wisconsin conference
UNITED METHODIST CHURCH

c/o Amwins Group Benefits
50 Whitecap Drive
North Kingstown, RI 02852

Wisconsin Conference of the UMC

2022 Retiree Medical Program

Your Retiree Health Benefits

Your 2022 Retiree Medical and Prescription Drug Benefits

This Post-65 Retiree Medical Program is available to you and your Medicare eligible spouse. To participate, you must be 65 or older and enrolled in Medicare Parts A & B.

The new program is administered by Amwins Group Benefits, LLC, a division of Amwins Group Inc. Amwins is known for its high customer service standards and specifically caters to Medicare-eligible retirees.

The retiree medical plan picks up where Medicare leaves off and is underwritten by United American Insurance Company. The retiree medical plan is based on utilizing Medicare directly as your primary coverage, with a supplement to address some of the deductibles and co-insurance within Medicare Parts A and B.

In addition, the program includes prescription drug coverage, utilizing a Medicare Part D plan for prescription drugs. The Medicare Part D prescription drug plan is underwritten by Express Scripts Insurance Company.

How to Enroll

- Review the information in this booklet.
- Determine your monthly payment on the "Payment Summary" page.
- Complete and sign the enrollment forms.
- Complete the Direct Payment Authorization form and include a voided check, if interested in monthly automatic withdrawals from your bank account.
- Include a check made payable to Wisconsin Conference of the UMC/Amwins Group Benefits, LLC for the first month's payment.
- Please return your completed documents to:

  Rev. Jean Ehnert Nicholas
  Conference Benefits Officer
  750 Windsor Street, Suite 104
  Sun Prairie, WI 53590

Your enrollment form and first month's payment must be received in order to activate your benefits.

If you choose not to participate, complete the enclosed Waiver of Coverage.

If you have any questions or need help with enrolling, please contact
Amwins Group Benefits Customer Care Center
Toll-Free at 1-877-248-2337
Monday through Friday, 8:00 AM to 8:00 PM EST

Retiree Medical Insurance Plan Summary of Benefits

Underwritten by: United American Insurance Company

Part B Deductible: $233.00
Out-of-Pocket Max: $1,500.00 *(Includes Part B Deductible)*

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD*

Services	Medicare Pays	Plan Pays	You Pay
HOSPITAL CONFINEMENT BENEFIT* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	**$0**
61st through 90th day	All but $389 per day	$389 per day	**$0**
91st through 150th day (While using 60 lifetime reserve days)	All but $778 per day	$778 per day	**$0**
Once Lifetime Reserve days are used:			
Additional 365 days:	$0	100% of Medicare Eligible Expenses	**$0**
Beyond the Additional 365 days	$0	$0	**All costs**
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	**$0**
21st through 100th day	All but $194.50 a day	Up to $194.50 a day	**$0**
101st day and after	$0	$0	**All costs**
BLOOD DEDUCTIBLE – Hospital Confinement and Out-Patient Medical Expense When furnished by a hospital or skilled nursing facility during a covered stay.			
First 3 pints	$0	3 pints	**$0**
Additional amounts	100%	$0	**$0**
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	**Balance**

Retiree Medical Insurance Plan Summary of Benefits

Underwritten by: United American Insurance Company

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

Services	Medicare Pays	Plan Pays	You Pay
OUT-PATIENT MEDICAL EXPENSES - - **In or Out of the Hospital and Out-Patient Hospital Treatment**, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
Medicare Part B Deductible: First $233 of Medicare-approved amounts**	$0	$0	**$233 (Part B Deductible)**
Next Medicare-approved amounts	Generally 80%	$0	**20% up to $500 (including Part B Deductible)**
Next Medicare-approved amounts	Generally 80%	16%	**4% up to $1,500 (including Part B Deductible)**
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	**0%**
Part B Excess Charges (Above Medicare Approve Amounts)	$0	100%	**0%**
BLOOD			
First 3 pints	$0	All costs	**$0**
Next Medicare Approved Amounts**	$0	$0	**$233 (Part B Deductible)**
Next Medicare-approved amounts	Generally 80%	$0	**20% up to $500 (including Part B Deductible)**
Next Medicare-approved amounts	Generally 80%	16%	**4% up to $1,500 (including Part B Deductible)**
Remainder of Medicare Approved Amounts	80%	20%	**$0**
CLINICAL LABORATORY SERVICES			
Blood tests for Diagnostic Services	100%	$0	**$0**

Retiree Medical Insurance Plan Summary of Benefits

Underwritten by: United American Insurance Company

MEDICARE PARTS A & B

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE – Medicare Approved Services:			
Medically necessary skilled care services and medical supplies	100%	$0	**$0**
DURABLE MEDICAL EQUIPMENT			
First Medicare Approved Amounts**	$0	$0	**$233 (Part B Deductible)**
Next Medicare-approved amounts	Generally 80%	$0	**20% up to $500 (including Part B Deductible)**
Next Medicare-approved amounts	Generally 80%	16%	**4% up to $1,500 (including Part B Deductible)**
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL - Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First $250 each calendar year	$0	$0	**$250**
Remainder of charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime max

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**Once you have been billed the first dollars of Medicare-Approved amounts for covered services (which are noted with two asterisks), your Medicare Part B Deductible will have been met for the calendar year.

Benefits are paid only for those expenses which have been approved as eligible by the federal Medicare program.

Benefits will not be paid for any expenses which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

The summary of program benefits described herein is for illustrative purposes only. In case of differences or errors, the Group Policy governs.

PRESCRIPTION DRUG PLAN SUMMARY

Underwritten by Express Scripts Insurance Company

American 5-Tier Medicare Part D Plan

This plan offers a five tier co-payment plan for prescription drugs. This is a plan with **no annual deductible.** You will be responsible for the following co-payments for your prescription drugs:

5-Tier Rx	Member Pays: *(30 Day Retail)*	Member Pays: *(90 Day Mail Order)*
Annual Deductible:	$0.00	
Initial Coverage Limit:		
Tier 1: Preferred Generic	$12	$24
Tier 2: Non-Preferred Generic	$12	$24
Tier 3: Preferred Brand	20% ($15 min - $45 max)	20% ($40 min - $120 max)
Tier 4: Non-Preferred Brand	25% ($30 min - $90 max)	25% ($60 min - $180 max)
Tier 5: Specialty	$90	$180
Coverage Gap: *		
Same as above		
Catastrophic Coverage		
Greater of 5% or $3.95 for generic and multi-source drugs, up to a maximum of the copays listed above. Greater of 5% or $9.85 for all other covered drugs, up to a maximum of the copays listed above.		

*After your total yearly drug costs reach $4,430, you will pay the same copay schedule as noted above. The co-payments shown already include the manufacturer discounts on brand name drugs by the Medicare Coverage Gap Discount Program.

MONTHLY PAYMENT SUMMARY

2022 Monthly Rates			
Plan Options	**Monthly Cost Per Member**	**Less Conference Contribution**	**Total Monthly Cost Per Member**
Medical & Rx & Vision:	$360.00	{Option_1}	**{Option_1b}**

Payment Instructions:

- A check for your first month's payment is required
- Please make your check payable to Wisconsin Conference of UMC/Amwins

If you are interested in monthly automatic payments from your bank account, complete the Direct Payment Authorization form and return it with a voided check and a check for your first month's payment.

If you do not sign up for automatic payments, you will begin receiving invoices from Amwins. Please return a check for your first month's payment in the enclosed return envelope. Payments are due on the first of the month.

RETIREE MEDICAL ELECTION FORM

Wisconsin Conference of the United Methodist Church
Underwritten by: United American Insurance Company

You must return your election form to put your coverage in force!			
Retiree Information (Please print)			
Name		Date of Birth	
Address		Social Security Number	
City		Sex	Phone Number
State	Zip Code	Medicare ID# *(From Medicare Id card):*	
Hospital (Part A) effective date *(from Medicare ID card):*		Medical (Part B) effective date *(from Medicare ID card):*	
Email Address		Date of Retirement	
Spouse Information (if enrolling)			
Name		Date of Birth	
Sex		Social Security Number	
Date of Retirement		Medicare ID# *(From Medicare Id card):*	
Hospital (Part A) effective date *(from Medicare ID card):*		Medical (Part B) effective date *(from Medicare ID card):*	
Please Choose Type of Coverage			
Effective Date: __/1/2022 **Check Desired Coverage:**	**Retiree Only**	**Retiree & Spouse**	**Surviving Spouse**
Medical & Vision:			

Please sign and date the next page

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RETIREE MEDICAL ELECTION FORM

Please sign and date below:	
Date:	**Retiree Signature:**
Date:	**Spouse/Surviving Spouse Signature:**
If you are an authorized representative, you must sign above and provide the following information: **Name:_____** **Address:_____** **Phone Number:_____** **Relationship to Retiree:_____**	

Please return signed election form to:

Rev. Jean Ehnert Nicholas
Conference Benefits Officer
750 Windsor Street, Suite 104
Sun Prairie, WI 53590

For Customer Service, please call: 1-877-248-2337
Monday through Friday, 8:00 AM to 8:00 PM EST

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MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM
EMPLOYER-SPONSORED GROUP PLAN

To enroll in Express Scripts Medicare® (PDP)
please provide the following information:

Wisconsin Conference of the United Methodist Church **Desired Effective Date: __/1/2022**

Retiree			
Last Name:	First Name:		Middle Initial:
☐ Mr. ☐ Mrs. ☐ Ms.	Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)		
Sex: ☐ M ☐ F	Social Security Number:		
Home Phone Number: ( )	E-Mail Address:		
Permanent Resident Street Address:			
City:	State:		ZIP Code:
Mailing Address (only if different from your Permanent Residence Address):			
Street Address:	City:	State:	ZIP Code:

Spouse or Surviving Spouse			
Last Name:	First Name:		Middle Initial:
☐ Mr. ☐ Mrs. ☐ Ms.	Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)		
Sex: ☐ M ☐ F	Social Security Number:		
Home Phone Number: ( )	E-Mail Address:		
Permanent Resident Street Address:			
City:	State:		ZIP Code:
Mailing Address (only if different from your Permanent Residence Address):			
Street Address:	City:	State:	ZIP Code:

Emergency Contact: (Optional)	
Name:	
Phone Number:	Relationship to you:
E-Mail Address:	

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Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.
  - OR -
- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Retiree:	Spouse or Surviving Spouse:
 SAMPLE ONLY	 SAMPLE ONLY
Name: _____	Name: _____
Medicare Claim Number	**Medicare Claim Number**
__ __ __ - __ __ - __ __ __ __ ___ Sex ____	__ __ __ - __ __ - __ __ __ __ ___ Sex ____
Is Entitled To **Effective Date**	**Is Entitled To** **Effective Date**
HOSPITAL (Part A) _____	HOSPITAL (Part A) _____
MEDICAL (Part B) _____	MEDICAL (Part B) _____

Select Your Enrollment Options Below (Please Check Desired Coverage)

Please check which plan you want to enroll in:

Retiree:	Spouse or Surviving Spouse:
☐ Rx	☐ Rx

Important Information About Your Medicare Part D Prescription Drug Plan

Express Scripts Medicare® (PDP) is offered by Medco Containment Life Insurance Company, which contracts with the Federal government. This coverage is Medicare Part D coverage and is in addition to your coverage under Medicare Parts A and B. You must keep your Medicare Parts A and/or B coverage in order to qualify for this plan. You must inform your former employer of any other prescription drug coverage you may have.

Enrollment Requirements

You can be in only one Medicare prescription drug plan at a time. If you are currently in a Medicare prescription drug plan, a Medicare Advantage Plan with prescription drug coverage, or an individual Medicare Advantage Plan, your enrollment in Express Scripts Medicare may end that enrollment.

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Important Information About Your Medicare Part D Prescription Drug Plan
You must live within the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands or American Samoa, and be a U.S. citizen or lawfully present in the United States to participate in this plan. It is your responsibility to inform your former employer of any address changes. You can join a new Medicare prescription drug plan or Medicare health plan from October 15 to December 7. Except in special cases, you cannot join a new plan at any other time of the year. If you leave this plan and don't have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), you may be required to pay a late enrollment penalty (LEP) if you go 63 days or more without Medicare Part D coverage or other creditable prescription drug coverage. Some people may have to pay an extra premium amount because of their yearly income. If you have to pay an extra amount, the Social Security Administration – not your Medicare plan – will send you a letter telling you what that extra amount will be and how to pay it. If you have any questions about this extra amount, contact the Social Security Administration at 1.800.772.1213. TTY users call 1.800.325.0778. Medicare beneficiaries with low or limited income and resources may qualify for Extra Help. If you qualify, your Medicare prescription drug plan costs will be less. Once you are enrolled in this drug plan, Medicare will tell the plan how much assistance you will receive and Express Scripts will send you information on the amount you will pay. If you are not currently receiving Extra Help, you can contact 1.800.MEDICARE (1.800.633.4227) to see if you might qualify. TTY users call 1.877.486.2048. Once you are a member of this plan, you have the right to file a grievance or appeal plan decisions about payment or services if you disagree. Read your *Evidence of Coverage* to know which rules you must follow to receive coverage with this Medicare prescription drug plan. This information is not a complete description of benefits. Contact Express Scripts Medicare for more information. Limitations, copayments and restrictions may apply. Benefits, premium (if applicable) and/or copayments/coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Express Scripts Medicare can release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.

I also acknowledge that Express Scripts Medicare can release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations.

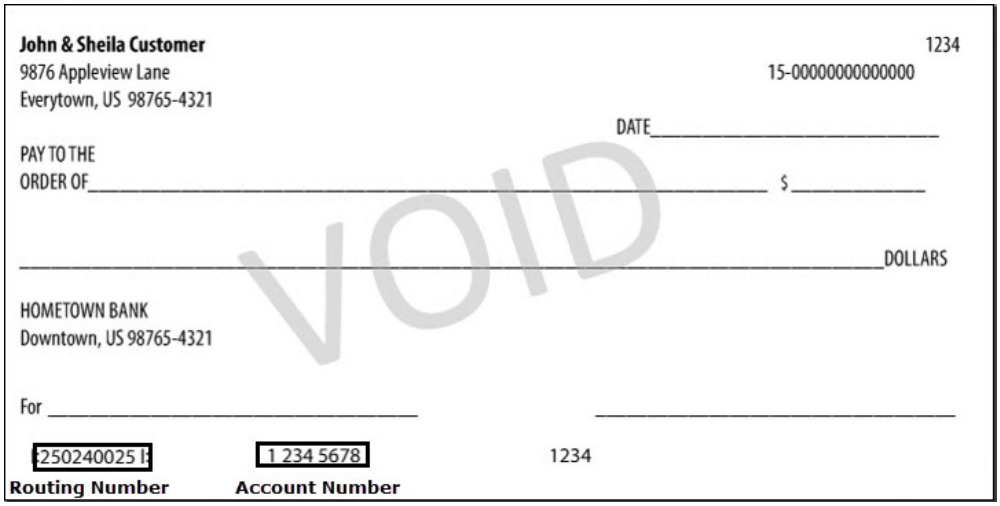
Retiree's Signature:	Today's Date:
Spouse or Surviving Spouse's Signature:	**Today's Date:**

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

DIRECT PAYMENT AUTHORIZATION FORM

Please read, sign and return with your Enrollment Forms

Name (Last, First, Middle Initial):		
Phone:		
Street Address:		
City:	**State:**	**Zip:**
Type of Account: ☐ **Savings** ☐ **Checking**	**Select Monthly Withdrawal Date:** ☐ **1st** ☐ **8th** ☐ **15th**	
Please fill in the below information:		
Routing Number:	**Account Number:** **Confirm Account Number:**	



Monthly payments are withdrawn on the 1st business day on or after the date you selected above. You will receive a confirmation from Amwins Group Benefits that we have set up your account information to withdraw from your designated bank account.

Note: Your monthly deduction will show as **Amwins** on your bank statement.

I authorize Amwins to withdraw my payment as communicated to me, by invoice or letter, from my checking or savings a ccount. I agree to notify Amwins in writing or by phone, if my account information changes or to stop the direct debit aut horization at least 10 days in advance of the scheduled transfer. I understand that the premium to be withdrawn may cha nge, in which case I will be notified in writing at least 10 days before the new premium is withdrawn. To the extent I have enrolled in preauthorized checking, I understand that the addition or removal of a dependent will impact the amo unt withdrawn, and hereby consent to such change. I understand that Amwins will confirm the new preauthorized amou nt, but depending on when I submit this request, such confirmation may occur after the amounts are withdrawn from my account. If my account is erroneously charged, my financial institution will immediately credit the same amount to the ac count up to the 15 days following issuance of the statement or 45 days after posting, whichever occurs first.

Signature:	Date:

WAIVER of COVERAGE

If you DO NOT wish to enroll in the Wisconsin Conference of the United Methodist Church Plan(s), please complete, sign and return this Waiver of Coverage form.

Retiree		Spouse (or Surviving Spouse)	
Name:		Name:	
Address:		Address:	
City:		City:	
State:	Zip Code:	State:	Zip Code:

Please Sign & Date Below:	
NO, DO NOT ENROLL ME (us) in the Wisconsin Conference of the United Methodist Church Plan(s). I (we) understand that by choosing this option, I am (we are) declining medical and prescription drug coverage, and will not be able to re-enroll at a later date.	
Retiree:	Date:
Spouse (or Surviving Spouse):	Date:
All applicable signatures are required for individuals declining coverage in the Plan.	

Reason for Declining Coverage:

ANSWERS to YOUR QUESTIONS

Q: Who can I call if I have questions?
A: Please contact the Amwins Group Benefits Customer Care Center toll-free at 1-877-248-2337, Monday through Friday, from 8 a.m. to 8 p.m. EST.

Q: How does the plan work?
A: Medicare has coverage gaps which are the costs that you must pay, like coinsurance, co-payments, and deductibles. This plan helps fill those gaps. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and then your plan pays based on your plan's benefits. You will receive a Medicare Summary Notice in the mail (in most cases each month), including information on the amount paid on your behalf and any additional amount due.

Q: Can my age 65 spouse enroll if I am not yet age 65?
A: Yes. As long as your spouse is eligible to participate in the Program and is age 65 or over. As soon as you become Medicare eligible, you can enroll on the first day of the month in which you reach your 65th birthday.

Q: My spouse is not yet 65. What will happen to coverage for my spouse after I enroll in this plan?
A: Your spouse will continue coverage under the pre-Medicare early retiree plan. Two months prior to your spouse attaining age 65, a Medicare enrollment packet will be mailed. At that time, your spouse should contact Social Security to enroll in Medicare Parts A and B in order to be eligible to enroll in the group Medicare Plan.

Q: Will I have to re-enroll in the Plan next year?
A: No, once you enroll, you remain in the plan unless you elect to terminate coverage.

Q: When will I receive my ID Cards?
A: ID cards will be sent once we process your enrollment materials. Medical and Prescription Drug ID cards will arrive in two separate packages.

Q: How are my medical claims paid?
A: As long as your physician accepts Medicare you will not have to send in any claim forms. Present your ID card along with your Medicare card to your doctor. Medicare pays the provider of the Medicare portion of your claim and forwards the balance due to the claims administration department. Remaining amounts will be billed to you.

Q: Do I still need my Medicare ID Card?
A: Yes. You will continue to use your Medicare ID card with this plan in conjunction with your Plan ID card.

Q: How can I find out if my drugs are covered on the new plan?
A: You will receive a copy of the formulary (List of Covered Drugs) in your fulfillment packet once you enroll. Some covered drugs may have additional requirements or limits on coverage. You can find out if your drug has any additional requirements or limits by reviewing the formulary. If your drug is not included on the formulary, you should first contact us and ask if your drug is covered. Please contact Amwins Group Benefits Customer Care toll-free at 1-877-248-2337 for more information about your prescriptions.

Q: How can I lower my drug expenses?
A: Generic medications often cost less than brand-name counterparts. Talk to your doctor to determine if a generic is available. You may also have the option of mail order, where you can receive up to a 90-day supply for one mail order co-payment.

Q: What services are not covered?
A: Services not covered by Medicare are not covered by this plan. Please contact us for the Medicare exclusion list. You may also call 1-800-MEDICARE or visit www.medicare.gov.

Disclaimer: The benefit information contained in this brochure is subject to change at any time, and the Company reserves the unlimited right to make benefit plan changes at any time. Any changes to the benefit plans implemented by the Company will be considered effective, regardless of whether notice has been given, on the date set by the Company. If you are ever in doubt about your retiree medical benefits, please contact Amwins Group Benefits at 1-877-248-2337.