath or your insurance Policy Issuers if you have questions regarding the ESRD period or other provisions of the MSP laws and their application to you.

[1] If you are a clergyperson who has opted out of Social Security, generally you are not eligible for Medicare.

Selecting Coverage Through Via Benefits

Cost Sharing

The amount you will pay for coverage can vary, depending on the type of Medicare Supplemental Policy you choose through Via Benefits. You will pay your monthly premiums directly to the Issuer you select for health care coverage (i.e., health insurance). If your Spouse will also be covered through Via Benefits, you will also pay your Spouse's monthly premiums directly to the Issuer you select for health care coverage. If your Spouse remains in a traditional group health plan (for example, the HealthFlex Plan), your Spouse's monthly premiums can continue to be deducted from your pay or retirement benefits.

Your Plan Sponsor may offer and fund a health reimbursement arrangement (also called a health reimbursement account or HRA) for eligible Participants. If you are eligible for HRA contributions, you can use funds in the HRA to help pay your monthly premiums for Via Benefits coverage and any other eligible health care costs (described below). You will be reimbursed for these expenses from the HRA to the extent that funds are available in your HRA. Be sure to obtain annual HRA funding information, if any, from your Plan Sponsor. Refer to the "*Your Via Benefits HRA*" section for more information. Eligibility for HRA funding requires selection of a plan through Via Benefits, unless otherwise approved by your Plan Sponsor.

Benefit Options

By participating in the Via Benefits enrollment process, you will work with a Via Benefits licensed benefit advisor (LBA) who will help you choose the Medicare Supplemental coverage(s) that best serves your medical, behavioral health and pharmacy needs, and fits your budget. You will have the opportunity to elect and purchase dental coverage, vision coverage or both, through Via Benefits. All coverage is optional, it is up to you to select what meets your needs. Your Via Benefits LBA can explain your options.

Your Plan Sponsor may elect to provide certain wellness benefits through Wespath in addition to the coverage accessible through Via Benefits. Please contact your Plan Sponsor to inquire about these benefits.

Pre-Tax Premium Contributions and Flexible Spending Accounts

Generally, retired Participants are not eligible for a "cafeteria plan" (i.e., a Code Section §125 plan) to: (i) pay for health coverage on a pre-tax basis, or (ii) defer money (contribute salary) to flexible spending accounts (FSAs). A limited exception applies to retired Participants who are actively at work, i.e., the working aged under the MSP Rules (see *Medicare Secondary Payer Laws* section).

Coverage During Disability

If you are a clergy Participant and you become disabled under the terms of Wespath Benefits and Investments Comprehensive Protection Plan (CPP), then your Plan Sponsor may elect to offer you coverage through Via Benefits 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, an employer's group health plan covers disabled Employees as the primary payer for 24 months of disability, after which the employee becomes eligible for Medicare coverage due to the disability. Medicare then becomes the primary coverage, and the medical coverage provider you select through Via Benefits (if you are eligible) pays secondary. Whether you remain covered as a disabled Employee depends on the policies and practices of Plan Sponsor. If your Plan Sponsor relationship terminates, for example, the 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.

A Plan Sponsor's personnel policies (and for Conferences, *The Book of Discipline*) have significant impact on coverage during disability. The Plan Sponsor can establish its own rules about HRA funding for disabled Employees. For clergy Employees, if the Participant terminates his or her Conference relationship, then the Plan Sponsor's policies regarding continued membership, coverage and HRA eligibility will apply. 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 HRA funding. 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.

Working Beyond Age 65 (Medicare Secondary Payer Rules)
If you retire and then return to work, you will once again be covered in a plan for active employees due to the Medicare Secondary Payer rules. The Medicare Secondary Payer rules require employer group health plans to be primary payers for employees age 65 or older, also called the "working aged." If a Medicare-eligible individual is covered by an employer plan on account of anyone's (his or her own or a spouse's) "current employment status," then Medicare pays secondary to that plan. There is a limited exception to this rule if an employee's coverage comes from a small employer (i.e., an employer with fewer than 20 employees), and that employer has elected the Medicare Secondary Payer Small Employer Exception (MSPSEE). Contact your Plan Sponsor about the Medicare Secondary Payer rules and their effects on your coverage through Via Benefits, including your access to HRA funding.

Early Retirement
These rules regarding coverage through Via Benefits apply only if you are eligible for Medicare, e.g., age 65 at the time you retire, or under 65 and disabled. If you retire before you are eligible for Medicare, any coverage available through your plan sponsor will depend on your plan sponsor's health coverage policies and its plan elections for early retirees. Plan Sponsors may exclude early retirees from the Plan until they are eligible for Medicare and Via Benefits coverage; alternatively, Plan Sponsors may require early retirees, if they are covered in the active plan, to pay a greater portion of the cost of coverage. Once you attain age 65, Wespath will inform Via Benefits, and Via Benefits will work with you to select a Medicare Supplemental Policy.

Postponing Participation at Retirement
If you are age 65 or older upon retirement and eligible for Medicare, you should receive the necessary forms and information to enroll in medical coverage through Via Benefits prior to your retirement. Generally, you can postpone your enrollment in a Medicare Supplemental Policy through Via Benefits if you have other coverage. You must inform Via Benefits and your Plan Sponsor that you have other employer-provided health coverage. Your Plan Sponsor's rules will govern whether you can wait to enroll through Via Benefits at a later date and will determine whether or not you may receive HRA contributions from the Plan Sponsor by postponing enrollment. You should consult with your Plan Sponsor prior to postponing your Via Benefits enrollment to ensure you understand if your future enrollment would be permitted or if HRA funding would be impacted.

Right to Terminate
Your Plan Sponsor has reserved the right to terminate its sponsorship of Via Benefits and/or HRA funding for Via Benefits, subject to the conditions of its Adoption Agreement with Wespath. If your Plan Sponsor terminates its sponsorship of Via Benefits, your coverage under the Plan terminates, including access to HRA funding from your Plan Sponsor. However, you may be able to continue coverage in your selected Medicare Supplemental Policy as an individual, subject to the terms of that policy.

Your Spouse and Dependents
Your Spouse and Dependents may be eligible for coverage through Via Benefits depending upon:

- your Plan Sponsor's eligibility rules relating to Spouses and Dependents, and
- whether they are enrolled in Medicare Parts A and B.

Plan Sponsors may elect to provide HRA contributions for spouses and dependents covered under Via Benefits. If funding is provided, it may be different than funding provided for primary participants. Check with your Plan Sponsor for more details about HRA funding for spouses and dependents.

In certain circumstances, civil union partners and domestic partners of Participants may be covered, depending upon: 1) the law of the State in which the Participant resides and Plan Sponsor is located, and 2) the rules and policies of the Plan Sponsor. For more about this coverage, contact your Plan Sponsor.

Surviving Spouses and Dependents
A Plan Sponsor can elect to cover surviving Spouses and surviving Dependents of Via Benefits Participants. The same general rules apply to surviving Spouses and surviving Dependents as apply to Participants. For more about this coverage, contact your Plan Sponsor.

Effective Date of Your Coverage
You will become a covered Participant on the date you elect coverage by signing the documents required by the Issuer you select. You will not be denied enrollment for coverage due to your health status. Your initial coverage election generally will not be subject to any applicable Pre-existing Condition Waiting Period. However, future changes or late enrollments may be subject to medical underwriting and pre-existing waiting periods and exclusions, in accordance with state and federal law. Coverage for your Dependents, if they are eligible, will be effective on the date they elect such coverage on the approved documents required by the Issuer they select.

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

- the date you cease to be in a class of eligible individuals as described above;
- the date your Medicare eligibility ends;
- the last day for which you have paid premiums for coverage.

HRA funding eligibility may also cease if you fail to select a plan through Via Benefits, unless otherwise approved by your Plan Sponsor.

Other Events Ending Your Coverage
When any of the following occur, the individual health insurance policy you selected through Via Benefits may terminate your coverage. If such circumstances occur, the policy you selected will provide you written notice that your coverage has ended. The issuer may terminate your coverage due to:

- Fraud, Misrepresentation or False Information—If you commit fraud or misrepresentation, or you knowingly give Via Benefits, the Issuer of the individual Medicare Supplemental Policy you select through Via Benefits or Wespath false material information. Examples include false information relating to another person's eligibility or status as a Dependent.
- Material Violation—If you materially violate the terms of the HRA Plan or the individual Medicare Supplement Policy.
- Threatening Behavior—If you commit an act of physical or verbal abuse that poses a threat to Wespath's staff, Via Benefits's staff, the staff of the Issuer of your individual Medicare Supplement Policy, or other Participants.

If your Dependents are also covered through Via Benefits, they will also have an individual Medicare Supplemental Policy. Therefore the information above regarding termination of coverage will also apply to them.

YOUR BENEFITS THROUGH VIA BENEFITS

Medical, Behavioral Health, Prescription, Dental and Vision Benefits for Via Benefits Participants
Your plan sponsor has elected to offer access to individual Medicare Supplemental Policies through Via Benefits. You can choose from an array of Medicare Advantage, Medicare Supplement and prescription drug policies. In addition, you may also elect and purchase separate vision and dental coverage through Via Benefits.

Prescription Drug Coverage
Prescription drug coverage is dependent upon the individual Medicare Supplemental Policy you choose. Prescription drug coverage is often included only with a Medicare Advantage Plan. Depending on the Medicare Advantage Plan, you may also need to purchase a Medicare Part D plan. If you purchase a Medicare Supplemental Policy or Medigap Plan, you will have to purchase a Medicare Part D prescription drug plan separately to obtain coverage for prescription drugs. You can purchase a Medicare Part D prescription drug plan through Via Benefits.

Behavioral Health Benefits
Behavioral health services are covered by Medicare and should be included in your medical plan. Please discuss any behavioral health providers and needs with your Via Benefits LBA to maximize coverage.

Your Via Benefits HRA

HRA Funding
A health reimbursement account (also called health reimbursement arrangement or HRA) will be established for each HRA-eligible Participant and used for the sole purpose for reimbursement of eligible medical expenses, as defined in Section 213(d) of the Code (including premiums for Medicare Supplemental Policies you select). If your spouse is eligible for Medicare and enrolls in a Medicare plan through Via Benefits, you will have a joint HRA that covers you and your spouse. This means you will have one HRA that is shared. If your spouse is not Medicare eligible and remains in an active plan, he or she will not have access to the funds in the Via Benefits HRA.

If you are an HRA-eligible participant, each year your Plan Sponsor will determine the amount that will be contributed to your account for the Plan Year. Generally, the amount is based on your age and/or years of eligible service. Contributions will be funded and available at the beginning of each Plan Year. Access to HRA funding is dependent on selection of a plan through Via Benefits, unless otherwise approved by your Plan Sponsor.

Participants enrolled in Via Benefits due to Medicare disability are not eligible for HRA contributions.

HRA Reimbursements
The HRA allows reimbursement only for eligible medical expenses (including premiums for Medicare Supplemental Policies). To be an eligible expense, the expense cannot otherwise be reimbursed or paid by the individual Medicare Supplemental Policy you select or through other insurance or similar 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, Co-insurance 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. The costs of some over-the-counter medications may be reimbursable from the HRA—but only with a physician's prescription order. In addition, as a retiree in a Medicare Supplemental Policy through Via Benefits, you may request reimbursements for premiums for vision and dental insurance or Medicare Part B premiums.

Expenses incurred by a Spouse or Dependent who is Medicare eligible and enrolled in a plan through Via Benefits are also eligible for reimbursement. Contact Via Benefits for a list of permissible and impermissible HRA expenses.

For more information about what items are or are not Eligible Medical Expenses, consult IRS Publication 502, *"Medical and Dental Expenses,"* under the headings "What Medical Expenses Are Includible" and "What Expenses Are Not Includible." (Be careful in relying on this Publication, however, as it is specifically designed to address what medical expenses are deductible on Form 1040, Schedule A—not what is reimbursable under a health reimbursement account. This IRS publication is available at **www.irs.gov**.)

Carryover of Accounts
If any balance remains in your HRA for a Plan Year after all reimbursements have been made for the Plan Year, the balance will be carried over to reimburse you for eligible medical expenses incurred during a subsequent Plan Year, as long as you maintain participation in a Medicare Supplemental Policy through Via Benefits.

Termination of HRA Participation
If you are no longer eligible for Medicare and return to an active plan, any unused funds in your HRA will be forfeited after 180 days after loss of coverage through Via Benefits.

Upon your death, if you have an eligible surviving Spouse, the eligible Spouse may be reimbursed from your HRA for eligible medical expenses until the account is exhausted or until such Spouse dies. If you die with a balance in your account and have no eligible surviving Spouse, or if your surviving Spouse also dies with a balance in the account, the balance of such account is forfeited to the Plan Sponsor.

Other Benefits Available

If your Plan Sponsor has elected the benefits described below, you may be eligible for some or all of the following benefits through Wespath's Benefit Plans department:

Wellness
The Plan may offer well-being benefits, at the election of the Plan Sponsor. For example, you may have access to biometric screenings or the Virgin Pulse walking program at no additional cost, through your Plan Sponsor.

Please contact your Plan Sponsor for more information about availability of well-being programs.

Blueprint for Wellness
You may be eligible for the Quest Diagnostics Blueprint for Wellness® screening at no direct cost to you, if your Plan Sponsor has elected this benefit for individuals covered through Via Benefits. The Blueprint for Wellness screening 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.

Virgin Pulse
You may be eligible for the Virgin Pulse activity program, if your Plan Sponsor has elected this benefit for individuals covered through Via Benefits. The Virgin Pulse program channels the health benefits of walking and other types of exercise, and rewards participants financially for their physical activity. Participants in Virgin Pulse:

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

CLAIMS

How to File a Claim

In order to obtain your medical benefits through the individual Medicare Supplemental Policy you select, you must submit your Claim to the Issuer of that Medicare supplemental Policy (i.e., the coverage you selected through Via Benefits). To file a Claim, usually all you have to do is show your ID Card to your hospital, physician or other provider. Typically, the provider will file your Claim for you. However, it is up to you to ensure the Issuer for your plan through Via Benefits has all necessary information to process your Claim. Once the Issuer for your Medicare Supplemental Policy through Via Benefits receives your Claim, the Issuer will send benefit payment directly to the provider. You should receive an Explanation of Benefits (EOB) statement telling you how much was paid and what you may owe.

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.

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

- Complete a Claim form. Claim forms are available from the Issuer'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 Issuer.

You should keep copies of any documents you submit with a Claim. Should you have any questions about filing Claims, contact Via Benefits or call the Issuer's office.

HRA Claims: All questions about filing Claims for reimbursement related to the HRA should be directed to Via Benefits at **1-866-249-7785.**

All Claims related to the HRA should be submitted, along with a completed Reimbursement Request form, to:

PayFlex Systems USA, Inc.
Via Benefits
P.O. Box 981156
El Paso, TX 79998-1156
Fax: **1-844-930-0236**

Claims Procedures
Usually, the Issuer will pay Claims within 30 days of receipt of all information required to process your Claim. If the Issuer denies your Claim, in whole or in part, you should 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 Issuer 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 Issuer will review its decision in accordance with the procedures it has established, which are described in your individual policy applicable to your Claim and on your Claim denial notice.

The Claim review procedures of the Issuer 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, Wespath, any of the Issuers 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

Appeals Procedures—Medical, Prescription Drug, Vision, Dental and Mental Health (Behavioral Health) Claims
The terms of the appeals processes for Claims under your individual Medicare Supplemental Policy through

Via Benefits are explained in the insurance policy for the individual policy provided by the Issuer. The Issuer has the duty to hear appeals of Claims under the Medicare Supplement Policy. You, your representative or your provider must submit all Claims for medical, prescription drug, mental health, behavioral health and vision benefits to the applicable Issuer. Claimants must submit ***all appeals*** of denied Claims for medical, prescription drug, mental and behavioral health and vision benefits to the applicable Issuer.

The final determination—***the final and binding appeal***—with respect to Claims for Medicare Supplemental Policy benefits rests with the Issuer of your individual policy.

Appeals Procedures—HRA Claims
If your Claim for reimbursement from the HRA is wholly or partially denied, you will be notified in writing within 30 days after the HRA Administrator receives your Claim. If the HRA Administrator determines that an extension of this time period is necessary due to matters beyond the control of the HRA Administrator and Plan Sponsor, the HRA Administrator will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the Claim to be decided, you will be notified and you will have at least 45 days to provide the additional information. The notice of denial will contain:

- the reason(s) for the denial and the HRA plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your Claim, why the information is necessary, and your time limit for submitting the information;
- a description of the HRA plan's appeal procedures and the time limits applicable to such procedures; and
- a description of your right to request all documentation relevant to your Claim.

If your request for reimbursement under the HRA is denied in whole or in part and you do not agree with the decision of the HRA Administrator, you may file a written appeal. You should file your appeal with your *Plan Sponsor* no later than 180 days after receipt of the denial notice. You should submit all information identified in the notice of denial, as necessary, to perfect your Claim and any additional information that you believe would support your Claim.

You will be notified in writing of the decision on appeal no later than 60 days after the Plan Sponsor receives your request for appeal. The notice will contain the same type of information provided in the first notice of denial provided by the HRA Administrator.

You cannot file suit in federal court until you have exhausted these appeals procedures.

ERISA and DOL Regulations Inapplicable
The HRA is considered a group health plan under the Code and the ACA. It is intended to be an excepted benefits group health plan under the ACA and Code because it is a plan for retirees. The HRA is also a Church Plan as defined in the Code and ERISA. 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 (DOL).

Grievances
If you have a concern regarding a person, a service, the quality of care or benefits under the Plan, you can write to your Plan Sponsor to explain your concerns.

Legal Action
No Participant or other Claimant may sue or pursue a cause of action in law or equity in state or federal court against the HRA, Wespath, the HRA Administrator, or the Plan Sponsor, 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 one (1) year 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

Your individual Medicare Supplemental Policy may exclude payment of certain expenses. You should contact Via Benefits or your Issuer for a description of covered benefits, exclusions and limitations.

Additionally, the HRA administered through Via Benefits will not cover or reimburse any expenses that are not permitted under Section 213(d) of the Code.

Right to Receive and Release Information
The Issuer and HRA 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 Issuer or HRA 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.

Your Medicare Secondary Payer Responsibilities
In order to assist your Plan Sponsor and Via Benefits in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Issuer, your Plan Sponsor and Via Benefits 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 Via Benefits promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

Confidentiality, Privacy And HIPPA

Wespath and all Via Benefits Plan Sponsors have a duty under HIPAA to maintain adequate separation of Plan functions and employment matters. Wespath 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 Protected Health Information (PHI) is limited to the minimum amount necessary to perform the Plan administrative functions. Anyone employed by Wespath who does not comply with HIPAA and the related provisions of the Plan is subject to disciplinary action and sanctions.

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 Sponsor's policies, rules and procedures;
- to remit HRA contributions to Via Benefits;
- to provide Wespath with notice of a Participant's termination of employment, return to employment, termination of Conference relationship or Change of Status, where the Plan Sponsor is made aware of the Change of Status;
- to provide Wespath 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 provide 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 Via Benefits and HRA 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

Wespath 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.

Wespath may terminate a Via Benefits Plan Sponsor's association with the Plan for any reason by providing the Plan Sponsor 90 days' written notice. In addition, Wespath may terminate a Plan Sponsor for breach of the Plan's provisions or the terms of the Adoption Agreement. If a Plan Sponsor's participation in the Plan is terminated, the Plan Sponsor cannot re-adopt the Plan for a period of three (3) years. The termination of a Plan Sponsor will not excuse the Plan Sponsor from making payment in full of all HRA contributions. Wespath 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 Wespath. Your Plan Sponsor must inform you of its termination from the Plan at least 60 days before the date of termination.

Miscellaneous Important Provisions

HRA: Not Insurance
The HRA is offered by the Plan Sponsor as a self-funded Church Plan only for the benefit of eligible clergy and Employees and their families, of organizations affiliated with the Plan Sponsor through The United Methodist Church.

Although 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 HRA. 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 Issuer of your individual health insurance policy provided through Via Benefits has sole and exclusive discretion to do all of the following:

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

The Plan Sponsor has sole and exclusive discretion to do all of the following:

- interpret the provisions and terms of and benefits available under the HRA;

- interpret the other terms, conditions, limitations and exclusions of the coverage provided through the HRA, including this Via Benefits SPD; and
- make factual determinations related to the coverage and the benefits provided under the HRA.

HRA: No Waiver
The failure of the Plan Sponsor or HRA Administrator to enforce strictly any term or provision of this SPD will not be construed as a waiver of such term or provision. The Plan Sponsor and HRA Administrator reserve the right to enforce strictly any term or provision of this SPD and the Plan at any time.

HRA: 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 Plan Sponsor, the HRA Administrator, Via Benefits 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.

HRA: Applicable Law
The HRA 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 pre-empted by federal law.

The HRA is intended to be:

- 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 construed accordingly.

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

- they are pre-empted 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.

Your Rights
If you have any questions about your rights under HIPAA, you should contact the appropriate department of the U.S. Department of Health and Human Services.

For HIPAA concerns (primarily), contact:

Office for Civil Rights — U.S. Department of Health and Human Services
200 Independence Avenue, SW
HHH Building, Room 509F
Washington, DC 20201

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 Wespath. An Adoption Agreement is the means by which a Plan Sponsor adopts the Via Benefits 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 Wespath through The United Methodist Church, as described in Section 414(e) of the Code.

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 (i.e., January 1 through December 31).

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 (i.e., the issuer of your insurance policy) 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 (Issuer) may request in connection with services rendered to you.

Claims Administrator
Claims Administrators are the carriers you selected for medical, pharmacy, dental, vision and behavioral health benefits, as appropriate.

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

Co-Insurance
The term Co-insurance 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*.

Co-Payment
Co-payment, sometimes called a “co-pay,” means the first-dollar amount you must pay for certain covered services under Medicare-eligible benefits 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 (if applicable). However,

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 coverage provided through the Issuer for the individual health plan you select through Via Benefits 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 an unmarried child and 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. No one may be considered as a Dependent of more than one Participant.

Employee
For purposes of this Via Benefits 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 Wespath 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 of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois, in its role as Plan Administrator. As of July 2016, The General Board is doing business as Wespath Benefits and Investments (Wespath).

Health Reimbursement Account (HRA)
Health Reimbursement Accounts are health reimbursement arrangements as described in IRS Notice 2002-45. HRAs are employer- (i.e., Plan Sponsor)-funded accounts that help Participants pay for eligible medical expenses. HRAs do not include any Participant contributions.

HRA Administrator
The HRA Administrator is the organization that determines eligibility for reimbursement of HRA Claims. For the HRA provided through Via Benefits, the HRA Administrator is PayFlex Systems, USA (as selected by Via Benefits).

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

ID Card
The term ID Card means the identification card that contains your Participant information. Your ID card is issued to you by the Issuer for your individual health coverage policy.

Issuer
For medical and hospitalization services and prescription drug benefits provided under the Issuer's medical Benefit Options, the term Issuer means the provider of your Medicare SupplementalPolicy through Via Benefits.

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 as 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.

Medicare Secondary Payer Small Employer Exception (MSPSEE)
MSPSEE is the exception granted by the Centers for Medicare and Medicaid Services (CMS) to an employer who employs fewer than 20 employees and the employer's group health plan is the secondary payer while Medicare pays primary for health claims.

Medicare Supplemental Policy
The Medicare Supplemental Policy is the individual Medicare Supplemental coverage you select through Via Benefits; it is also called your "policy."

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 Co-insurance, Co-payment or Deductible. In other words, Out-of-Pocket is the amount that you as the Participant is responsible for paying "out of your own pocket."

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. When an individual reaches the annual Out-of-Pocket Maximum, the coverage through the Issuer then will pay 100% of additional eligible charges for covered services for that individual 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 or Medicare guidelines.

Participant
The term Participant for this Plan typically means retired Employees of Plan Sponsors who are eligible to participate under the Plan's terms and the Plan Sponsor's Adoption Agreement. References to "you" and "your" throughout this SPD are references to a Participant. In some cases, Participant may also refer to an actively employed individual at least 65 years old or a disabled individual who is eligible for Medicare supplement benefits under the Plan Sponsor.

Plan (HRA Plan)
The Plan is the Via Benefits HRA-only group health plan sponsored by your conference or employer for Medicare-eligible participants.

Plan Sponsor
The term Plan Sponsor means your Conference or your employer if it has executed an Adoption Agreement for Via Benefits.

Plan Year
The term Plan Year means the 12-month period ending on December 31 of each Calendar Year (i.e., January 1 through December 31).

Policy
The Policy is the individual Medicare Supplemental coverage you select through Via Benefits.

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

- the General Conference;
- a general agency;
- a Jurisdictional Conference;
- a Conference or annual 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.

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 Your Plan Sponsor (HRA Plan Administrator)

Plan sponsor name: _____

Street address: _____

City, State, Zip: _____

Phone number: _____

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

Agent for legal process: _____

Street address: _____

City, State, Zip: _____

Phone number: _____

Name and Address of the Third-Party Administrator for HRAs

PayFlex Systems USA, Inc.
Via Benefits
P.O. Box 981156
El Paso, TX 79998-1156
Fax: **1-844-930-0236**
All questions about HRAs should be directed to Via Benefits at **1-866-249-7785**

Internal Revenue Service Identification Number

The corporate tax identification number assigned to this plan sponsor is _____.

Method of Funding Benefits

HRA benefits are self-funded or self-insured from accumulated assets and are provided directly from the Plan Sponsor. Medicare Supplemental Policy benefits selected through Via Benefits are fully insured products provided by the applicable Issuers.Behavioral health benefits for non-working Medicare-eligible Participants, if applicable, are fully insured products provided by the applicable Issuer.

Wespath
BENEFITS | INVESTMENTS

Caring For Those Who Serve

1901 Chestnut Ave.
Glenview, IL 60025-1604
wespath.org